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SENATOR HEIDEMANN: (Exhibits 1 and 2) If everybody is ready, I think we're going to go ahead and get started, and hopefully Ruth will be here shortly to join us. Thank you all for coming today. Senator Johnson and Senator Jensen weren't able to be with us today. They are both out-of-state so they asked me to help run things today, so please bear with me. With that, we'll get started. We need to approve the agenda, and if there are no objections we're just going to go ahead and approve it. Everybody is okay with it. Okay, the agenda is approved. And now we have to approve the minutes from the August 8 meeting, and if there are no objections to that, we'll approve that also. Okay, the minutes are approved. Now on number 4, the feedback from the Hastings and the York tours, which I was in Boston and wasn't able to go so I missed that, so fill me in. []

SCOT ADAMS: Well, just to get conversation started while everybody else collects their thoughts, there was time spent at the Hastings Regional Center. We broke into a couple groups, Senator, to take the tour, three groups to go around the different facilities, buildings, and that, and program descriptions were given about what is going on there. I wasn't in all groups but it was an animated conversation back and forth, and led to providing additional information in written format after the fact to a number of members. And so I think that part of it was positive. Tom, I think, was a wonderful host at York, and as a former private-sector guy, you could just see the opportunity to sort of kick in to gear with potential donors come to the fore. None of us are probably potential donors to Epworth Village. At the same time, this is sort of a knack that Tom has, and the record should reflect how good he is at that, at that particular task. In any event, I think we also had a good, clear understanding of the services there and the important role that they play, as well. []

SENATOR HEIDEMANN: Sounds good. []

SCOT ADAMS: I think it was good time spent. []

SENATOR HEIDEMANN: Any other feedback or thoughts? []

BETH BAXTER: Just a comment about the Hastings Regional Center tour. I mean, I appreciated the opportunity to meet there and have the public comment. I think it's probably important for the community to have an opportunity to understand what this task force is doing. I think on the tour what I found really interesting and wished maybe we could have done a little bit more of it, was actually talking to the youth. When we were probably halfway through, some of the youth groups were coming back from an activity, and so that was really helpful. Kathy kind of initiated some questions with a couple of the youth, and I would really recommend maybe we have an opportunity that somebody do that, talk to the kids there a little bit more about their experience, because that was really helpful. []

KATHY MOORE: Yeah. I think that...I guess I had two or three thoughts, and that was one that you just touched on. I think whenever we can talk to youth, that's always helpful, and there's a couple of ways to do it, either informally like we did, or when I've toured other facilities in other states sometimes they'll just convene a group of youth or you can join one of the groups and just pose questions. And kids usually really appreciate learning that there are people who care who are trying to discern services that they're receiving who want their opinion and who might then take that information forward. So it's usually very rewarding to the kids who particpate in there, as well as insightful to us. I think, secondly, in terms of the public input opportunity, I wished that we had, in you will, done a bit of a presentation about the Hastings Regional Center prior to getting the public comment, because people spoke based on their community perspective, but it wasn't necessarily reflective of the current Hastings structure or capacity or whatever. So in a public meeting opportunity in the future--I mean, it was our first one, I think we were all just kind of pulling it together--it might be nice to give a bit of a presentation about whatever the facility or the topic is, and then also receive public comment, because there was a lot...a lot of the comments were directed at the LB1083

issue, the adult exodus, and the adult capacity that hasn't been developed. But it wasn't really direct...and it was just saying, don't do this to children, as well, which didn't really reflect the reality of the child population there. And then probably the only other thing I realized after we left that we hadn't toured, they were in the process of moving the school and the cafeteria because the air conditioning has now broken in Building 3, and so we didn't tour those areas. And I had toured those areas previously, but for people who hadn't previously toured them, that might be a good idea for folks to get that perspective at some point. []

LIZ CRNKOVICH: This is more a question than a comment, because talking about the kids and talking to the kids, and I don't know how you would do it, but is there any merit in tracking a couple of the kids that are there in terms of discerning what services they've already been provided prior to any commitment there? Because I wonder if that wouldn't give a picture of what is out there or lacking out there in different parts of the state? And I guess you would have to think it through in terms of how you...you know, the confidentiality issue and the (inaudible), and I don't know if that would be helpful or (inaudible). []

SCOT ADAMS: You know, I'll leave the decision and the judgment about helpfulness up to others, but we could easily redact identifying information and give you the treatment histories and backgrounds on individuals for folks. I have seen the Medicaid thing, and usually each kid, there are multiple pages of treatment experience. []

LIZ CRNKOVICH: Well, and again that could tell two things. It could...one, it could talk about services and the effectiveness of them. The other could talk about, I don't want to use the word pathology, but the nature of the dynamics of the individual youth too, in terms of (inaudible). []

BETH BAXTER: Or the system. []

LIZ CRNKOVICH: Right. []

BETH BAXTER: I mean, oftentimes, it's a reflection of how the system works or doesn't work. []

LIZ CRNKOVICH: Approached. Right. []

SENATOR HEIDEMANN: Tom. []

TOM McBRIDE : One of the things, or a couple of the things, I was really encouraged by the fact that when you talk to staff out there, they believed that their program was doing what it was designed to do. And I am a firm believer that if you have people working for you in a program or working with you in a program that don't believe they have the best program, they should probably look somewhere else. And the people that we talked to really believed in what they were doing. Kind of dovetailing with what Liz had said there, I think that it would be interesting, and it surprised me that there was no aftercare follow-up, you know, no tracking post-discharge. When we have to pay a great deal of attention, and it's very difficult, but it would be nice to see that post-discharge (inaudible). []

LIZ CRNKOVICH: In fact, in drug treatment, isn't...? I mean, the more I'm learning about it, the aftercare is absolutely key, that without a really good concrete aftercare plan, it's kind of a (inaudible). []

CANDY KENNEDY: Yeah, I would agree. I would have also have liked, as well as the youth, but maybe family members, as well, as how that journey was for them, how effective, what worked, what did not work, and today, aftercare. []

LIZ CRNKOVICH: Because I think you can follow it backwards, then, into those things we want to work on: prevention, community, that type of thing. []

KATHY MOORE: Yeah, it would be nice to be able...there were just three youth in the mental health RTC beds, and so it would be very, very helpful to look at those three and get the history, their placement history, to really understand...and maybe even look...I think that there were ten in there as of April, or some date immediately prior to June. So it would be useful to get the profile of perhaps all ten of those, look at where those others are, and just see how thick that file is or what placement options, and then take a separate look at the substance abuse kids. But in looking at those kids, it would also be useful to do, because I think what Liz is saying is, there doesn't appear to be follow-up...not only is there not aftercare treatment for most of the kids, but there also isn't follow-up in terms of how well they're doing and whether they have other repeat events, etcetera. []

CANDY KENNEDY: Yeah, and I know Liz had a little personal history because she was familiar with some of the youth that were there, so she understood... []

LIZ CRNKOVICH: More than one, unfortunately. []

CANDY KENNEDY: Yeah. She understood some of the history. []

SCOT ADAMS: I'd like to just sort of clarify for you, while there may not be a great deal of aftercare provided by Hastings Regional Center, everybody leaving there has aftercare planning (inaudible). []

LIZ CRNKOVICH: Right. Right. []

SCOT ADAMS: And so I just wanted to make the distinction between who...what the (inaudible), and so what part of the system of also doing the tracking and all those other things. []

LIZ CRNKOVICH: And is it concrete in terms of each individual...yeah, that's true. []

TOM McBRIDE: And one of the things they are not finding out is even though you have those services in place, is did they, in fact, take place, and where is that youngster...you know, how they function, and stuff, and it's a tough thing to do, it's a tough thing to follow. []

SENATOR HEIDEMANN: Ruth, we're just getting feedback from the Hastings tour. If you have anything to...you'd like to add, comment, or... []

RUTH HENRICHS: Probably not right now. []

SENATOR HEIDEMANN: Okay. []

JEFF SANTEMA: I'm just curious, Senator Heidemann, for how many of the task force, was this your first time seeing the Hastings Regional Center (inaudible)? []

TOM McBRIDE: Well, we were on a short timeframe for the York tour, so if anybody wants to come back, we'll be more than happy to give you the buck-and-a-half tour. []

KATHY MOORE: Well, and what might actually be interesting would be to also look at the profile of ten of your kids and look at the (inaudible) between them. I think that could be...that would help give us the system perspective that Beth was talking about. []

TOM McBRIDE: We can certainly do that. []

SENATOR HEIDEMANN: Any other additional comments or feedback? []

CANDY KENNEDY: I was very impressed with Tom's facility and how he is focused on the education piece, as well. I thought that was very important and very commendable.

[]

TOM McBRIDE: Thanks. []

RUTH HENRICHS: You know, I think mine is a very general observation. I hadn't been there in years and years, but it was the vastness of the campus and the underutilization, so many buildings, and it just seemed like it was an old place in a very lovely place, but it was troubling to me when we left. I mean, it was just the general overall experience of being there. So many buildings that we're maintaining that are not used, are not usable. And I guess if I had any encouragement, it was that we have reorganized now in the HHS department, and we're going to operate on a CEO model, and that to me brings hope, because, to me, there are a lot of just pure business decisions that that visit welled up for me. And I would love to see cost analysis on tearing things down and rebuilding right on the spot. I don't care. I'm not arguing one way or the other on that. But to me it was just, I'd love to see the business side of that campus and how it could be utilized more efficiently for the people of this state and for the children. I wouldn't...you know, that was hard for me to see those buildings (inaudible.) []

SENATOR HEIDEMANN: I've been through Norfolk but I've never been through Hastings, and I need to do that. And that was an eye-opener. I went through there this summer. You talked about the air conditioning was broke down. What's the general upkeep of Hastings, do you believe? []

KATHY MOORE: Well,...and we tried to get a handle on some of that, and I think we're going to have to, at some point, perhaps devote a meeting or a half a meeting to that, because we have our map of...and it's in the Chinn report and we may want to revisit this discussion when we get to the Chinn report. The campus itself is mowed and kept presentable, but the actual number of buildings...and I'm going to pull these a little out of the sky, but there's about 12 buildings, and the utilization of one of the buildings, Building 7, is now going to house the majority of the youth programming because that's

where they're moving the school and the cafeteria to, or back to. There is still some vacant space in that building, and then this adult program, the Bridges, is in a second building which I think is Building 8, but they are only utilizing the third floor of that building. And again, I don't have square footage, but it's pretty huge. Then there is the administration building where we first met, which is utilized for some training of staff and I think some other external folks, but I don't...I'd like to look at the calendar, if you will, the number of people that utilize it, etcetera, and then there is a chapel, so that... []

BETH BAXTER: Actually where we were was kind of the education-type (inaudible). Administration (inaudible). []

KATHY MOORE: Oh, that's right, the education...so that's five. []

BETH BAXTER: But I think the Hastings Regional Center and the Norfolk Regional Center just, you look at them physically and they tell a story of what has happened, not only in Nebraska, but I think nationwide with just how we look at mental health and substance abuse service and care for individuals. I mean, I think they really are a reflection of this move towards recovery orientation and moving people back into the community, and those types of things, so. And I don't think anybody disagrees that HRC has worked really hard to try to maintain and develop even a physical environment that's conducive, that people want to be there. But it's just really a challenge, I think, just because of how old the buildings are, the vastness. I mean, my goodness, I mean they housed maybe a couple of thousand individuals when they were (inaudible.) []

KATHY MOORE: And they now have 50 or 60, so there is now way you could compare. []

BETH BAXTER: And another challenge for them too is just what we experience, you know, statewide, with this healthcare-short individuals. You know, they can't...they don't have a pharmacist any longer, and you know that's just a challenge. They don't have a

psychiatrist, they don't have psychiatric...you know, psychiatrists there. And those are environmental issues that the state can't impact real well, that just make it kind of much more challenging to maintain those effective (inaudible) there. []

SCOT ADAMS: If I could just add a couple of comments, Senator, in particular. One would be that if we want accurate information in regard to what's going on at Hastings, Will Gibson, the CEO of Hastings is in the room, and so he could describe the buildings and what goes on accurately. Secondly, Beth, I don't disagree with what you said. They certainly were facilities that were built for, at one time, housed 2,000 people there, and now we're measured in scores. But I did want to sort of temper something you said. While we don't have the pharmacist on staff, we do have pharmacy services that has been privatized with the local provider, and so the service is available. Likewise with the psychiatrists. We do have a psychiatrist who does physically come out and who is available via telephone from the Lincoln area, but we don't have a psychiatrist on staff. So I'm not quibbling with you overall, but wanted to just sort of temper some of what you said (inaudible). []

BETH BAXTER: Well, and I think my...I guess my point really is just, those are environmental factors that impact our whole system, that's just a challenge for all of us, and then I think creates some extra challenges for Hastings in that. So it's... []

SCOT ADAMS: The traditional way of doing business is very much changing. []

LIZ CRNKOVICH: Well, I'm 100 percent Irish so I've never been politically correct in my life, but is our whole juvenile justice planning going to center on Hastings and what happens in Hastings? Because from a judicial perspective, while I want kids close to family, I want the services that they need in the state of Nebraska. And if they're in Hastings, that's fine, but I think there has to be some discussion about whether that means getting rid of this old stuff and building up something new, or are we beating a dead horse, trying to preserve what's there instead of changing it and making it new

without detracting from the community of Hastings, as well? That was one thing from the public hearings that everybody who came to that public hearing had a genuine concern about our task and about kids, but had also a genuine concern about their community and what's going to happen in their community. And I think we have to...how do we recognize both of those things and kind of balance them so that we don't put up inadvertently a roadblock to what, frankly, the court's main concern is, is having that whole array of services for kids across the state? And we kind of don't talk about that, but we all had impressions about the program, and (inaudible) frankly was glad that you kind of spoke about the physical setting, because it is the elephant in the room and we have to (inaudible). []

RUTH HENRICHS: Well, even the Chinn report talks about what is acceptable and expected for the treatment of children today, and it's not the same as it was. It's not dormitory style, it's not 30 kids lined up in beds. And we've done our best, as a state, to put money there, it sounds like, to do what beginning renovations that we can do. But I guess I want to go back to the point, I totally agree with you, I'm not speaking against...you know, I know there are politics in every decision, and I understand the value of that campus to the community in Hastings. And I want to temper and put with, if that needs to be "equationed" in, then I want us to be very diligent in saying, okay, if there are these factors that say we need to stay there, and that's not a negotiable, I would want to be strongly in favor of looking at what is the best treatment facility and type of treatment for children on that campus. And if that's selling the farmland around it that we own, and tearing down old, inefficient buildings, and building something new in Hastings that is what the state needs, I want to speak in favor of that. I want our children to receive the best possible care, taking into account the dynamics that I know we have to play with. []

