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COMMITTEE ON HEALTH AND HUMAN SERVICES  
February 11, 2005  
LB 332, 534, 551, 606, 613, 728

The Committee on Health and Human Services met at 1:30 p.m. on February 11, 2005, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB 534, LB 332, LB 728, LB 606, LB 618, and LB 551. Senators present: Jim Jensen, Chairperson; Dennis Byars, Vice Chairperson; Doug Cunningham; Philip Erdman; Gwen Howard; Joel Johnson; and Arnie Stuthman. Senators absent: None.

SENATOR JENSEN: While we're waiting for the rest of my committee to arrive--I think we wore them out. Wednesday night we were here until a little after six. Last night we were here until 8 o'clock on hearings. I hope we don't go quite that late tonight, or this afternoon. But there are sign-in sheets over there at this table. If you are going to testify, we would ask that you would fill out one of those before you come up and testify, and then drop it in this little wooden box on the testifying table. And also, when you do come up to testify, if you would give us your name, spell your last name for us, so that we have that in our records. These proceedings are transcribed, they're recorded. If you're carrying a cell phone, I would ask that you turn the ringer off so that, again, that doesn't go off in the transcriber's ears. But when you do come forward, give us your name, spell your last name for us, tell us if you represent an organization or if you're speaking in your own behalf. Then also we do take proponent testimony first. After we hear all of that, we will take opponent testimony, and neutral testimony, if there is any. The senator introducing the bill has then the right to close on that, and only a senator can do that, as we move through the process. Before us today we do have six bills, and I would ask that if you do have written testimony, that you give that to our page, Jill, who is here, and the correct number is 12. If you don't have that many, why, we can make copies. However, if you do want the entire committee to receive those copies, why don't you bring those up ahead of time, so that she can do that in time for all the senators to read it as you are giving that. I'm going to ask that you hold your testimony to no more than a page-and-a-half. That's about three minutes of testimony. If we do that, then everybody has an opportunity to speak and if something goes over that, then it just makes it a little tougher for

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the person following you. Also we would ask if somebody who testified ahead of you had said the same thing you were going to say, please hold your remarks and go on to something else, so that we have a variety of discussion and not a repeat of the same thing over and over again. With that, I will introduce you to Senator Gwen Howard, who is from the Omaha area. She's new to the committee this year. I welcome her to our committee and the input that she's been able to bring forward. Our other committee members will be here shortly, but I think that we will go ahead and begin. Senator Synowiecki is here to introduce LB 534. Welcome, Senator.

LB 534

SENATOR SYNOWIECKI: (Exhibit 1) Thank you. Thank you, Senator Jensen. Good afternoon. I am Senator John Synowiecki. I represent District 7 from Omaha. Today I bring LB 534 for your consideration. The Legislature previously passed the Nebraska Behavioral Health Services Reform Act, in an effort to move the state to a more community based mental health service delivery system. This legislation contains provisions revising the Nebraska Mental Health Commitment Act. LB 534 would change the current statute to permit an advanced practice registered nurse who is certified in a psychiatric or mental health specialty to perform the evaluation of a person admitted for Emergency Protective Custody. Advanced practice registered nurses are highly qualified medical professionals. APRNs must meet the requirement of a licensed registered nurse in the state. They must additionally complete an approved APRN program, which consists of a year of academic work and 500 hours of clinical practice. Additionally, APRNs must pass an approved credentialing examination and meet requirements for continuing competency. All APRNs certified after 1996 must have earned either a master's or doctoral degree. APRNs provide mental healthcare in certified areas such as mental health and have the authority to prescribe and manage medications, manage chronic health problems, and order, conduct and interpret diagnostic and laboratory tests. I strongly believe that a medical professional with these credentials ought to be able to perform an evaluation under the Nebraska Mental Health Commitment Act. Senators, as

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your state transitions towards a community based mental health service delivery system, it is critical to make certain our communities have the necessary resources to carry out this mission. Given the geographic configuration of Nebraska, I have very serious questions relative to the availability of licensed psychiatrists and/or psychologists in all our areas of Nebraska during emergency situations. This legislation expands the resource base for the Nebraska Mental Health Commitment Act. I want to thank the committee for giving full consideration to LB 534.

SENATOR JENSEN: Thank you, Senator Synowiecki. Are there any questions or comments from the committee? I don't see any. Will you be here to close, John?

SENATOR SYNOWIECKI: I'll be here for the testimony.

SENATOR JENSEN: Sure, very good. Thank you. May we have the first testifier in support, please, on LB 534? Anyone in support? I might mention that now the committee is joined by Senator Doug Cunningham from Wausa, Nebraska, and Senator Joel Johnson from Kearney. Thank you. You may proceed.

SUSAN MUHLBAUER: (Exhibit 2) My name is Susan Muhlbauer, Muhlbauer is spelled M-u-h-l-b-a-u-e-r. And I am here as an individual testifying, but I have also hand carried two support letters for written testimony. The first is a letter from the president of the Nebraska Psychiatric Nurses Association in support of this amendment. The second is a letter from Dr. Virginia Tilden, who is the dean of the University of Nebraska Medical Center College of Nursing, also in support of this amendment. I am an advanced practice registered nurse. I am board certified in adult mental health nursing. I also have a Ph.D. in sociology. My specialty area is severe and persistent mental illness. I have worked in the state of Nebraska as an advanced practice mental health nurse since 1994. I would like to speak in support of this amendment. I believe that the skills available through the advanced practice registered nurses are certainly adequate to provide this service, and I also believe that it provides an opportunity for areas of the state that are in medically underserved or frontier areas to have access to the type of mental health services

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that this provides. I am certainly open to any questions, and I thank you for your consideration of the addition of this amendment.

SENATOR JENSEN: Thank you. May I ask how many nurses are contemplating or entering this field? Do you have any idea? Certainly it's an area that I think we do even have a shortage of nurses so trained as you are.

SUSAN MUHLBAUER: At this point in time at the University of Nebraska Medical Center, there are tracks in the graduate program. I do know that in the Capstone course at this point in time, for the psychiatric mental health nurses, there are, I believe, either 16 or 18 students. In the integrated program that has the mental health and the family nurse practitioners, I believe there are six. And there will be additional groups entering this fall.

SENATOR JENSEN: Generally, how many of those stay in Nebraska?

SUSAN MUHLBAUER: For nurses, a goodly number of them stay in Nebraska. Many of them--a part of what is done is done through teleconferencing. Many of the nurses are in their own communities and remain in their own communities, coming to a specific site, at times.

SENATOR JENSEN: Great. Thank you very much. Any questions from the committee? Senator Johnson?

SENATOR JOHNSON: Just a follow up on that, Senator Jensen. In the past there have been joint programs with Creighton University on the psychiatric level. So are we talking that this would represent the total for Omaha, these numbers, or would there be numbers on the Creighton side potential, as well?

SUSAN MUHLBAUER: I'm familiar with UNMC College of Nursing. I am not familiar with Creighton's numbers, so Creighton's numbers would be in addition to these numbers.

SENATOR JOHNSON: Okay, so there are additional numbers. Thank you.

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SUSAN MUHLBAUER: Yes, sir.

SENATOR JENSEN: Great. Thank you for your testimony. I do have letters of support from the Nebraska Hospital Association (Exhibit 3), and another letter of support from the Nebraska Physicians Association (Exhibit 4). Thank you.

LINDA JENSEN: (Exhibit 5) Hello, I'm Linda Jensen. My last name is spelled J-e-n-s-e-n, although I'm not related to you. (Laughter) We always have to say that, don't we? I'm here today representing the Nebraska Nurses Association. I'm from Kearney, Nebraska, as Senator Johnson knows. We are, of course, the largest nursing organization in Nebraska and represent over 20,000 nurses, and we send out our bill tracker to all the schools of nursing. And we wish to thank Senator Synowiecki, Senator Combs, Senator Johnson, and Senator Price for bringing this law forward. I also have testimony here from--and I will give you--that is written from a nurse practitioner who actually is the nurse who cares for my family member. And she is also supportive of this bill. As some of you know, I do have a family member who has a serious mental illness. And over 10 years ago, we did have to use the commitment process to obtain mental health services that were very desperately needed. The police we worked with were very understanding and caring; however, the process of being handcuffed and shackled is very humiliating and distressing, for both him and for us. It was probably one of the most horrific times of our lives, and it's something you don't ever forget and it really still distresses me when I think about it. But modern medicine is miraculous and this person today is living in his own apartment, working full time, and we're enjoying his being with us at many family activities. And he's being cared for by a psychiatric nurse practitioner, and we appreciate her caring and the extra time she's able to spend with him. So that if hospitalization did have to occur--there are times when people with mental illnesses are...they do understand their need for care and their need to be safe from voices or their feelings of homicide or suicide. And so if they're being cared for by a nurse practitioner and she or he can help them be hospitalized in a timely manner and treated appropriately, it seems to make sense. And it could be more early intervention, which can save money and lives, shorten hospital days, improve outcomes of treatment. And being

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from Kearney in a somewhat more rural area, we do have a terrible shortage of psychiatrists and psychologists there, and we don't even have very many nurse practitioners, although we do have--there's a few out there that are going through the UNMC program that Susan was talking about, because it's a lot of distance learning, which they can work with, and do their practicums with other psychiatrists in the area. And some of those--I think those are planning on staying, so we're hoping we're going to get some built up there some time. So I think there is a great need for this bill, and shouldn't be a great deal of cost with it, so I hope that you can advance it to General File.