KATHY MOORE : And I think the other thing that needs to be factored in, there was a hearing between our tour and this meeting about allowing an exception for a two-year period of time for government agencies to have more than two 20-bed units. And the

rationale for that is that when the kids were moved from Lincoln to Hastings a year and a half ago, I don't know why but the rule that two 20-bed limit was not factored into that decision or it was decided, and say bottom line is, the kids who have been in other than the substance abuse beds, have been paid for out of general fund money. And so this exception would allow the other kids in the RTC beds to be paid for with Medicaid dollars. And while that seems prudent for the state to utilize federal money, there also was that question of whether we were talking about expanding Hastings. And I guess I would like us to really look at this from a blank page approach, as Ruth, I think, and Beth and everybody, what is it that we would design? If we didn't have the Norfolk Regional Center, the Hastings Regional Center, it felt to me like our task under LB542 was to figure out what it is we would put forward as the ideal system. But at some point we then have to interface those other realities, the realities of this pending regulatory change, the reality of the Hastings community's needs. And it appears as though everyone is really waiting for the recommendations of this committee by November to begin to guide a variety of next steps, so we've got to have some level of detail to our discussion that equips us to appropriately make a recommendation about Hastings. Even though the intent of LB542 was broader than Hastings, I think we have to make sure that we've got the knowledge to make a specific recommendation about Hastings. And that may mean anybody who didn't tour, touring; it may mean some of us going back; I don't know what that means. []

SENATOR HEIDEMANN: This is...just very blunt, in your opinion is there a need for a Hastings-type setting? []

KATHY MOORE: I don't think so, very blunt, and I'm not Irish. []

LIZ CRNKOVICH: (Inaudible) excuses for me. (Laugh) []

KATHY MOORE: If I...in the ideal world, what I would do is create some beds. And I've not done enough research to tell you exactly how many, but I would probably create

about ten beds out in the Panhandle someplace, and I would create 20-ish beds in central Nebraska, and I would create 20-30 beds in the eastern end of the state. And those beds would be for a variety of services. Some would be substance abuse, some would be sex offender treatment, some would be RTC for behavioral health issues. And then I would build around that this whole system of care within the juvenile justice system similar to what Missouri has done in their regionalized model, whereas in each region, they have this array of about seven levels, if you will, of care, treatment, and punishment. []

SENATOR HEIDEMANN: So instead of seven, you would think three different areas. []

KATHY MOORE: Oh, well, the size of the state...in Missouri, within each region, they have seven levels of care. And so in Nebraska, I would say we would need at least three regions, maybe five, with that same array, with that same mix of levels of care, treatment, and punishment. []

SENATOR HEIDEMANN: Scot, same question. And this is all for my benefit a little bit, and I don't want to get too far off here, but to me it's beneficial anyway. []

SCOT ADAMS: A couple of ways to go about answering that question sort of objectively, and then responsive to Kathy. What I would say is, today there appear to be a need for the Hastings Regional Center by virtue of the nature of the background, where most of the kids...in fact, I think I can say 100 percent of the kids have had prior treatment experiences in the community settings at different levels, who are still in need of some treatment experience. So that's sort of point one. Point two is, as a state--this is less tangible--but as a state we seem to have an attitude among courts, among providers, in particular, that if a kid fails at a lower level, that the only step is a more intensive level. We know that that's a true statement. But that's a culture. If a kid blows up in a lesser level, there's a tendency... []

LIZ CRNKOVICH: It should be a flow back and forth, and not just a flow of up, up. []

SCOT ADAMS: Yeah. But the reality is it just flows up--uphill. And so if that culture could change, then I think the entire game is a new ball game. Point three: The idea of five centers is a very expensive proposition. 24/7 operations are just expensive and would require far greater resources. A subpoint to that: In the last year or so we've had about ten from the Scottsbluff area and 100 from Lincoln and Omaha, and then a smattering of maybe another dozen from the other parts of the state. The nexus really is Omaha and Douglas/Lancaster. I mean, you solve that, you've got 90 percent of the issue addressed in terms of the service area. So I would quibble, perhaps, with that. Point four: Intentioned with that is the language of LB1083 that speaks to community-based services. And I would like to take just a quick moment to say that a community-based has at least two meanings. One means noninstitutional. That is to say, non-regional center, non-state-run institution, and for some people, non-hospital, so it means a lesser level of care. The second meaning about community-based is that it is geographically close. That is to say, it is not, for instance, out-of-state, which would be not community-based, but far away. And so that term, community-based, which is in law now in LB1083, (inaudible) important driving dynamic. That leads to point five, (laugh)...I don't know how may I've got but (inaudible). (Laughter) Anybody who wants to (inaudible) can do this. (Laughter) But that leads to, I think, one of the (inaudible) (laughter), if Hastings is one of the critical questions, and I agree with that, then I think another critical question is, how are we going to fudge on community-based? I don't think we can afford five centers, for example, and we may have to agree that some number of out-of-state placements is okay, whether it's that five, 50, or 500. []

LIZ CRNKOVICH: You know, Kathy mentioned that last...I don't know if it was at Hastings or the meeting before, for a certain population of kids, for example the sex offenders, in the big scope of things it is a smaller number of kids who needs that residential treatment. Unfortunately, they're probably the most dangerous in terms of the repercussions of not being treated. But do we have enough in the state to develop one

center just to treat those kids? And that might be one example. But in...I know you shook your head immediately because you are thinking family, which is appropriate. Kathy, you made an interesting comment about kind of a multistate compact, if you will, you know, between states in close proximity who might say we could collaborate--fight over which state is going to house the facility--but a place where we could all have.... I don't know. Those are...I mean, I do think thinking bigger than that and not just totally black and white. []

SCOT ADAMS: And in essence, that's what we have now. We have, I think 34 kids in some quasi-level of interstate compact that they are out-of-state. []

LIZ CRNKOVICH: But they're all over (inaudible). []

SCOT ADAMS: Well, out of state is still out of state (inaudible). Missouri (inaudible). []

KATHY MOORE: Well, what I was suggesting is that we are within a four-state federal HHS region, and there has been discussion off and on through the year about Iowa, Nebraska, Kansas, and Missouri, sitting down and saying I'm going to specialize in this category of child. And building into that planning process, funding for transportation for family to get there, etcetera, because I agree, the ideal is to have them in close proximity. Close proximity can be accommodated through transportation and other matters, to some degree in extreme circumstances. It's not ideal. Right, exactly. What I don't want to do is walk away from this conversation with having proposed five facilities. What I was trying to say is that regionally...and we already have regions; we have three districts...I don't know what they're called right now. []

SCOT ADAMS: Six. []

KATHY MOORE: Six, whatever...within each of those, what I want is a decision-making process that says I need close proximity to X number of beds, but I also need close

proximity to aftercare, to outpatient services. I wasn't just talking bricks and mortar; I was also talking purchase of service. And as an example, I just got back from Scottsbluff last week where they are building a very large new detention facility. And in talking with the director of that facility, he actually tried to persuade his county commissioners to build fewer detention beds, and instead build some beds for staff-secure, for residential treatment, etcetera. So my point is, there are locations that exist where an additional half a million to million dollars could build out to whatever need is identified, as opposed to having a campus with X number of acres and 12 buildings, and us trying to fit what we need within a campus that we're spending between $6 million and $10 million on. So my point is, again, that when I'm talking about this array, I'm only talking a small number of beds. I think we've all acknowledged Omaha and Lincoln sends the vast majority of kids. Hastings' testifiers, if you will, said Omaha and Lincoln wants everything. You know, they believe that we are trying to take their money out of Hastings and put it in Omaha. But the point needs to be made that the children in Hastings have come from Omaha, and that it makes it impossible, or very difficult in the best of circumstances, for their family and their case managers and their school to be a part of their program. []

BETH BAXTER: And I think this is where we go in terms of the system of care concepts, and discussion around, because, Scot, some of your comments too. If we would look at children, where they've been, kids don't fail in placement or services; it's generally the service doesn't meet the individual need of that child. And in just visiting with providers around the discussion, around what the children or the youth who are at the HRC, you know they've failed every place they've been and providers won't take them any longer. And I agree we have to have a safety net within whatever we develop, but also I think what...and it goes to that system of care principles, is we have to have this flexibility. Because if you talk with providers, they say we could keep this youth if we could just have some additional flexibility, or support, or additional staff, or additional.... But we've been fairly rigid, I think, in our service definitions, willingness to pay for those add-ons that would keep a youth in a, wherever they're placed, rather than disrupting that, and

then costing more. So I think it really...it helps us get at all of those discussions around this system of care. []

TOM McBRIDE: You know, whenever you talk about the provision of that care, you certainly have to look at economics of scale for any of us sitting around here. However, if you were looking at the substance abuse beds at HRC, all being paid for at the RTC level of care, if those kids were stepped down into community private provider placements, I think you would see a great deal of those kids that would come out at treatment group home level, which would be a significant savings in and of itself. Despite that, it's still a more costly per diem there than similar treatments modalities in the private sector. If there was a plan coming out of 542 that said we want ten beds out in the Ogallala area, and we as a provider were stepping up to the occasion to build those, we would be looking at leveraging private funds, as well as our own funds, to begin that building process. So I don't know that it would be more expensive. I doubt seriously if it would be more expensive. []

SCOT ADAMS: And I'd like to go back to Kathy's point, because I think it fits in well with what you're saying, Tom, as well. I appreciate Kathy that you were talking about sort of a decision-making process in five areas, in your original thought, as opposed to five facilities per se. And that, I would like to just sort of highlight that as one of the issues I think that this group has to struggle with. We have six behavioral health regions, we have five service areas, and I don't know how many district court processes, each of whom has something to say about this. So we've got too many decision-making processes. What I think we need to have is agreement as to who gets to make the call. []

KATHY MOORE: Which is one of the questions that I sent to Jeff (inaudible): who makes the decision... []

_____: And under what circumstance. []

KATHY MOORE: And who takes ultimate responsibility and who is held accountable. []

SCOT ADAMS: Exactly. []

KATHY MOORE: Those are the three...we need those up on the board. []

SCOT ADAMS: I think those are important, more so than actually the services. []

LIZ CRNKOVICH: This is kind of a question in terms of our ultimate goal. And I know we're all throwing out ideas, but is it the idea that through this process we will, after discussion and throwing out ideas, do some compromising and collaboration to come up with a product that all the varying perspectives can feel comfortable with? That's our ultimate goal. That's a question, right? []

SENATOR HEIDEMANN: I question how we're going to get to that point (laugh) times. []

LIZ CRNKOVICH: But some things...and I don't know, maybe it's just the way...for example, this is the way I think. I know Beth talked initially, at the first meeting. My focus, of course, was those kids in the system, and Beth made the statement, no, we have to deal with them all, in or out. It took me...it was a process for me, in effect, kind of talking to people, to get to where you have to talk about having all the services first and what services do you need...this is by way of saying, Beth, I came around to your way of thinking, okay? (Laugh) And then talk about the divisions within that and how they get there. But we also...I...ultimately, what will help compromise...this is, again, just a suggestion...is having that conversation about the ideals and the common, not a mission statement, but what are some common beliefs that we have as a state about the behavioral health needs of children. For example, again Beth, you just stated one right there: that it is not the children who fail in the system; that it is usually reflective of the services being provided or the right service to meet the needs of the kid. I mean,

that might be one example of a common kind of, this is a philosophy that we share, even if there are ins and outs. Another one might be, just to come up with some definitive statements I think that would guide us toward consensus, ultimately, about a plan that's all things being equal, children should...if they can't be home, they should be as close to home as possible. Now, that doesn't negate what we're talking about too, that occasionally some kids can't be, even when you shake your head. But if you know that there is a general philosophy in the state that as best as we can meet the needs of the child in the home or in the community, and those almost have to be prefaced or premised to our ultimate.... And I don't know how many we need; you know, five or ten; I think we probably, number one, would find that we all agree on those. You've got consensus on that, Beth. []

_____: Beth, are you looking for this, to give this...(inaudible)? []

BETH BAXTER: Yeah, that there's the... []

_____: And (inaudible). []

_____: But if we had it in front of us as we have our discussions. I know we kind of sat around, obviously...a couple of glasses of wine helped a little bit, but (laughter)...and look at what we talked about wasn't government or OJS or judges or anything. We sat and said, in the ideal world, what are the various services that the kids need in the state of Nebraska? And we kind of boxed them into different things, but just laid out, if you had your wishes, your wish list, what would you want? RTC, foster care, home, body, body, body. I think that will get us closer to consensus, because what we're going to get stuck on, I fear, I worry, what we're going to get stuck on is we can't do that because I know what they're going to tell me back when I go back to the office, and we can't do that because I know what they're going to tell me in Hastings, and we can't.... But if we don't come up with a collective ideal goal, we'll never be able to work because we want to also then be able to compromise from that political perspective. But you

can't even do that until you have that (inaudible), can you? []

KATHY MOORE: And I think we can probably...and this, number 6 on the agenda... []

JEFF SANTEMA: Hopefully there will be some things that (inaudible) we will come to, to help in that process. []

KATHY MOORE: Yeah. Because I think a lot of people have given this some thought, and I'm hopeful that you will be pleasantly surprised at how much consensus there is. I think the disagreement or the uncertainty is how we get to that place that we might all agree is utopia. []

LIZ CRNKOVICH: Because another one might be that point...and all right, you can throw up when I say this, but this is what drug court has taught me, is that kids don't just go up, up, up; that it is that whole spectrum where because they're growing up and they're learning at various levels, they might go up, they come back, they (inaudible) a different array of services. []

TOM McBRIDE: That's an important point. I was thinking of Beth's comment, and I'd make 11 points here. (Laughter) You know, I think one of the things (laughter). []

SCOT ADAMS: You could get my job if you get to 11. []

LIZ CRNKOVICH: I jumped ahead because I worried that we (inaudible). We need that open discussion. I just hoped it would (inaudible). []

TOM McBRIDE: Well, when we're talking about this, we've got 500,000 kids under the age of 20, roughly, in Nebraska. There is going to be thousands, tens of thousands of those kids that never access behavioral health services anywhere. There are going to be tens of thousands of children that, if we consider that they touched a treatment

position somewhere, anywhere, one time, and because they had to touch it again it was a failure, we're setting ourselves up for failure. Because these kids are going to move...you know, when you have a severe mental illness, behavioral health issue, some I think we have to realize that there are going to be those kids that...while we work with them, they may be stabilized, out receiving some additional services, working well in that, but they're going to need aftercare, they're going to need follow-up services. And I just (inaudible). []

LIZ CRNKOVICH: Well, probably the first premise is that childhood and adolescence is a process of growing, learning, maturity... []

KATHY MOORE: Testing. []

LIZ CRNKOVICH: Testing. If we don't even acknowledge that basic premise, we're really going to (inaudible). []

KATHY MOORE: Did you have more points? That's only one. []

TOM McBRIDE: I'll settle...I'll defer my other ten to Scot. []

KATHY MOORE: Because I think again we had a brief discussion, I'm thinking at maybe the Hastings meetings, about the word "prevention," because we've all talked about the role of 542 and does it really encompass prevention. And similar to this, as we sat down--and we do have a pretty thing and an ugly thing that we'll pass out--but one of the things that we talked about was that prevention also is an ongoing process; that there is primary prevention that will hopefully keep those tens of thousands, hundreds of thousands, away from the behavioral health system. But then there is the secondary prevention that reaches out to the child when they first touch the behavioral health system, and gives them exactly what they need to keep them in line with normal child development process, and keeps them from having a recurrent second event of

negative behavior or negative illness. And then...but some of those are going to fail, and so some kids are going to keep coming back and back and back, and there we hit tertiary prevention which either prevents them from ultimately going to the correction system or someplace else, or prevents their children, the next generation, from encountering the same. So it seems to me that that whole thought of prevention needs to also be circular and part of the ongoing process, and that that's also a guiding principle, if you will. []

SENATOR HEIDEMANN: I think this has been very helpful, if not to anybody it has been to me. We do need to keep moving on so that we eventually accomplish what we're here to accomplish, so with that we're going to move on to number 5 on the agenda, the SIG information discussion. And for this part of it I'm going to turn it over to Jeff here, and he's going to facilitate that. []

JEFF SANTEMA: (Exhibit 3) Thanks, Senator Heidemann. This is somewhat of a cleanup from your first two meetings when you asked for your concern about what has SIG already done, what has the state infrastructure grant already produced in terms of data, etcetera. This was a summary of information that I think Mark DeKrai put together and he e-mailed this to you prior to the meeting, so this may be a duplicate that's come around. []

CANDY KENNEDY: Actually, I did look at this last night, and I called Pat Lopez because the whole section about the Federation of Families and the regional family organization is not correct, so they're going to make a corrections and send that out. So please ignore what's in here right now. []

JEFF SANTEMA: And you'll notice that in the context of this document there are a number of recommendations. For example, about six pages into the document there are a series of specific recommendations there, with a graph that looks like this. And there are other charts that have recommendations about state interagency advisory, and

there are some specific recommendations in this document, as well. There are things that the SIG grant has done. We have members of the task force who are also members of that infrastructure grant. I don't know that the task force needs to have a lengthy discussion about this. I think two points is maybe Scot if you would like to elaborate a little bit more on the process that went into getting this in formation together, and then maybe the next question is, do you want more from SIG and what it is that you'd like. []

SCOT ADAMS: Thank you. And my apologies; being new I'm not quite sure what has been accurate or not accurate (inaudible). In any event, I...the SIG process is one of those streams that have been moving within the state for about two and a half years. It is about three-quarters of a million dollars per year in resource to the state from SAMHSA, and largely led by Pat Lopez on contract to Health and Human Services, and Mark DeKrai with the University of Nebraska. Others have been key components to that, but in terms of staff day in and day out, those are probably the key folks. It has been led by the Medicaid division, and in that regard a man by the name of David Cygan has been another key staff member to the process; David is no longer with the department. And so that's sort of background. I talked to Pat and to Mark about trying to figure out, because I, literally this stuff is measured by the foot in terms of the product of SIG so far. And not wanting to overwhelm the committee and in talking with Jeff, wanting to come with a reasonable amount of sort of meat, if you will, in terms of material for this group to learn from and to gain from, we came to these documents in terms of the things that we felt were of substance. I certainly would encourage you to have conversation, or I can have that conversation with Mark for other items that you may want, but we tried to sort of identify some of the key stuff either by virtue of indicators or demographics or the thoughts process or the background on SIG to give you sort of a good sense of what's there. Recently, a decision has been made to have SIG be co-led by the Division of Medicaid Services, and the Division of Behavioral Health. The reason for that really is because it's a behavioral health thing, if you will. And a growing sort of policy, I suppose, perspective, it says that Medicaid is an

insurance company but is not a policy arm, if you will, and so movement more in that direction. However, we didn't want to upset the apple cart so badly that everybody got confused and tossed out of the wagon, and so the co-leadership concept emerged. In line with that, then we have had conversations with SAMHSA and with Georgetown University, which provides technical assistance from the national perspective to this. And in short, we have sort of looked at many of the recommendations of SIG, and again you can see those. Many of those have evolved from pilot projects. Some of those are summarized within the material that you have. And the intention of SIG was large systems issues, not unlike what this is about with regard to children's behavioral health. The two are really quite parallel in terms of their task and hopes and dreams. And across the nation, what has happened is there are a number of these SIG grants in process in various states. They start of with sort of the 30,000-foot issues of funding, decision making, structures, service array, that kind of stuff. And then get sort of frustrated with conversation at that level. You know, 95 percent of the folks in the room can sort of agree on 30,000-foot perspectives with regard to children's behavioral health. It becomes sort of the implementation of, Tom, we don't need your service anymore, but we need another one over here, that people get a little nervous about, (laugh) that kind of thing. And so as it comes down to ground level and what a particular principle means in concrete action, that there becomes more controversy and more disagreeing. In an effort to try to keys out some of the dynamics and variables in these sort of large-scale system issues, the SIG tried to develop a series of pilots, and so you see a series of pilots in there. []

KATHY MOORE: And are those starting with...? I just had a brief (inaudible). Are those starting to...? []

SCOT ADAMS: Why don't you hold to that until we get through all that. We may catch that, Kathy. Can you write yourself a note? []

KATHY MOORE: Yes. []

SCOT ADAMS: Okay, thank you, and I just wanted to make sure I get through all the (inaudible). []

KATHY MOORE: Okay. []

SCOT ADAMS: Because even though if it doesn't sound like it, it's a coherent thought to me. (Laugh) Thank you. And so in that regard then, some pilots with that. Now, in the case of any particular pilot, there may or may not, in fact, be a relationship between the on-the-ground experience of testing this out and the larger principle at play. And, in fact, we have some disagreement with that in terms of looking at that, and so I think some of this will be sort of redefined in terms of its directionality. As an example...and this is not to say that there isn't value, it's just that it's sort of off-point from the original SIG (inaudible), in our view. For instance, one of the things that I think was sort of neat, and yet maybe not SIG-like, is the pilot with regard to docs and medications of zero- to 5-year-old kids. You know, if you can change that behavior, okay, maybe. Anybody here every change a doc's attitude? You know, (inaudible)? Where's the judges? Yeah, okay. So, you know, I'm not just sure the big scale issue there that's involved in it. So...and I don't mean to pick on that pilot again. I think there could well be value there; I'm just not sure it's a systems issue so much as a footnote perhaps. So I think we're going to take a look at the SIG direction and process and intentionality, and refine that somewhat. I do not expect wholesale, dramatic, oh-my-goodness changes, but I do expect sort of a retooling and focusing in on larger issues that the state confronts. Thank you, Kathy. I appreciate that. []

KATHY MOORE: My question...I was just trying to follow your conversation. Are the pilots in Attachments 11, 12...? I was trying to discern what all this packet included, and I was having a problem with that. So does the discussion of the pilots begin with Attachment 11, which is about halfway to two-thirds of the way through? []

BETH BAXTER: Which one is that, Kathy? []

KATHY MOORE: The social, emotional, and behavioral screening. Is that the first pilot discussed? []

SCOT ADAMS: No. There is a summary of the pilots in here. []

BETH BAXTER: There's the...what, the mobile crisis? (Inaudible.) And the comprehensive family assessment? []

SCOT ADAMS: Yes. One of them was the financing. For instance, in Attachment 15 you've got basically an effort that begins to describe the financing strategy. This is a good example of what I was talking about at a more general level. One of the problems the system faces is how...Medicaid pays for a service. You bill Medicaid. It pays a bill. How can you best leverage protection and safety and money, Division of Behavioral Health money, perhaps private insurance, Medicaid, perhaps even private pay, first dollars income, in a way that is coordinated, unproblematic, doesn't make parents have to go to court to get ordered in, that kind of stuff. So that's a pretty big...that's a fairly big issue. And then with (inaudible) and the mobile crisis kinds of stuff, the thought was that... []

KATHY MOORE: So is this a pilot, 15 that you're pointing to, or is it just (inaudible)? []

SCOT ADAMS: In and of itself, not, but it touches on the example of what was talked about. Some of the pilots have not done, some of them are (inaudible) on proposed in there. And this represents...(inaudible) the mobile crisis thing was an example to try to test the (inaudible) of funding for mobile crisis intervention services. That's a proposed pilot and this talks a little bit about that and describes it (inaudible). []

KATHY MOORE: Okay. But there isn't a list of the pilots in here? You can tell me later if

you... []

RUTH HENRICHS: Attachment 4 kind of, way in the beginning, Kathy, I think, was some of them. It doesn't necessarily tell you which ones are implemented and which aren't, but it does kind of begin to get to that. []

CANDY KENNEDY: Yeah, but it should be...I think there is, like one of the visuals that (inaudible). []

RUTH HENRICHS: Scot, I have an observation that's just an observation because I was on numerous of these SIG committees. And some of them met twice and then they just lost touch with us, so I want to express frustration. But I would hope...I'm encouraged that there's been some reorganization with what is left of this grant. I want to agree with you that...and I want to encourage you now that you have some leadership on this, to lift it back up to what you said are the difficult...we can talk about it at 30,000 feet, and then when we get down to whether Tom should close and we want something else, that's where we go. I want to encourage you to keep it at the level of where I think your real difficult issues are. I mean, if we can't discuss how we're going to move funding or braided funding or whatever the issue is, yeah, that's tough, and it's state government issues. But Medicaid was leading SIG, and that wasn't going anywhere fast, and I want to encourage you to bump that conversation up, because we get to these task forces every three years, or we get a grant and we can't have that difficult discussion, or we walk away from it and we go to some pilot that might be a really nice pilot. But you're right, Scot, it doesn't get at the underlying systemic issues. It is funding; it is how we're going to pay for this. Tom will survive if he has to close one program and open another. []

BETH BAXTER: I think the SIG...you know, I mean participating in the SIG process, you know. I mean, really, I think if you look at Attachment 2, it's the...Attachment 2, the third page, that really sums up SIG in terms, this attachment here, in terms of the work and

the grappling work that people put into the SIG process. You know, the subcommittees and the steering committees. Now, being a part of the steering committee, some of...and I think this...there was a lot of effort, a lot of people, a lot of effort, a lot of energy and resources put into this. And I think I really has a lot of merit in terms of looking at the infrastructure, kind of a system, and trying to bring it down to another level. Some of the maybe where SIG got a little bit derailed, and maybe it was looking for opportunities to try out some of these concepts. But, and this is just my frank observation as part of the process, I think there were some, like the mobile crisis, that that was an idea somewhere, and the comprehensive family assessments, that these were going to be implemented anyway within the state, but let's see if we can get SIG resources or thinking or ideas behind these (inaudible). But it is almost like let's take what's already moving down the track, and let's try to attach this to it, whether maybe we were going down...you know, we had these ideas here, and we didn't go out and look for what the committee has recommended, really didn't get an opportunity to be further. We looked for things already down the track and let's attach our thoughts to them rather than... []

SCOT ADAMS: The effort was to try to make something concretely over value, that in particular, if they, of protection and safety, could value from comprehensive family assessments, as an example, possibly the crisis stuff, that had systematic implications at a larger level, like the braided funding (inaudible) or earlier intervention rather than waiting for backend interventions, that kind of thing, to make sense. And so it was an effort to take pretty heavy conversation and give (inaudible) concrete value out of that. []

CANDY KENNEDY : And actually a whole thought process involved with everyone involved with that is a whole different thinking when you are talking braided funding, working together, not keeping everything siloed separately. I mean, it's a huge, huge thing... []

SCOT ADAMS: Yeah, it's a lot of stuff, so. []

CANDY KENNEDY: ...and necessary for, I think, for Nebraska to do, to move forward with the infrastructure. So I understand. I understand what Beth is saying about we kind of jumped into it very quickly there. But it was...if somebody was actually doing an action to get that thought process going and to actually do it, so I think that part of it is commendable, as well. Like when you say, we all come from different perspectives, sort of look at things differently, is very difficult. And when you actually see it in action where it's working, it's much more understandable and you can see where that's going. []

RUTH HENRICHS: I just want to encourage us to keep bumping it back up, because the change on the committees that I was on in SIG, always bumped up against change that needed to happen within HHS and Behavioral Health and Medicaid. It was that interrelationship that had to have change in order to get funding and do things differently. And when we bumped up against, we couldn't get the data or they weren't working together, it got bumped down to we need to do something. And so then we funded something...and I agree with you, Scot, that those are probably all good things, but I want to just encourage us to go back to the tough stuff, because you folks, in the state's system, have the data, and you have to figure out how to talk. We want a common assessment. We all pretty much probably agree with that, you know, and access. But we've got to keep bumping it back up to you. And when that got frustrated, we all got sent home from the SIG committees, never contacted us for months on end, and now all of a sudden these little pilots popped up. I'm not being cynical. I'm trying to be straight and say we've got to keep bumping it back up, because the change has to come in how you work together. []

LIZ CRNKOVICH: That's because we have to do what we are demanding that our families do. And we're refusing it. When I have a family per the Supreme Court, I have to expect them to gain insight into their problems and make substantive changes to correct those dynamics. That's what we demand of our families. I think we have to be willing in the state to do what we demand of our families, whether it's state agencies, individuals, or as a whole. And that's what you're talking about. We can't be

manipulative, we can't be in denial, we can't put up the roadblocks. We have to be willing to gain insight and to make substantive changes. And when it gets tough, we want to change therapists; that means get a new committee and do whatever. Isn't that right? []

_____: That's a very good analogy. Wow, that's terrific. []

LIZ CRNKOVICH: If that is a goal, how can we...how can we possibly demand of our citizens what we're refusing and unwilling to do ourselves? I guess that's an integrity thing. []