SENATOR JENSEN: Thank you, Ms. Jensen.

LINDA JENSEN: Do you have any questions?

SENATOR JENSEN: Any questions? Maybe if you can get them out there and exposed to that rural life, they'll love it.

LINDA JENSEN: That's right, or if they've already lived there. I know often they do have families there, so maybe.

SENATOR JENSEN: Super. Thank you. Anyone else wish to testify as a proponent? Anyone as an opponent? Neutral testimony? Seeing none, Senator Synowiecki? He waives closing. (See also Exhibit 6) Is Senator McDonald here? Senator McDonald is on her way; we'll just wait for just a few minutes. I might mention, joining the committee is Senator Phil Erdman; he's from Bayard, Nebraska. While we're waiting, can I see a show of hands of how many wish to testify on LB 332? We do have a few. Two, three, four, five, six. Okay, thank you. Thank you.

SENATOR McDONALD: I am assuming you're waiting for me.

SENATOR ERDMAN: Yeah, we were, so we voted. (Laughter)  
Just kidding.

SENATOR JENSEN: Thank you. Welcome, Senator McDonald.

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SENATOR McDONALD: Hello, hello. Sorry I'm late. It look me a little while to walk down the hall. Senator Jensen and members of the Health and Human Services Committee, I'm Senator Vickie McDonald, and I'm here today to introduce LB 332. LB 332 creates the Office of Problem Gambling Services within the Division of Behavioral Services and provides additional funding for problem gambling services in Nebraska. The need for problem gambling services in our state continues to grow; 41,610 Nebraska adults experience problem gambling behaviors each year. It is estimated that problem gambling costs society a minimum of \$5,100 per problem gambler. This amounts to well over \$212 million in social costs to the state, if left untreated. Adolescent gambling rates are two to three times that of adults; 26,000 teens and preteens took the Nebraska Risk and Protective Factor Survey this last year or, excuse me, actually this year. The survey compiles statistics on drug and alcohol abuse and gambling among school-aged children. Fifty percent of the students surveyed reported that they have gambled. Of the students that have gambled, 32.4 percent reported they had gambled over the past year for money or something of value. Fifteen percent of the students that have gambled had done so in the last 30 days, so the 30 days preceding the survey. Seventeen percent of the students that have gambled said that they have been preoccupied by their gambling behaviors, and five percent of the students have gambled reported they had spent more than they intended. Research has shown that a full array of easily accessible problem gambling services reduces the incidence of problem gambling, regardless of the availability of gambling opportunities. Statistical evidence indicates that problem gambling is a growing public health issue in our state. We believe that the best solution is a focused public health approach that addresses problem gambling at the community level. A balanced approach should consist of public awareness and education about problem gambling and the services available; prevention; treatment options and services; statewide coordination of problem gambling services; a public policy which funds problem gambling services from existing gambling revenue; goals that include prevention and reduction of gambling-related problems; promotion of balanced and informed attitudes, behaviors, and policies; and protection of vulnerable groups. LB 332 provides a framework for a focused public health approach to

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problem gambling through an adequately funded, structured program. It sends a clear warning. Funding the legislature has set aside for problem gambling must remain solely dedicated to problem gambling. Statutory funding designated for use in the gambling assistance program must not be siphoned off to fund other behavioral health areas. Nebraska voters expect money in the Compulsive Gamblers Assistance Fund to go to the treatment of problem gambling. The gamblers assistance program is accomplishing great and amazing things, even though they have only 1.5 full time employees. They have a toll-free help line that fields over 225 calls per month. Outpatient contracted services from four providers and 21 individual counselors provided professional counseling and assessment for more than 820 individuals last year. Outpatient service delivery this year is already 28 percent higher than last year. GAP is--and that would be the Gambling Assistance Program, and I will call it GAP--is training and certifying compulsive gambling counselors. They made 151 presentations to raise awareness of problem gambling, but there is unmet need. In the year 2004 providers documented 550 hours of unbilled service. Over half of the providers delivered services beyond their contracted amount. There isn't any extensive promotion of the program, and no funds are spent on prevention. LB 332 addresses this unmet need. Now to the bill itself. The administrator of behavioral health will appoint the program administrator for this office. The program administrator must have a background in education, assistance, and counseling for individuals and families affected by problem gambling. The program administrator will be responsible for the administration and management of the office. The duties include administration, coordination, and oversight of problem gambling assistance programs in Nebraska; development and management of a data system; a comprehensive array of community based problem gambling services for individuals and families; coordination and oversight of assistance programs; prioritization and approval of all expenditures of funds received and administered by the office; cooperation with HHS Regulation and Licensure in credentialing of counselors, programs, and facilities; promotion of research and education to improve the quality of assistance programs; recruitment and retention of counselors; ensuring access to problem gambling assistance programs. The funding for the Office of Problem