JEFF SANTEMA: Pardon me. And I think the purpose of the exercise with the SIG information with respect to this task force is because it had some type of relationship with the statutory task that you have. And so the goal was to just make you aware of what this was, and then if you could review this and provide to Senator Johnson's office any additional information that you need from the SIG process that will help you in your process. I think that's the main goal of this exercise, is to ask you to...and what further you need. There are going to be things that the SIG grant is doing. It's a multiyear grant. It has some time left to go, which is not very, very distinct from what you're doing. And you don't necessarily have to be dependent on what SIG has done or what the SIG recommendations are, but they may, to an extent, inform your own thinking. So that's the main purpose for this information to you. []

BETH BAXTER: Well, just again, I mean truly the SIG...I have participated on the steering committee, and we've grappled with these issues a long time, and I guess I...and Candy is a part of that, with other folks a part of that process. But, you know, grappling with infrastructure-type of questions, you know, how do we take what you were describing, Missouri, you know, with these regions, or whatever. We've looked at how do you develop this organizational and financing structure then that supports these things within the system. So we've grappled with those; we've talked about those;

looked at what we have, how can we improve, what can we change, those kinds of things. So I think the SIG process, there is a lot to help inform us. And I know at the last steering committee we had, you know, it was very well-taken in terms of these projects that will somehow concretely show us that maybe we can get this, what we demand of our families as substantive change, to how do we integrate funding, how do we work together, braid, how do we collaborate on this statewide level. But that was really kind of a ray of hope for us and some kind of change. []

TOM McBRIDE: I would like to echo what Ruth had said about taking on those type of things, and I think that we're in a better situation right now for addressing those than we have been for a long time. And I think that looking at the SIG grant that...I've got volumes of studies of planning things that we've looked at just in Nebraska for the last 20 years. And you get so far with them and then you just finish it and you stick it up there, and I think that from a public perspective, from a provider perspective, we jumped into this late because we weren't paying enough attention to it. We were looking at it as just another study, and I think that there is probably that danger of this committee, as well. So I think just echoing what Ruth said, we've got to have substantive things come out of these committees. And the SIG committee has garnering a lot more attention than what it did before, and I'm encouraged by that. []

CANDY KENNEDY: Yesterday I was at a meeting and we actually we had a bit of this conversation. I've only lived in Nebraska, back in Nebraska, about eight years. And we talked about all the studies, all the pilot projects, all the different committees, all the task forces that have been done in the past probably ten years, and all the great things that had been done. But basically that's where it sits. It always seems to end, and that's what happens. And actually in Nebraska right now we were talking about all the different things that are going on, all the different committees, and they're kind of, a lot of them are overlapping, doing similar things, but it always...there was a new grant for some education with children's mental health just in Lincoln right now. There was a project that went on in central Nebraska; they had a big grant that did the same thing. And

again, nothing...the money ended. It didn't continue. So they're going to do this again, and that's what we...and I am very, very hopeful that our task force, that's not going to happen, that we can somehow...I know it's such a...we're very limited on time. But if we could take...there are some wonderful things going on in our state that are very, very appropriate. And we have some...we have us here, we have new leaders, so I think it's an opportunity that we'll probably never have again to actually get something done and get it moving. So I'm just hoping that that's... []

KATHY MOORE: I agree completely, and I think part of why I was trying to get a handle on Beth and a couple of people at our previous meeting said we don't need to reinvent the wheel. SIG has brought forth good information. And I'm trying to get a handle on what we've been provided. I don't know what to ask for. I mean, I (inaudible) have a third of the pile. And so my questions really are focused on what of this is the best, and Beth was helpful in pointing us to Attachment 2. I would agree that gives the symbolic framework. I was looking at Attachments 9 and 10, which are focus group results. And those appear to be relatively recent, end of last year, beginning of this year. And so has there been a subcommittee that has discussed these results, you know, where? I guess I'm trying to figure out what SIG is doing so that we don't redo it, but has anything occurred like (inaudible) Attachments 9 and 10? []

SCOT ADAMS: Kathy, if I understand your point. I think it would be useful to take that and draw your own conclusions about where you want to go with it, from the level or standpoint of (inaudible) policy. []

KATHY MOORE: Okay. []

SCOT ADAMS : I wouldn't worry about bumping into (inaudible) duplicate or that kind of stuff, because we (inaudible). They're complementary, they're similar, but I think that the point here is policy and (inaudible). []

KATHY MOORE: So if there are recommendations here that we deem valid, just build in, in there. []

SCOT ADAMS: Yeah, (inaudible). And I would also say that I view this at this point in time as a dialectic process (inaudible) 542. You asked about SIG; SIG responded with some stuff. Now that I think you identify what further questions and comments and ideas as that generate, throw it back to SIG, see if (inaudible) have some other kinds of things, so. I understand the frustration of you don't know what you don't know. I live my life in fear of that principle. And so just go with the questions that you have, and if you've got some more stuff that's responsive to that, we'll be absolutely happy to provide it. And I think as a result, policy and practice, which is how I sort of see this (inaudible), will support, reinforce, and encourage one to the other. []

SENATOR HEIDEMANN: I think we need to continue to move on here. I think we'll go from number 5 and start with number 6, the process and planning discussion. I believe we've probably touched base on this a little bit in a prior discussion, but we need to continue on. And I think once again Jeff will kind of lead us on this one. []

JEFF SANTEMA : (Exhibit) Thank you, Senator Heidemann. There are just a couple of catch-up issues from last time. There were a couple of requests. There was a homework assignment, if you will. What's being handed around now reflects your responses, and Kathy I'm going to be extra copies of what you and Ruth and Judge Crnkovich have provided. So that is coming around now for your review. Also there was a question the last meeting about funding and where does Nebraska rank in terms of funding for behavioral health. It seems to be difficult to get anything more recent than FY '04 in terms of state rankings, which was the year LB1083 was passed. But this is some information just for your review, and puts Nebraska at about 39th or 40th. And the color pages that are coming around, you can see in FY '04 the difference in funding for institutional care, like regional center-based care as opposed to community-based care. Those kinds of things are in that. I apologize that there is...it seems to be difficult to get

more recent data, and different sources of information about rankings like this. The other question related to what is the current capacity, and where are the services now for kids, and so on; is there an inventory? There will be some more discussion of that later on in the agenda, and we'll have some kinds of information to give to you then. Just a very a quick reminder, and again you talked earlier about the shortness of time and being able to move on to decision points, etcetera. I want to remind you that four additional meetings are scheduled and you have those dates. There is one September 19; two in October, October 10 and October 31; and then November 14. We hope to begin today with this small group working session exercise to get toward some specific ideas about certain things. For example, we'll be handing out a little bit later a draft outline for the report for you to look at, and then to add to and to make your recommendations about the general framework and then the kind of general discussion about content for the report, so to get at a bigger picture-level with that. Senator Jensen would like...he apologizes that he could not be here with you today, but he would like to get down to getting feedback on specific recommendations, beginning with your next meeting in September. And so hopefully we can facilitate that type of process so that you can accomplish your tasks by the assigned time. In terms of depth of the report, how detailed is the ultimate planning going to be, I would just like to ask you. My sense is that in the time frame that you have, it will probably necessarily not be an extremely detailed plan, but it will be a specific plan nonetheless. But it can't get done necessarily to a great level of detail. Could I ask for your general reaction to that as a premise, that it's not going to get...that the plan is going to be generally with direction, specific recommendations. You talked about some of those this morning with respect to if it's HRC or what else it might be. But it's not going to get down...okay, and I take from your...that as you...generally there is a sense among the group that... []

SCOT ADAMS: Jeff, could I interrupt at this point or would you like me to wait? []

JEFF SANTEMA: No, Scot. It's fine. []

SCOT ADAMS: What I would like to maybe say about that comment is, again as we talked just moments ago, the tension between a 50,000-foot and on the ground level. And as I understand 542, and as you've described the output of 542 to be metaphorically a 50,000-foot level plan, also part of 542 then is the requirement that HHS, DHHS, develop an implementation plan as a result of the 50,000-foot. Now (inaudible) just an interesting intension that I just want to voice, and that will be that I presume that a group of good folks like this, developing a 50,000-foot plan, will identify a number of things, and even in the handout you've handed out, a lot of good ideas. The administration may agree with some of that, none of it, or all of it. And so the development of the implementation plan as directed by law, has an interesting moment of what do we do with the part that we don't like, you know? And I just don't want to do anything other than sort of voice that potential conflict out loud. I didn't make the law, but I do live with it in a variety of different ways. And Jeff and I have talked briefly about this, and I think, and I don't mean to speak for Jeff, but I sort of want to throw out for the group that there may be a 50,000-foot plan, there may be a less than comprehensive implementation plan, and that both documents are available to the Legislature to do what it's going to do, that will sort of, I suppose, be the court of last resort, if we can mix pieces of government in metaphors. I'm not sure we can. But in any event, I sort of just wanted to sort of say that out loud for people, because in addition to the good work going on here, there are other dynamics, factors, and elements to (inaudible) to come into play in the implementation of any law, and that one of those well be an administration perspective on some of the things that we all say. []

RUTH HENRICHS: So just let me be clear, (inaudible) kind of telling us that even though we're going to do this work, we don't have any implementation power, so we could do this work, and the administration can say, that's great that you recommended this, but we don't like it, so thank you very much? []

SCOT ADAMS: Well, let me offer a particular example. If for instance one of the things you say leads to the development of the need for $5 million of new resources, I'm pretty

sure the government is not going to agree with that recommendation, and so we have a tension. And just because this group says it, it ain't going to happen all on its own. Both that recommendation for $5 million, and for however we translating that in an implementation plan, going to the Unicameral through which, you know,... []

RUTH HENRICHS: So our report goes really to administration, not back to the Legislature. []

BETH BAXTER: No, I think it goes to the Legislature, because what I see this process, it goes to both but it doesn't stop there, because I guess my...maybe it's just my perception assumption here, is that this informs potential legislation. And we...I mean, just the honest to goodness truth, we've rarely had substantial changes through the executive branch of our state when it came to behavioral health. They generally are championed by the Legislature, and those kinds of things. []

LIZ CRNKOVICH: And not overnight either, right? I mean, isn't this just kind of the...it might be the beginning or the end, we don't know, but if we are planning what the real needs are--not make-believe--but what are the real needs in the ideal albeit there might not be a penny to support then, then we start people thinking, and thinking about how we can support them through any number of areas, whether that be our tax dollars, whether that be the private sector, and things like that. That was my idea that this was a...but if we, again, it goes back to what Ruth said, if we don't...if we...I have to analogize. When people make recommendations to me based not on the kids' needs but what they think might be out there, it's like, don't tell me that. Tell me what this child needs, then let's figure out what's out there and how we get it. That's my idea. That's what I thought we were doing: what do we need. I don't think anyone is naive enough to think that it's all going to (inaudible). []

CANDY KENNEDY: Well, so maybe we could possibly put the shoe on the other foot and see what is it, the issues that you guys are focusing on in trying to make some

changes, and how can we work with that. Would that be...? []

SCOT ADAMS: You know, I think we are all about pretty much the similar issues, funding issues, decision-making authority, services, a mix, and how to balance state between urban and rural, quality of access. I think we are going to agree on those at a fairly...I think where we'll disagree on, are new resources, as an example. There may be others. []

BETH BAXTER: It's a partnership, and obviously the analogy of what I think one of the things that works in the regions, the Nebraska Behavioral Health System, which includes the division, the regions, the regional centers, is that there is this complement there; that there's this partnership where the division can and cannot do certain things, the region can and cannot do certain things. But there is this complement. There is almost this balance. []

SCOT ADAMS: Symbiotic relationship. []

BETH BAXTER: Right. Where if the division can't...you know, they can't go after additional funds. But those of us at the level where people's needs need to be met, we can do that, because of that (inaudible). []

LIZ CRNKOVICH: And it's the difference between, no, we don't need brand-new siding on the house because that's a luxury, or, yeah, we need to get the house painted but we can't afford it this year because we have to get the dental bills paid. I mean, they are two different things, aren't they? []

BETH BAXTER: Absolutely. []

LIZ CRNKOVICH: So you're not...? Are you suggesting we shouldn't spit out what we think we need, or we should but with the understanding someone might say either that's

a luxury, we can't, forget it, or I see we need it but not right now because we have new (inaudible)? I mean, there is a difference in my mind. []

TOM McBRIDE: I don't think that we...you know, if we take anything other than, yes, we're looking at the 50,000-foot thing, you can't see kids specifically from 50,000 feet. You've got to get down there and do some of those groundwork changes. And I think we have to be forward enough to say, these are specific things that, according to this task force and members, we're recommending to the Legislature be adopted as far as part of the new system. This task force exists until 2012 or 2010? []

JEFF SANTEMA: The task force has a life until June 30, 2010, to oversee...it's oversee implementation. []

TOM McBRIDE: So it's...and I think it would be foolish of us to come in and say, okay, we've designed a brand-new system, go in, and everything is implemented just as we made it. But I think we have to have that... []

RUTH HENRICHS: And Tom, I think it would be equally foolish for us to spend time second-guessing, well, the Governor or HHS or whoever, doesn't like the idea so let's not propose it. I for one am going to propose spending $5 million because I think if we could get the cost analysis, I could prove to you, if I could get somebody to deliver it to me, that within a certain amount of time frame, 2-10 years, I'd have that money back in the state coffers and I'd be saving money going forward. So I, for one, want us to make those recommendations, and I don't have any interest in trying to second-guess, well, there's not enough money so we won't... []

LIZ CRNKOVICH: Cause no one will think about (inaudible). []

KATHY MOORE: And better yet, I believe we already are spending that money; we are just not spending it effectively. And so I want us to have enough information so that we

can accurately articulate what we're spending and what we're getting for that expenditure. So again, we keep looking at Hastings because that's the biggest pot of money, and it's unfortunate for Hastings, but we have to look at that because if any of us do understand that we are in a no-new-money environment, both in the administrative and legislative branches at the moment. So while I completely agree--and I'm really glad, Scot, that you raised this, because you're absolutely correct--I think too many of us have sat on those committees where we said, you know, here are our recommendations, you know, go for it. And a few of us have continued to try to be a little Sheltie and herd it in the right direction. But I think 542 put us in place to really do this job and to stick with it and continue the discussion. So to Jeff's point, while he said not too much detail, I think I had, at the last meeting, said let's not spend a lot of time and pages on background. To some degree what we've done is irrelevant unless it can inform what we want to recommend. So in terms of saving time and paper, that's where I would save the time and paper. I want any voices--and that's why I looked at the focus group--I want any voices of children and families that we have access to, to be reflected in what we plan, which is to Tom's point as well. And then I hope that we can get to some combination of Attachment 2, which might be a structure, but also beginning to put our feet on the ground and saying in this structure this is how we're going to walk forward, albeit regionalized or whatever, and here is about how much it's going to cost. And then my vision is that probably that next step, having done the Kids Count report for 14 years, I know that we don't, as a state, have access to all of the dollars that we're spending or all of the clients; that in each region there is some of those numbers that aren't necessarily compiled into one source. So I hope we can begin to get a better handle on it. Don't know whether we're going to get that done by January, but that may be something that we should try to be looking at simultaneously. []

SENATOR HEIDEMANN: I just want to ask one question. Is Hastings failing the kids that they are asking to serve? []

KATHY MOORE: We don't know that. []

CANDY KENNEDY: That's the question I was going to ask is... []

SENATOR HEIDEMANN: Because if they're not failing them, why would we want to spend $5 million or $6 million to do something else? I'm just throwing that our there. []

KATHY MOORE : Well, when this discussion started, I brought a piece of legislation to Senator Synowiecki that said, let's create a plan, let's do what we're doing in 542. He said, we're not going to get any new money; we are already spending $10 million at Hastings that was later identified as $6 million or $8 million, and we're spending that for a small number of kids. So the answer to your question is, we don't know how each of those children are faring as a result of what they get, but we do know that we could serve a lot more children probably equally or more effectively for that same amount of money. []

LIZ CRNKOVICH: Because it's not all going to treatment; it's going to just keeping up those old buildings and all that other kind of stuff. []

KATHY MOORE: So it's a hard question...yes, we need the answer to your question, but we also need to answer where could we, as a...if we decide, yes, we're serving them very effectively, the point then becomes, if we don't, we shouldn't, shame on us for spending $6 million to $10 million to serve 43 children or 50 children, and taking those children, taking 100 of those children 95 miles away from their family. []

CANDY KENNEDY: Well, not only that, or if there is not enough beds, or out of our state, and paying the monies that cost for that. And what is it that they do above and beyond what the other facilities are doing? []

LIZ CRNKOVICH: Well, the drug treatment program can't be any different than any of the residential drug treatment programs. To my knowledge, it is no different than any of

the residential drug treatment programs for adolescents, certainly in Omaha, probably in Lincoln. So I'm not saying that as a negative. It's probably doing what it needs to do. []

TOM McBRIDE: I think initially where it came down was that we were looking at the dollars, and the fact that we had a facility that we had said that wasn't good enough to keep the adults in, we wanted to move them out, and what's it going to take to, for dollarwise, to bring those up to speed, and that kind of thing. I don't think anybody looked at it from the standpoint of what's the treatment outcomes there. Those are...you know, the LMHPs, the staff, the psychologists there, they're professional people. And we would hire some of them, but it's the discussion around that, that... []

TERRI NUTZMAN: Also remember, there's a certain type of population, okay, that is at Hastings Regional Center, that they are serving, and that population comes from the YRTC-Ks, okay. So you cannot lose sight of that. You know, that is...it... []

CANDY KENNEDY: What exactly does that mean, Terri? Just... []

LIZ CRNKOVICH: It means that a youth has been committed by a judge to the Office of Juvenile Services for commitment to Kearney. []

CANDY KENNEDY: That's what the K means. []

LIZ CRNKOVICH: Um, at Kearney. Youth Rehabilitation and Treatment Center in Kearney. []

CANDY KENNEDY: Okay. []

LIZ CRNKOVICH: And that would be one area that would be distinguishable because...the two kids I saw, we...that usually means they failed on probation, that community services have been tried, often group homes or RTCs or whatever, have

been tried.... Well, I don't want to get into a discussion about whether it's higher or lower or whatever, []

_____: (Inaudible) let me get to Beth, because that (inaudible) right service at the right time for the right kid. []

LIZ CRNKOVICH: The one thing that is different is that they're committed to Kearney, and so in some sense...and then the Hastings... []

TOM McBRIDE: But they're not a committed Kearney child, (inaudible) when they move to Hastings, otherwise, they wouldn't be qualified for Medicaid services. []

CANDY KENNEDY: Yeah, I was going to say, what does it mean when you're a K kid, to go to Hastings then? []

TOM McBRIDE: It means that they're...they can perform (inaudible). []

_____: Well, I think it describes something (inaudible). []

KATHY MOORE: On paper, they are still committed, but somehow Medicaid is paying for it. []

TERRI NUTZMAN: That's correct. They are still a committed kid at Kearney, even though the (inaudible)... []

_____: They don't go back to Kearney after their treatment though, do they? []

TERRI NUTZMAN: If they mess up they go back to Kearney if they're still in...at HRC. []

LIZ CRNKOVICH: So in terms of the fact that they're there, and if they run away that

could be a felony or things like that, it's different than other residential treatments. But in terms of the actual drug treatment program, it isn't any different. []

TERRI NUTZMAN: It's basically the same. []

_____: And then the other issue is, you toured HRC, you know it has quite a bit of security there. []

TOM McBRIDE: But one of the things they talked about in there, are these kids appropriate for the community, as well. You know, like any other RTC or treatment group home child. []

BETH BAXTER : Could I back our discussion. I just want some conversation here, and I don't think it changes the direction here, but the discussion around funding and those types of things, and system issues. I mean, it just reminded me back in 2000 when we were one of these sites who have these comprehensive children's mental health grants, and looking at data, looking at outcomes for children and families, working out a process of how we serve children based on these core values and philosophies. And when we wanted to take what we did with the children who were in the professional partner program, apply that to a broader group of children, when we went into the whole process of this major federal grant, we didn't think there would be a whole lot of additional funds to do things for children and families. But we believed that there were mechanisms that we could implement that would, as Kathy said, that would take the dollars that are being better there, and use them somewhat differently. And so in...it probably started in '99 or 2000, when we started thinking about the integrated care coordination unit. At that time, Nebraska, we had a $7 million deficit in child welfare. Well, that is no time to go to state leadership and say, have we got an idea for you; we're $7 million in the hole. But it was the time to do that because we were able, because we had some...(inaudible) it's a process, you know. We had these outcomes. We had some good successes with kids. We had learned things. We had had some

failures, and so forth. But it was pitching that idea that because we had these outcomes, we could take the dollars, we could...we were pretty confident we could do it for less than what historically had been done, because it was a different way of thinking, and we could achieve better outcomes for children and families. And that was the experience. So we went in and we pitched this idea for 90...we'll take 95 percent of what the state is paid for services; not personnel, not travel, not operations, not those things, but just what they've paid for the services for those kids--the placement, the child welfare. Because at that time Medicaid was tied up in the at-risk contract with ValueOptions. But we...I just say that because we...you know, it wasn't the time that one would normally think you would go pitch something new to the state, but it brought outcomes with it and it brought this national kind of initiative with it. And yes, we have been able to sustain; maybe not 100 percent of everything we set out to do, but a good portion of that. And I think...and it's built around those system of care principles. It looks at (inaudible). []

CANDY KENNEDY: And to me, the most important thing, as I've spoke with families and youth--they're not youth anymore; youth, pre and post--what Beth is saying was created, and it's a difference between night and day. To me, it works; it actually does what it needs to do. The will to do things. That's what we want to (inaudible). []

KATHY MOORE: Part of the challenge is, and you're going to see some stuff from us with silos. But Senator Heidemann, to your question, part of the challenge is that right now I just visited the Scottsbluff detention center and the Douglas County detention center. And they have a percent of their children who are in detention for 3 months to 9 months. Now, detention is supposed to be a week or two. While they are in detention, the Office of Juvenile Services is paying them, per day, $175, $198. []

_____: In Douglas County? []

KATHY MOORE: And Scottsbluff. One hundred and seventy. Now, you say, well, what does that have to do with this? Well, many of those children for the 3, 6, 9 months, are

awaiting placement in a facility that looks more like the discussion that we're going to have around this table. And what we keep failing to do as a state is put all of that money in a bag and say, okay, we're already spending $170 times 60 days--somebody do the math for me, whatever that is--couldn't we better spend that money by creating ten more beds at Epworth or Ute Halle or something? So that's my point: that we're looking at silos of kids in protection and safety, juvenile justice, and we now need to say, okay, in the behavioral health system where can we use some the dollars from these other silos? That is the discussion that we have to get to, I think. []

SENATOR HEIDEMANN: I can guarantee you this discussion is not over yet. []

KATHY MOORE: Are you sorry you asked the question? []

SENATOR HEIDEMANN: No. Right now, we've got to keep moving. It was a good discussion that we had but it isn't over, and I can tell that. There were some very good points that were brought up that I would even like to comment on, but we do have to keep moving. So we're at number 7 right now. Jeff. []

JEFF SANTEMA: Thank you, Senator Heidemann. What we've tried to structure is a working session for you, and a working lunch, if you will, about an hour and 15 minute type of exercise before you come back after lunch. This last sheet that's coming around is a division of the group, and the groups in different rooms within the Capitol that you will be meeting in. We will bring your lunch around to you then so you can have lunch in those locations. And we have basically asked for three things from this activity that you do, to sort of begin to take a wide end of the funnel and begin to narrow it down. The first is taking that draft outline that you've been given, and to talk among yourselves about how you would like to fill in that outline and how you would like to see the structure and the basic content, generally, of the report to be like, so to get your decision, get your consensus on that. Secondly, to talk a little bit at the (inaudible) level of integration. The third point is to take LB724 and to begin to be more specific about

reform focus areas so that then specific recommendations can flow from those primary focus areas of reform. As a task force, you've talked about a number of different areas of the system, and that informal conversation has been very, very helpful and enlightening. And those...and we'll see from your standpoint whether you think this type of exercise is helpful for you as you get into smaller groups and do some of this specific work. And if you have any questions, Erin and I will be circulating among the groups over the, for the lunch hour and see if you have any questions or if you have any needs as you.... Do you have any questions at this point? []

SCOT ADAMS: What happened to LB606? []

JEFF SANTEMA: LB606 was indefinitely postponed. And it's not been passed out to you in any way to say this is what you should agree with or do. It's just an example of a piece of legislation, a comprehensive piece of children's behavioral health legislation that was introduced in 2005. []

KATHY MOORE: And interestingly enough, we used it to draw from originally when we started working on 542. []

JEFF SANTEMA: So that's another piece of information for you or...and then we'll have more (inaudible) the intent would be that when we come back at 1:30, roughly, again to reconvene here at 1:30, that we'll take some time for you to report your feedback so that we can get information down so that we can begin to work. And then we'll have the rest of the agenda following that, if there are no further questions, Senator Heidemann, I think at this point we'd be ready to recess then, for the working sessions. []

KATHY MOORE: What time are we supposed to come back? []

JEFF SANTEMA: 1:30 p.m. []

WORKING LUNCH - RECESS []

SENATOR HEIDEMANN: I think we better get started here again. Just a few things to announce. It is our intention to get done by 3 p.m., so we have to keep things moving. If it does go a little longer and that, I've got a meeting scheduled shortly after 3 p.m., so I'll have to turn it over to someone else. Once again, there was a request that we please speak into the microphone. There are some people in the audience that were having trouble hearing what was being said, so if we could do that it would sure be appreciated. Also, if anybody needs copies of anything, we can get you copies. Roger is more than willing to help us out there. So continuing on with the agenda, we're at number 9, and it is time to report back everything that we got accomplished besides eating lunch. So with that, we're going to start with Group 1 and Scot. []

SCOT ADAMS: Great. Thank you. Well, we ate lunch. No, I'm just...okay. Three tasks. And with regard to the first one, looking at the draft outline, we added a couple of subchapters under Item 1. Item C, which we would say would be some sort of statement of focus that would speak to the intention to focus on all of our kids as part of the planning, not a particular segment here or there. Secondly, a statement about the value and primacy of values. And thirdly, that there be some kind of a listing from a 30,000- or a 50,000-foot level of the principles generally held that we sort of addressed early this morning that we think we can come agreement upon. Under Chapter 2, current system, a sub (inaudible) that speaks to identifying all of the sources of money involving the system, and we suggested those include the Department of Education, Behavioral Health, Medicaid, private insurance, Protection and Safety, the regional center, and private contributions to the system, and that there might be a means by which to leverage private contributions, especially on the capital, but perhaps also operational basis. Chapter 3, system reform objectives. We had about four of those. The first one, a common assessment coupled with the capacity for specialized assessment as needed, would be an important component, that somehow we encourage the development of common assessment language, protocols, tools. Secondly, that we strive to work within

the existing state financial resources. []

LIZ CRNKOVICH: I'm not laughing. []

SCOT ADAMS: You're on my team. (Inaudible.) (Laughter) []

LIZ CRNKOVICH: You're just looking at me like (inaudible). (Laughter) []

SCOT ADAMS: There are some qualifications. And just to recognize that the representative from the Governor's Policy Research Office walked in, let me say that again: Strive to work within existing state financial resources. []

LIZ CRNKOVICH: To the extent possible. []

SCOT ADAMS: With a couple of subpoints. The subpoints include: encourage private-sector investment in community-based services, what about tax credits to build new a institution or facilities, as an example; secondly, seek to unify and leverage multiple operational streams of financial support to maximize impact; and thirdly, redirect and reallocate existing government resources. Major point 3: prevention focus needed as a system reform objective. And point...(inaudible). Okay, Chapter 4, we had no particular recommendations under that one. Chapter 5, suggest an additional Chapter 6 of legislation. Point 1, clarify the center of authority for resource allocation; secondly, clarify the roles and responsibilities among courts, behavioral health planning regions, and the Department of Health and Human Resources, and law enforcement; and C, behavioral health parity legislation. That is all question number one. []

JEFF SANTEMA: Is this something you can make copies of (inaudible)? []

SCOT ADAMS: I can make copies of it. yeah. I think the phone number (inaudible). Questions number two spoke about system of care issues, and we had five items to

report on that. Again, the common assessment tool we thought was an important step for system reform--"systematizing" the system, if you will. Secondly, we propose a notion of regionalized case management. This could be through existing behavioral health regions or it could be a privatized system. There is a key question between the role of the juvenile court and others in this that needs to be addressed. We did not come to a conclusion on that point. Point 3 is part of the system that detention is a system component. []

TODD LANDRY: I'm sorry. Can you repeat that? []

SCOT ADAMS: Detention, or a detention facility, process capacity, is a system component. Fourth, the juvenile courts would like to have case management and parole/probation function. Sometimes they interfere with one another currently. And five, level 5 placement and/or facility is needed in the system. The final question talked about highlights, key areas for reform in a (inaudible). And we suggested a specific recommendation by this group on Hastings. Secondly, however we get there, don't make parents have to give up rights to get into treatment, through the courts. And thirdly, create the section of children's behavioral health, statutorily. []

JEFF SANTEMA: Within the Department of Health and Human Services. []

SCOT ADAMS: That would be my preference. But... []

LIZ CRNKOVICH: That could be up for debate. []

SCOT ADAMS: That would be consistent with the Governor's initiative. Finally then, I think all of you...is that correct? All of you them have gotten these pictures? So that was part of our conversation, and useful information. This sort of looks like it, but the key point is that the various streams that you have on your larger diagram include private-sector involvement and flow of people into the system. And two, an assessment

center. From the assessment center, then recommendations flow back to courts and could make decisions about placement in cases of juvenile justice or could flow to other providers, or it could flow a variety of ways. Then from the assessment center, children and families are referred to providers of care who would then bill the various sources for revenue to support that, a particular service. Two (inaudible) thoughts, the key thought being that assessment is critical to everything, and that common language seems to be critical to everything. Secondly, and once you take the step of assessment center and common language, you don't need to have a center as much as a common assessment protocol process, procedures, forms, language, format. It could be much more mobile and less tied to bricks and mortar than an assessment center is, but we wanted to use the language of assessment center to indicate the commonness of assessment process there. And then the final thought with regard to that is (inaudible) sort of dangerously close to managed care, which may or may not be a good idea, but the common assessment is managed care. Come in for an assessment and they sort their (inaudible). That is managed care. So I just wanted to highlight the potential danger of that for people in case anybody wants to think about that. []

TOM McBRIDE: But I think it comes closer to a single point of entry. And one of the things we talked about is if that was in a regional basis, there would have to be an understanding that...you know, like currently, if they...and I'll go into like a child welfare service, if a program exists in a central service, they've got to serve those central service area kids first, and sometimes they won't approve somebody coming from out-of-district, but there's got to be that latitude...you know, placement. []

SCOT ADAMS: And that's a great point because the intention was that you keep treatment services assessment closer to home. That is the definition of community-based. []

SENATOR HEIDEMANN: That's what we've heard from Group 1. So now we're going to move on to Group 2, and Ruth is going to tell us what Group 2 accomplished. []

RUTH HENRICHS: Group 2 is laughing. Todd took many of our notes, so why don't you fill in as we go along. Quite honestly, we spent a lot of our time talking more about Section 4 on the outline, and really sort of just said, Jeff, you'll do the history. And a lot of the top part we saw as just gathering data and writing it. So honestly, when the three of us were there, and then the Senator was able to join us, we didn't talk a whole lot in detail about those first ones. And when we talked about the...we saw most of our work and input probably going into the planning recommendations, and felt that...I think our consensus was that we felt we needed more data before we could make a specific outline (inaudible) there as to what we wanted the specific recommendations or whatever to be, but we saw that as where we would have most of our input. We spent our time really talking about the second point, which was the system of care, and a fair amount of time, I believe, talking most specifically about maybe even process more than outcome, saying that what we believe we need to do is to define, whether it's one of these two charts of somebody else's, and kind of what you talked about, Scot, in terms of the continuum of services that we think needs to be available in the state of Nebraska for children and families, starting with prevention, intervention, and going all the way to locked, secure facilities for children who need to be there for a long time. Then we talked some about the need to have the data that tells us, at least to best guess, or whatever, what we're current...how many of each of those different kinds of services do we need in this state--what are our projections for how much outpatient, and how much subacute, and understanding those would be projections. And then we also said that what this table needs is the data that defines where do those children come from. If the data tells us that Nebraska needs 40 subacute beds for kids, then do 38 of those kids come from Omaha and Lincoln and two from the west, or two from Omaha and 38 from the Panhandle? And what we were saying is that we need that continuum--that's our task--and then to define those. And, you know, whether it's one or more of those charts, we talked some about assessment, and agreed, I believe, with the comments that you made about assessment. We talked...and then we also had some very specific conversation about Kearney and Geneva and Hastings. And I think our consensus was,

we really need to get the data and the continuum. And it's cart before the horse to say...to really...for us to talk much about that until we have data that says what is the need that we have. And then when we know what the need is and where the kids are from, then we take a look at what needs of children and families are best met on the Hastings campus, if that's...or are any of them met there. But probably something would be. Do you want to add to that? You've outlined what we wrote on the continuum. []

TODD LANDRY: Yeah, just to kind of maybe frame it a little bit differently. I think what Ruth has indicated is a good synopsis of what we talked about. The group essentially came down to, if we are going to look at planning recommendations, if we're going to look at system of care, we need to answer three core basic questions. What do we want, which is that system, that continuum, front end to back end, and what do we want compared to what we have? The second question is, where do we want it, and how many do we need? And the third question is, who provides that service and held accountable to it? Those are the three kinds of core sections that we think that...we answered those questions, the planning piece and the system of...the governance pieces, and those pieces will largely take care of themselves or will flow from them. []

JEFF SANTEMA: Todd, how would the governance flow from...pardon me for asking a question. How would the governance flow from an assessment of what we need, where do we want it, and who's going to provide it? []

TODD LANDRY: Yeah. Who provides the service and who's held accountable to it? Who's held accountable to it? Is HHS and OJS going to be held accountable to it? Or are the courts going to be held accountable it? If so, then we need to clean up some legislation, and the courts have to then take control of that process, versus dual adjudication of probation, and OJS, which is what we're seeing now. So to a large extent when we decide who is going to be held accountable to the outcomes that we're supposed to get, you're going to be able to figure out who's going to be able to govern that piece. []

JEFF SANTEMA: So you're deciding governance by accountability then. []

LIZ CRNKOVICH: Within...not to add more bureaucracy to bureaucracy, but I do kind of pinpoint at your number 10 about an advisory panel composed of a variety of disciplines. Now, you didn't do it for this purpose, for accountability. []

SCOT ADAMS: It's tough always putting things in writing; you always get quoted out of context. []

LIZ CRNKOVICH: I know. That's why you learn in law school never to (inaudible). Does it have to be, I don't want to say battle, but that issue of it's either got to be the court or the department. That was one area we kind of got stuck on, because I said, there isn't a judge around who is going to say, yeah, I'm going to hand over a kid to an agency, if that judge does not have confidence that the agency is accountable, that the workers have a clue about the services that...blah, blah, blah, you've heard that argument. Do we need a kind of entity, whether it's where certain members...you know, you have to be accountable to the taxpayers if you're a decision maker. But could it be an entity that's comprised of the three levels of government and the private sector and the...I don't know...accountable in some way, whether it's legislatively, that assure...? Because what we're talking about is, who's going to assure that the services are out there? Who is going to assure that they're competent in that way, that they do the right thing, that they're culturally competent, that they're all consistent in the job that they do? Who's going to...? That kind of thing. And maybe it is the department, maybe it is the court, but...or is that a battle that needs a more neutralized kind of oversight? I don't know, but I just throw that out to complicate things. []

TODD LANDRY: And I think it's a good question, and I would, I suppose, (inaudible) seconds, I would argue for the fact that we need an entity to be held accountable for him. I'm not saying that that entity also provides the oversight, and I don't think that

would be appropriate. There is oversight, but there is also accountability. I think we need to have clear accountability, but also have the oversight (inaudible). That would be my personal opinion. []

JEFF SANTEMA: So, right now in the state of Nebraska, the state behavioral health authority within the Department of Health and Human Services, and we have six regional behavioral health authorities. []

TODD LANDRY: Well, right now I would say, from a children's behavioral health perspective, it is spread across the entire spectrum. It's in OJS, it's maybe in the regions with children's behavioral health. Certainly the courts are playing a role. It's spread out across the entire spectrum right now. There is no central accountability (inaudible). And maybe we're not ever going to be able to get there. Ideally, though, I think we're all served best when there is a central accountable entity that's in charge of ensuring that whatever the task force or the Legislature ultimately moves forward with, actually gets (inaudible). []

RUTH HENRICHS: And whoever provides that oversight should not deliver service. []

LIZ CRNKOVICH: Or have the checkbook. Oh, sorry, did I say that? []

BETH BAXTER : And it depends on the definition of service. And I'm just saying that's probably an important thing to include, just in the discussion. Because if you look at case management as a service, or not as a service, because there are certain benefits to being able to manage the care if you have this accountability for that youth, because you're able to direct certain things so that...that's just part of the discussion. That's good. []

SENATOR HEIDEMANN: Is that all with Group 2 then? All right. We'll move on to Group 3, and Beth. []

BETH BAXTER : I hope we were on the right track. We're going to tag-team this, so I'm going to talk about the number 1 in terms of the draft outline, and really we added a little bit under each of those areas. We looked at the introduction to have legislative and planning history, thought the planning piece would be a good addition. The LB542, then LB1083 as introduction, and then I went ahead and added, just looking at what the values of this is. And so I think we talked about that, as well. As far as the current behavioral health system, I think everybody has covered that, just looking at what we currently have. I guess we would add in there the family organizations, the provider network array of services, and then I also added looking at system partners--those who have some responsibility for children but--like education system--but they're a partner in the process but they're not in the HHS flow chart. System reform objectives, I think we talked about utilizing the guiding principles, and then we thought that some of the areas that I had outlined, and just what I had submitted to Jeff in terms of assessment, coordination, array of services, and so forth, cultural competency, data driven, quality assurance, evaluation, funding, those types of things, in collaboration we could look at pieces within reform objectives. Planning recommendations, just look at the funding and implementation strategies, how are the current dollars, what are the current dollars and where are they used, and how are they spent, looking at organizational structure. And then what services do we need to address individual needs. And we just thought in the appendixes part we just want to utilize a variety of handouts and information that's been presented. And then Kathy is going to talk about number 2, system of care. She's got a handy-dandy little... []

KATHY MOORE : And we modified this, again, one more time. Just as a little background, this one originally showed, in a way, the point Todd Landry was making, that under the current structure we've got these silos of juvenile justice, protection and safety, behavioral health, and economic supports. And currently, if you'll look at that line across the bottom, that's really where behavioral health is. We've got five different divisions in Health and Human Services, and there isn't responsibility or accountability,

and there's a lot of confusion about funding. And so what we tried to show here was that this oval down here would be the Division of Behavioral Health Services; could be the children's behavioral health services subdivision, if you will. But that ultimately that would be the entity responsible for making sure that behavioral health services were provided to each of these categories, if you will. I mean, you look across the top, we've got a juvenile justice system which includes the courts and probation; it certainly includes OJS, which is under HHS. There are some questions about law and how we involve family in juvenile justice cases. But again, there's a need for a give and a take; both of those systems need to feed each other. Medicaid is where the money is, and typically that's what goes down to the behavioral health system. CFS means children and family service. That also includes public assistance programs. DD is, again, a separate agency--developmental disabilities. But the development disability thread runs through so many of the children that we're talking about. And then we added the public health agency, which currently exists, again, off by itself, but it sets policy, it regulates, etcetera. And so what we were trying to say was that ultimately the behavioral health agency or system would be responsible for making sure that, first of all, assessment occurred, so that as soon as a child was born, if you will, through the pediatrician's office or a newborn visitation program, through the school system when the child turns five, there would be assessment, so that behavioral health would be a thread that runs through the life of every child. And then all the way through to aftercare for circumstances where a child moves more deeply into some of these systems. The items kind of on the either side are talking about the family being involved, transportation, close to home. Those are guiding principle kinds of things. Down at the bottom we talk about prevention, ongoing, primary, secondary, that repeat cycle of prevention. And then down at the bottom would be all of the services that would be available through any of these circumstances. And this is pretty rough, but we felt like if you took this and then incorporated what Beth provided and what Terri, which actually draws upon what Scot and Todd provided, that you would then get the combination of the guiding principles. Beth has a pretty good set of guiding principles that also begins to lay out a system of care. Terri talks about some more detailed level and types of care. And then

Beth, on her third page, began to look at dollars. And what we basically indicated is that there is a need and it's similar to what Ruth was talking about in terms of needing more data, in addition to knowing how many children there are that need what things. We know that in each of these existing silos there are already those dollars being spent by OJS on the kids in detention, by OJS on the kids at the YRTCs, by Protection and Safety, by Medicaid. We somehow need to identify all of those dollars that the additional data that needs to be factored in so that we know how much current general fund/federal/regional money we're currently spending on behavioral health, and then how we want to more efficiently direct those expenditures. And did I...? I think that pretty well covers our number 2 unless I missed something, and I would...you know, if...it sounds like many of us are on similar pages, so my administrative person who created the first pretty charts that we later rejected, would be happy, I'm sure, to try to turn something like this into a prettier item. I would say...I don't think we actually got to number 3, but I did pose a question. I guess I...and I think...I hope we all can discuss it, but when I looked at number 3, and looked at LB724, I wanted us to remember that in a way LB524 (sic) might serve some or all of the function that 724 served for adult behavioral health. So the fact that we've got 724, we then had 1083 which technically included children, and then we had 524...542--excuse me, I said 524--that hopefully we can condense our process a bit and not have to take another full planning process, and that there seemed to be at some head shaking around that, so I don't know that we came to a full recommendation, but that seemed to be consensus. []

SENATOR HEIDEMANN: Todd. []

TODD LANDRY: Yeah, just as a point of clarification, I do want to point out that when you were referring to this chart, that both CFS, DD, and Medicaid are divisions of the same department, not separate departments. []

KATHY MOORE: Right. Did I use the word "department?" Sorry. And we actually had (inaudible)... []

LIZ CRNKOVICH: She noted that on the pretty one though. (Laughter) []

KATHY MOORE : Yeah. []

LIZ CRNKOVICH: That's right, because you did say five out of the six (inaudible). []

KATHY MOORE: Yeah, I did. I did (inaudible). But I also...that's a good point because technically OJS is under CFS, but we were really also looking at this systems, and so there's still a juvenile justice system that includes courts and probation, so it gets real blurry. But thank you; I do appreciate the clarification. []

LIZ CRNKOVICH: Well, and it also clarified how really then that agency is intimately involved in every single aspect of (inaudible). []

RUTH HENRICHS: Kathy, in the listing...I mean, in some ways what you added to the chart on the bottom is the continuum of (inaudible) health services. []

KATHY MOORE: Exactly. []

RUTH HENRICHS: But you are, I assume, talking here about you're assuming that substance abuse...this isn't just mental health. []

KATHY MOORE: Correct. Correct. Yeah, because at one point...you would have to add substance abuse, sex offender treatment. I mean there's a lot of things that could be added to that. []

RUTH HENRICHS: Okay. And it needs to be clear when you clean up our little chart here, I think just to make sure that anybody who picks it up understands that we're talking about both mental health and substance abuse as part of behavioral health in

that continuum. []

KATHY MOORE: Good. Good. Well, and I think, you know, it was also interesting when I sat down and looked at this after I did it, when we originally talked about what we realized is that when you look at the juvenile justice system or the protection and safety system or the behavioral health system, if we think we have one, you have group homes, you have treatment group homes, you have acute care, you have all those things in each one. What was interesting to me is that assessment is done sooner in a couple of them than it is in others, and that when you look at families coming to HHS for family support services, that many of them may never be assessed for behavioral health services, and yet perhaps if they were---and that speaks a bit to your assessment center, if you will--that what we need is somebody responsible for keeping their eyes open, if you will, for anybody who needs behavioral health services based on the assumption that the sooner intervention occurs, the less likely they are to go more deeply into the system. So, yeah, however we can clarify that, I agree. []

TODD LANDRY: But you're not necessarily suggesting that every single person in the state or every child in the state would need to be formally assessed. []

KATHY MOORE: No. What I'm saying is there...the Academy of Pediatrics has a new tool that they are recommending. It's not brand-new but that they are recommending that every pediatrician use quarterly on every child, and it's a very quick, you know, here's ten questions for the mother to answer, and if those questions are answered every quarter of the child's first three years, it increases the likelihood that a pediatrician would identify some of those conditions. And so, yeah; no. []

SCOT ADAMS: For budget purposes, I understand it was about a two-bottle night to put this together? (Laughter) When you go through the revision and we are looking at doing an expansion of this... []

LIZ CRNKOVICH: It depends on if you're joining us. []

KATHY MOORE: And whether we should switch to margaritas or not. I added salt to my V8 this morning, and (inaudible). []

LIZ CRNKOVICH: And are you bringing the Brie? []

SCOT ADAMS : Who said you couldn't have fun? []

SENATOR HEIDEMANN: Why don't you tell us about a request to more formal... []

JEFF SANTEMA: I wonder if it would be reasonable to ask the group leaders, then, in each of the three groups, if you could crystallize your feedback on those things you mentioned, and e-mail them to me if that would be okay. And then I can e-mail those out to the rest of the task force. Thank you. []

SENATOR HEIDEMANN: Okay. Hopefully that took care of number 9 on the agenda. We'll move on to number 10, the services discussion. I believe Jeff has got something to hand out, and we'll turn it back over to him. []

JEFF SANTEMA: (Exhibits 5, 6, and 7) Thank you, Senator Heidemann. There are a number of things that are coming around, and we'll let those. First, is the packet of three (inaudible), so take the full.... The first thing that is coming around is a...this brief time of discussion is just meant to address the topic of service capacity, development of needed services. And it goes through the kinds of things that you were talking about as you came out of your work groups. One of the questions from one of the work groups is, do we know or do we have an accurate picture--inventory, if you will--across the state, of the availability of services along the continuum of care, the capacity of those services, etcetera? And I think the answer...I suspect that you all can answer that question. I suspect that the answer is, no, we don't have that now. Is it something that

we could get eventually? It may be. The first grouping of sheets, starting with the chart, is something that I think maybe Scot and Todd could address in a moment, where that came from. And the second sheet are selected slides from a presentation by Jerry Deichert. He has done a great deal of demographic research. We extracted some slides from that presentation. You can see the date of that presentation. And the slide that I wanted to draw your attention to is the second from the last slide, which in terms of projections of the population of those under the age 18, and projected changes to that population through the year 2030. But there are some other slides in there that we thought might be of interest to you. The last bigger piece if rather dated, but we thought that it would be of some value. And it comes from 2001, the WICHE Mental Health Program, and it's a study on "Prevalence, Utilization and Penetration," which we thought was particularly useful. We understand that this have been updated and we may be able to access it for the task force, an updated study. But we thought the information was very helpful in terms of extrapolating from national numbers, the percentage of population when children would have severe emotional disturbances. But I think the more important pieces, in terms of talking about...and there are other things about services that we can talk about. But if Scot, if you'd like to begin to talk about this data? []

SCOT ADAMS: This was an effort to gather the "What have we got?" question, as Jeff noted. And we pulled this from the three major areas of children and family services, and their work with ICCUs, expanded to foster care. And so it's something of an elongated list in the sense of if it seemed like it sort of touched on behavioral health, for instance you could argue Kearney and Geneva, one way or another, (inaudible) point of view on any given day. Similarly, to foster care. If the Medicaid services, the number of providers with whom they contract, that kind of thing. We were obviously unable to give complete data across the grid, as you see a lot of blanks in there. We wanted to do the best that we could in terms of at least giving a snapshot of what is. So the intent is really not to be comprehensive in total, I wouldn't want people walking out of here thinking that this is really the "it" of it all, but rather a reasonable approximation of what's going on. []

RUTH HENRICHS: Can we talk about subacute, Scot? When we talk about subacute, do we have that now, because does it say...? What...would anything in kids be classified as subacute now, or is that a total void that we have in the continuum? []

SCOT ADAMS: You know, Ron...and I'm sort of looking at Ron in the back, if you could help provide some kind of an answer to that? Did you hear the question, Ron? Basically, the question was, the category of subacute care and whether or not we really have a category of subacute care, in particular for children. But I know that from the Medicaid perspective, it's sort of a complicated, sticky-wicket in terms of their rules and regs. And so can you shed anything that would be useful here, or at least confuse us more? []

RON SORENSEN: We intend to create a subacute level care for adults and (inaudible) reform, and we started that and learned that, to do it for Medicaid it had to be in a hospital. So we created a subacute-like service in the community (inaudible). Medicaid is now in the process though of writing or revising rules to include subacute service to (inaudible) review today. So it is in the process for creating adult subacute level of care at the hospital. So the (inaudible) acute and subacute (inaudible). []

RUTH HENRICHS: What about children? []

LIZ CRNKOVICH: What does that mean? Then we could probably say, oh, yeah, there's (inaudible). []

RON SORENSEN: I don't know what they've got planned for children's subacute service. But they haven't discussed that with us, I know that. []

TOM McBRIDE: We were just told that RTC treatment group home enhanced our subacute. []

RUTH HENRICHS: Pardon me? []

TOM McBRIDE: I say, we were...you know, in utilization reviews and placements and stuff, you know, we're...RTC, treatment group home, day treatment, are considered subacute levels of care when they refer to us. []

SCOT ADAMS: You know, how I would view it, just because it doesn't sound confusing enough yet, would be to say that subacute is slicing a deli thin slice of cheese even thinner between acute care services in the hospital and highly intensive services, in the effort for the department or Medicaid to pay less. I think that's the short version, that somehow the kid is not absolutely (inaudible) but would, in fact, then be managed and would still need a very intensive level of care, but we don't want to pay for all that goes along with acute care. []

RON SORENSEN: That really sums up what happened in this process, that there were some different rates, and we agreed to create subacute level of care, (inaudible) created (inaudible) and didn't (inaudible). []

RUTH HENRICHS: Is it true that subacute very frequently involves security? []

RON SORENSEN: Yes. It's a secure service. []

RUTH HENRICHS: So there would be a difference in a...what I'm pushing is the continuum, because everybody, including myself, throws around the word "subacute," and I'm trying to understand what that is, if we're building it. []

SCOT ADAMS: It's a secure level of care. []

RUTH HENRICHS: It's a secure level of pretty intensive services, but less costly than a

hospital because you don't have quite as many ancillary services to support. []

SCOT ADAMS: Well, even that's in some level of discussion, because Medicaid rules currently say subacute has got to be in a hospital. I think probably, in subacute, the difference might be that you may not have daily psychiatric visitation. []

RUTH HENRICHS: Okay. Thank you. []

RON SORENSEN: And one of our problems has always been, in utilizing (inaudible), a (inaudible) psychiatrist will tell you that in a hospital people may go in and out to subacute, acute, subacute, back into acute, depending on what's going on in their lives. And so they don't really like it a lot, to tell you the truth. They would prefer to call it inpatient, but as Scot said, it's an issue for us to...for (inaudible) people to keep (inaudible) hospital. []

BETH BAXTER : But we've developed, I think in Richard Young Hospital, has developed a subacute service, and it...I mean, it started out...it's a less intensive and it's by degrees. And there's that ability of the individual to move, if they need to be bumped up to an acute level of care; if their acuity increases, their symptoms increase, then they can go up to acute, go back down to subacute. So it's the difference in the daily psychiatric interventions or how often they see that psychiatrist. The length of stay. You know, acute, we look at it to be maybe 4-8 days, and subacute to be 20, 30-plus days, like that. So we would...I mean, Richard Young has developed it in the hospital, and then looking at developing...I mean, then Omaha has developed it outside of the hospital, external. But for adult purpose, it's been an extremely beneficial level of care for us because it meets specific needs of individuals, and then it helps people move through the system. []

KATHY MOORE: I'm trying to reconcile the draft...I'm trying to figure out how I would figure out how much money this costs? []

SCOT ADAMS: About $125 million. Yeah, it's...if you put that with the very first document you got in the first meeting of 542, that's where we laid out all the money. I think the total is $120 million that day. It's around 120, 125 for those... []

TODD LANDRY: And that would be for behavioral healthcare services only. []

SCOT ADAMS: Yeah. So Medicaid is about 110, that top third. The Division of Children and Family is about 6, $5 million to $6 million. And the bottom is about $5 million...$4 million to $5 million altogether in rough numbers. This is somewhat more expansive than strict behavioral health. For instance, in that 120 we did not include Kearney and Geneva because that day we were thinking it didn't feel like behavioral health. That's just one that's on the cusp, depending on how you look at it. []

KATHY MOORE: So...well, what I'm also trying...I was looking at...huh? Well, I was looking at your sheet. []

BETH BAXTER: Right. It is $110 million. Right. []

TODD LANDRY: But her sheet only includes that which is designated under the division of...essentially the Medicaid component. There is also an additional 5 in those next two divisions that are non-Medicaid. They come through those other two divisions, so that's an additional, roughly, $10 million to $12 million. []

RUTH HENRICHS: Not in the 125. []

TODD LANDRY: No, it's in the 125. It's not in the 110 that that just referred to. []

LIZ CRNKOVICH: Does OJS struggle with...? Because of the issue of funding and who pays, is there a kind of disconnect or a kind of schizoid thinking within OJS in terms of

that case management versus parole function and/or your...? You know, you didn't think of the YRTCs as behavioral health, and then they are behavioral...? I mean, it's not just my bone that I won't quit chewing on? I think it is another elephant on the table that doesn't get talked about, and it's part of the discussion we had. It wasn't that probation and OJS fight; it was more if the department has taken on an entity that they didn't realize involved accountability and services that needed to be provided by Medicaid wouldn't pay for, or if they're not comfortable with that parole function. Do we need to talk about it so we can talk about more collaborative agreements, or things of that nature? Because, again, when you talk about...that's a big key to the behavioral health services of kids within juvenile justice. And there is a disconnect...it's not spoken outright. It's as clear to me as it is clear that the sun comes up every day, based on day-to-day experiences, that it's problematic, and it needs to be addressed, and it also involves not just outcomes, therapeutically, but I wrote the word "recidivism." What's one of the outcomes that you want to look at in behavioral health that involves the delinquent kid? And if you send them to Kearney. Has anybody done a study of the delinquents kids and the various placements, whether it's Clarinda Academy or Cooper Village or Kearney, or the kind of recidivism that you get? We did, not a scientific study, just a look-see about five or six years ago--the battle was with the county then, not with the department---and I said, take our Douglas County kids. And we looked at those who went to Clarinda, those who went to Kearney, those...you know, some of the out-of-state behavior modification kind of places--and this was before any administration here and even before this government. The recidivism rate for Kearney was 50 percent; for Clarinda it was like 85; for Epworth it was up...that meaning 90 percent of Epworth recidivated, meaning only 10 percent did--50 percent though. So anyway, that's not to get off subject, but to get back to.... If this is to be a substantive committee, if we are really talking about behavioral health, we have to talk about that issue, and either just say we love it, or we hate it, it's an albatross, and we're trying to get rid of it but we won't talk about it, and do it indirectly, because here's what's happening. Certainly in Douglas County. We have a lot of kids who need a lot of services, but they are acting out in very dangerous ways--guns and drugs--and we can't ignore that a 14-year-old just got

charged as an adult. But then we get some 17-year-olds who come to juvenile court who are way more serious than that 14-year-old. So I guess that is my dog with a bone, but I will feel if we end up in December without ever being honest and talking about that issue, we will have missed a wonderful opportunity to be real in terms of our kids. Sorry. I'll shush, Senator Heidemann. []

RUTH HENRICHS: And Liz, I'm not going to argue against that but I'm just going to say I think the first thing we have to know is what do we need. Do we need...? We're not evaluating the services right now at Kearney. I agree with you that is critical for all of us whether you're a private provider, like the one I'm at, or whether you're at Kearney, or wherever; the quality of the service and the accountability for what we do should be there. But I think, first of all, we need to know what that continuum is, and do we need a Kearney at all? Do we need what they offer or does our continuum say, no, we don't need a Kearney with peer support or whatever they do? We need a Kearney that does subacute, or something; I don't know; a detention. []

LIZ CRNKOVICH: I agree with you, and that's one thing we talked about, because I kept getting stuck on some of these, and you talked about the wish list. And so you're right. And that's where I threw in the level...you know, if you go back to that point system that was created through Office of Juvenile Services about the different levels of risk, and blah, blah, blah. Then let's not talk about YRTCs or anything; I agree with you. In the wish list, talk about this kind of accountability, this kind of secured facility, a level 5 or blah, blah, blah. But Kearney gets thrown in, and Geneva, by name, without really knowing what they are or what they do, as opposed to getting thrown in as a part of the continuum. So maybe that's where I'm...so we're not in disagreement. I just... []

RUTH HENRICHS: Right. I don't think we are. I mean, I still say I want to know all the different levels of service are that we need, and then it would be my expectation that if we're going to support Kearney, it's going to deliver one of those. And somebody is going to be held accountable to hold Kearney accountable. []

TODD LANDRY: And I think that your comments, you know, I think I don't find a lot of fault with. I will state that Kearney, Geneva, Hastings, Lincoln, Norfolk. Let's not confuse, those are facilities. At any of those facilities or many more across the state, many kinds of services can be actually provided there. So I think we need to be careful not to confuse a name of a facility or a location of a facility with services. So when you ask, what is it that they do there, it could be many things, as it could be many things at Epworth Village in York, at Ute Halle, Cooper Village in Omaha, at whatever it may be. So I think there is some confusion sometimes there when we tend...just as at Hastings, as we found in our tour, there is at least three kinds of services being provided there, and some would argue perhaps other kinds of services, as well, certainly depending upon how you bill. I do want to point one quick thing as it results to Medicaid paying for anything at Geneva or Kearney. Medicaid, as I understand the rules, does not pay for any services at a locked-down facility, and so I don't think there is any question about us knowing or not knowing whether or not Medicaid will pay for those services. We know at those two facilities they won't because of the milieu that is being used there. []

LIZ CRNKOVICH: Correct. That's why certain services sometimes are not utilized when they're necessary, because Medicaid won't pay for them--like detention. []

KATHY MOORE: But I believe the Chinn report identified, and I've heard from other national sources, I think that is still open for discussion. I think there are some states where there is a separate facility on a Kearney campus. []

TODD LANDRY: Yes. As currently configured, it is not being promoted. []

KATHY MOORE: Okay. So, there isn't...I don't want us to walk away thinking that we couldn't add the substance abuse beds. []

TODD LANDRY: No, that's right. As currently configured. Yeah. []

LIZ CRNKOVICH: And I'm not angry, by the way. That's just the Irish that (Inaudible). (Laugh) We call it passion (inaudible) lest anyone confuse the two. []

TOM McBRIDE: Scot, does this include, with the beds and stuff, does that have the outstate providers included in that, as well? []

SCOT ADAMS: It should. []

TOM McBRIDE: In all of those numbers? []

SCOT ADAMS: It should, Tom. []

TOM McBRIDE: Is there a way, then, to...and I don't...maybe it's not even important to do...but, you know, as you look at treatment group home or residential treatment, that we also are utilizing some of those beds out of letters of agreement, that come out of, you know, other divisions, even though they're not associated with (inaudible). []

SCOT ADAMS: Yeah, it's an interesting thought. I would think on the Medicaid side (inaudible) who they paid, and so I would think that however the contract is set, it would be...it would not matter to the Medicaid side. Todd's division I'm less sure of. []

TOM McBRIDE: I'm just looking at basically what you've got, is you've got somebody out at the Division of Children and Families or Behavioral Health that even though that's not a recognized bed number in there, it's being utilized in that (inaudible), you know. Because if we've got a youngster that Medicaid won't pay for, but yet the case manager says, well, you know, we want them in this level of care, it's coming out of somebody else's funds down there. It's still up there in the beds, but it also doesn't indicate... []

RUTH HENRICHS: It's being paid down here. []

TOM McBRIDE: And the units, we can...how can we find out how those are measured? Is it, you know, like a day or...some of these I'm not familiar with, if it's... []

SCOT ADAMS: Oh, what a unit is? []

TOM McBRIDE: Yeah. What the.... Is that a code anywhere? []

SCOT ADAMS: It's typically either a slot or a bed. []

TOM McBRIDE: Pardon? []

SCOT ADAMS: It's typically either a slot or a bed. A slot, in the case of outpatient, would be an hour, roughly. Med management would be in the 15-minute category kind of thing. Partial could be half-day or a day depending on the nature of that. It would be nice to have Web site to send you all the data because you're all going to have individual questions. []

KATHY MOORE: Is this on a given day or over...? What period of time is reflected in this? []

SCOT ADAMS: Help me out further, Kathy. Where are you looking at? []

KATHY MOORE : Well, does this tell me that on a certain day in the year 2000 there were 50 people paid for inpatient through nine providers? The very first one. In other words, is it on a given day? Is it a snapshot of a day? []

SCOT ADAMS : In the case of those, it would be, I think, an average available census. I'm not sure that that's on any given day that we got that many people in there, but available beds. The beds among providers tend to go up and down a little bit, and so for

our planning purposes it would seem to be this group's kind of purposes it would parallel. That was what we count on, if you will, in the system. []

KATHY MOORE: And so to Tom's question then, if we were to look at, for instance, the Hastings behavioral...the Hastings chemical dependency beds I'm assuming are in the 82 YRTC count. []

SCOT ADAMS: No, that's Geneva, it says. []

KATHY MOORE: Or 172, I mean; I'm sorry. []

TODD LANDRY: No. That's our number of (inaudible). []

KATHY MOORE: Okay. So the chemical dependency beds would be... []

SCOT ADAMS: (Inaudible.) It should be under the RTC beds. []

KATHY MOORE : And then the behavioral health beds from Hastings, because they haven't been paid for out of Medicaid, would they be under Behavioral Health or Children and Families? I don't see any... []

SCOT ADAMS: It should be under Children and Families. []

KATHY MOORE: But I don't see any RTC level under Children and Families. That's why I'm... []

SCOT ADAMS: Yeah. I don't know the answer to that. I'll ask (inaudible). []

KATHY MOORE: And I'm not trying to split hairs. I'm just trying to figure out exactly what we...because it would be nice then eventually... []

_____: Well, it would be a big number added to the 125. []

KATHY MOORE: Right. And then you would ultimately hope to be able to allocate some dollar amount to each of these, so that's what I'm trying to do. []

TOM McBRIDE: I think those...if the previous conversation is correct, those would fall under the RTC beds, yet the funding would come out of one of the other ones. []

KATHY MOORE : Well, but...yeah. Okay. (Inaudible) figure that out. []

BETH BAXTER: So maybe in our Division of Children and Family, there's RTC and then acute. If you look at the other piece here, there's, what, 16 RTC and 6 acute would be...that are Hastings Regional Center. Maybe they're just not listed (inaudible). []

SCOT ADAMS : They may not be listed. There are no acute anymore at Hastings. []

BETH BAXTER: Right. Okay. But they're over here. I mean there aren't any there but they're still listed as a service. []

JEFF SANTEMA: Is there any sense if there were to be an inventory of capacity requested, the statewide capacity inventory, or availability of services inventory? Very quickly, what would that involve to get that done? []

LIZ CRNKOVICH: Could you repeat that? I'm sorry. []

JEFF SANTEMA: If there was a desire for a statewide inventory of services for children just to answer the question that was raised earlier--what do we have now?--and a way to determine what do we need and where do we want it, that type of thing, how would that be done? How would the inventory be accomplished so that there were accurate

numbers? []

KATHY MOORE: And I'm assuming this is the beginning. I thought the beginning, which is to the heart of my question. Maybe that's what you're asking (inaudible). []

JEFF SANTEMA: This is not geographically specific. This is just... []

KATHY MOORE: Correct. []

BETH BAXTER: Would it be helpful to take this and add the mental health piece here and the Division of Children and Families, and then identify where...? Is that what you're saying? Identify where the services are, the...? []

KATHY MOORE: And it might even have to be a bit of a "what." []

JEFF SANTEMA : Would you like more information by the next meeting, on (inaudible) on what, how that could be accomplished? []

KATHY MOORE: Um-hum. The where and the what. Like, of these RTC beds, how many are chemical dependency versus (inaudible). []

JEFF SANTEMA : Okay. So as not to take up a lot of your time now, we can get more information. []

SCOT ADAMS: I love the obsession with detail. At the same time, are we really going to need that? The split between all that? []

KATHY MOORE: Oh, yeah, I think so. []

SCOT ADAMS: For this? []

KATHY MOORE: Well, if we have to be able to figure out what...yeah, how to allocate how much money... []

SCOT ADAMS: Geography, I agree, especially in a state where we've already made the decision through 1083 that we are behavioral health, and thus coming together. It's really an anachronism to talk about mental health and substance use. It's all behavioral health. []

KATHY MOORE: Right; right. []

SCOT ADAMS: And I think we ought to adopt that sort of perspective in this committee. []

KATHY MOORE: Do we have...? I think we need, for instance, how m any sex offender beds we have, how many...? And there are some set categories that I think we need to know. In the ideal world, you would then look at your court records, your... []

JEFF SANTEMA: And I apologize if I seemed to indicate that we could that inventory by the next meeting. I was talking about what...and understanding of what would it take...whether it would be available to the task force. []

KATHY MOORE: (Inaudible) we need to be clear about what it is we truly need. I guess I don't know how you recommend allocation of funds... []

SCOT ADAMS : Well, for instance, 27; compared to what, you know? What is 27 CD beds going to do for you, and is that too many, that too few? []

CANDY KENNEDY : Well, Scot, you probably... []

SCOT ADAMS: It means nothing. []

CANDY KENNEDY: Yeah, it would, Scot, if you wanted to know, at maximum, maybe at one time, how many were used... []

SCOT ADAMS: Bingo. Now you've got context. []

CANDY KENNEDY: ...consistently. So you know how many that year. []

SCOT ADAMS: That maximum is a contextual number. How do you find out what maximum is as opposed to what is? []

CANDY KENNEDY: I don't know. Don't you have it? []

SCOT ADAMS: Yeah, me neither. That's what I'm saying. It sort of feels like... []

BETH BAXTER: We have prevalency studies, those types of things. That's some of the information that's been provided for us. But I do think...I mean, just the experience on the adult system, let's say, that there is merit in knowing how many mental health, how many substance abuse, because we know on the adult side our substance abuse services are somewhat limited, and that's an area that we continue to try to build that capacity. So I think it is...it's great to talk about it as behavioral health, but it is also important to understand where kind of the speciality service lies. []

CANDY KENNEDY: And maybe what services are being utilized more than others, as well. []

SCOT ADAMS: And my point is, as long as we keep talking about mental health and substance abuse, rather than building person capacity and thus system capacity, you're going to build mental health beds or sex offender beds or these beds, as opposed to

system capacity. That's my argument with regard to this conversation, is it feels like you're going down the wrong road. []

RUTH HENRICHS: But there is a system capacity for substance abuse beds, dual diagnosis beds, and mental health beds. []

SCOT ADAMS: Not if you think about it as behavioral health, and you staff, you train and deploy people and resources to be able to do both. []

RUTH HENRICHS: That's right. But in order to know what (inaudible) and how you're going to get there, you've got to know where you start. []

SCOT ADAMS : And that's a very different question of a 50,000-foot plan. IT's a very different level. Instead of talking about we need ten more beds in Scottsbluff for substance abuse, we might be saying we need to train 15 staff members in Scottsbluff. That's a whole different question. It's a way different cost. And I think you get to the same point in terms of capacity potential. []

RUTH HENRICHS: I don't think we could say we need to train 15 unless I have some data that told me that was what it was. []

KATHY MOORE : One of the challenges in terms of the data, in the ideal world we would be able to go to the courts and to the other creators of clients, if you will, or identifiers of clients, and say, during this same period of time or on any given day there are X number of kids who have been put into these systems who have been identified to have a drug and alcohol problem, or who have been identified to be sex offenders. I mean, that would be, again, your context. We would be clear about what the population need is, and then we'd be able to draw services from that. Now, I think we can get some of those numbers from some Children and Family Service files, some from some court files, some from Foster Care Review Board files. But I think that's...I think we have to go

through some of those exercises to get at capacity. []

LIZ CRNKOVICH: For example, UNO did a...I told you, did a study for us before we started drug court. They did a study of all the kids that came in for arraignment. And through that process, through questioning, through doing UAs, they were able to reach certain conclusions that, say, of all the kids that came in for that first hearing before a court within a 90-day period, half of them used drugs, and of that one-half, a quarter of them could be deemed chemically dependent. I mean, that gives you kind of a picture of (inaudible). []

KATHY MOORE: And we did a similar thing, reading your files for methamphetamine. In that context we didn't break out child use from parent use because that wasn't what we were looking for, but, yeah, those... []

LIZ CRNKOVICH: What we probably need to look at...and through the court is one way to look at who are these kids and whether the (inaudible), how many...like you say, how many (inaudible) sex offenders. []

KATHY MOORE : An I'd have to look at the justice program. I know it won't include Douglas County, but the justice program has a whole new level of information that they didn't have before, so I don't know what they can provide. But they may be able to give us some of those answers. []

SCOT ADAMS: If this committee comes out with the recommendation that says we need five more beds or X number of beds in the Scottsbluff region and ten more in Valentine, 13 more in Lincoln, I'll be dumbfounded. (Inaudible) get anywhere close to that. And we can take time with that, but it's ten until 3, and next time it's going to ten to 3, and we will have not talked about something else. And so, you know, (inaudible) pleasure of the committee. []

LIZ CRNKOVICH: Do you think that's phase 2, after this whole...? []

SCOT ADAMS: At least phase 2. []

LIZ CRNKOVICH: Not even this committee. After the December report down the road, and that that's... []

SCOT ADAMS: Doesn't that sound like implementation to you? It does to me; I should put it that way. That's all I'm saying. We're taking time arguing this, as opposed to item whatever else, which would be public comment. []

KATHY MOORE: Well, and the only...and I'm not going to...I'm not really arguing one point or another, except that when Beth turns in our "so what should be in the report," we did feel that the report needed to include recommendations for next steps that would include some dollar amounts and some implementation strategies. So I do think we are hopeful that we are further down the road than simply saying, here are the guiding principles and there shall be created a children's behavioral health plan. []

TOM MCBRIDE: But would they even be able to identify how many different service providers, by region, to just look at that? []

SCOT ADAMS: You know, I think we can probably do all of that. The more categories of information you ask for, the opportunity for error goes up dramatically with each category, of course, so as you think you're getting closer to truth, you are getting, in some cases, further away from truth by adding more precision and detail. But let me say very clearly, we can certainly get the information in most of the cases. And let me take one last stand and I promise I'll shut up. One hundred and twenty-five million spent on children's behavioral health. If we move 20 percent of it to something else, do you think we're going to be close? I mean, isn't that a big number to move? That's going to be a huge number to move. We'll be lucky if we get out of single digits. And, you know, ten

beds versus seven just isn't going to matter, I don't think, in the big picture of things, in my opinion, and the committee can do what it wishes to. Thank you for listening. []

SENATOR HEIDEMANN: I think we've had good discussion today. We do have to keep moving. It is now seven until 3. []

KATHY MOORE: Very diplomatically stated. (Laughter) []

SENATOR HEIDEMANN: It is time to move on though. Sometimes you think you're moving, and sometimes you think you're stuck in the same spot. I guess everybody can just come to their own conclusion on (laughter) where we're at on that one. But it is...we do have a few minutes here to gather some public input, some public comment, if anybody out there would like to share with us. We must have covered it all today. So seeing no public...anybody wishing to make a public comment, we'll go with number 12, which is adjournment. I do believe we are meeting again September 19. Is there anything else that you would like to...? Okay. With that, I appreciate everybody's time and effort here today, and hopefully, for your sake, Senator Johnson will be back next time. []