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Gambling Services will come through the Compulsive Gamblers Assistance Fund which includes revenue transferred from the State Lottery Operation Trust Fund, as required by Section 9-813, and that's \$500,000, plus quarterly allocations of a quarter of a percent of lottery revenue; revenue transferred from the Charitable Gaming Operations Fund, as required by Section 9-1101, and that's \$50,000; and a new source of unclaimed prize funds in the State Lottery Operation Trust Fund, up to a combined--this is a combined maximum--of \$2.5 million per fiscal year from all sources. Let me repeat that--total funding for the Office of Problem Gambling Services from all three sources would be a maximum of \$2.5 million per year, all paid from gambling revenue, nothing from the General Fund. Current annual funding for the Gamblers Assistance Program, as per state statute, is approximately \$750,000. The funding increase in LB 332 is an additional \$1.75 million, and I know I've taken a lot of your time introducing this bill, but I want to impress upon you that we have an unmet need for problem gambling services in our state. LB 332 is a way to provide these services while providing additional structure to the problem gambling program. I appreciate your patience and Jerry Bauerkemper, with the Nebraska Council on Compulsive Gambling will follow me. If you have any specific questions about the need for more services and so on, please direct those questions to Jerry or to one of the other professionals that are here to testify in favor of LB 332. I do plan to stay for the testimony and will close. Thank you.

SENATOR JENSEN: Thank you, Senator McDonald. Any questions? Seeing none, thank you.

SENATOR McDONALD: Thank you.

SENATOR JENSEN: May we have the first proponent, please? I do have letters of support from Deb Hammond (Exhibit 1), John Dittman (Exhibit 2), and also one from the State Advisory Commission on Problem Gambling and Addiction Services (Exhibit 3), and those will be entered into the record. Welcome.

HARLAN VOGEL: (Exhibit 5) Thank you. I'm not Jerry Bauerkemper; he's be coming next, I think.

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SENATOR JENSEN: Okay.

HARLAN VOGEL: My name is Harlan Vogel, and I represent the Heartland Family Services in the Omaha metropolitan area. Mr. Chairman, members of the Committee, I want to thank you for the opportunity to address the increased funding for the Gamblers Assistance Program in Nebraska. I'm a little nervous, so I'm a little bit stumbling over my words. I've been working with pathological gamblers and affected family members since 1995. I am nationally certified and state certified as a pathological gambling therapist. I am also state certified and licensed as a mental health therapist. I am currently the program coordinator for the treatment of problem gamblers at Heartland Family Service, which is located in the Omaha metropolitan area. I have been working with pathological gamblers and those affected by pathological gambling for over 10 years. In 1994 when I first started working with Heartland Family Service gambling treatment program, there was only one therapist in the area that treated problem gamblers, and that was me. I worked out of a small office in Council Bluffs, and the majority of gamblers I worked with were sports bettors and track bettors. They were mostly middle-aged Caucasian males. Currently, Heartland Family Service still has an office in Council Bluffs, where we have one full time therapist and two part time therapists working in our Iowa gambling treatment program. In 1996, HFS, Heartland Family Service, established the first gamblers' treatment program in Omaha. This program was initiated in response to the establishment of the lottery and the number of Nebraskans that were now traveling across the bridge into Council Bluffs to gamble at the casinos. In our Nebraska program, we currently employ two full time therapists, two part time therapists, and all of the therapists in the gambling program are licensed mental health therapists, and three of us are certified in Nebraska as certified gambling therapists. I'd like to point out that we employ more therapists in our Omaha office than our Council Bluffs office. Even though the casinos are in Council Bluffs, the Omaha area is vastly affected by those casinos and the problems that accompany them. In the 10-plus years I have been working with gamblers in the Omaha metro area, I have witnessed pathological gamblers go from being defined as mainly middle-aged Caucasian males, who bet on sports and dogs or horses, to a much broader definition.

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The definition of problem gamblers has increased. The typical gambler at Heartland Family Service at this time is between the ages of 16 and 70. He or she will be Caucasian, African-American, Asian-American, and sometimes Hispanic. They will be either male or female, and they are very rich, middle income, poor, or no income. They are business people, homemakers, firemen, policemen, electricians, nurses, janitors, car salesmen, teachers, bank employees, railroad employees, computer programmers or technicians, college students, high school students, or active in the military. They can be retired, on disability, or homeless. The reason they seek treatment varies. It can be the 16-year-old school bookie who stole prized possessions from his grandmother to pay off gambling debts when he decided to hold onto some of his bets, and then the bets went wrong. It can be the 55-year-old wife of a small business owner. She eventually lost thousands of dollars chasing the trance-like effect that she achieved when she played slots. It can be the 67-year-old retired teacher who lost over half his retirement savings chasing his losses playing blackjack before his spouse started getting contacted by credit agencies for overdue bills. It can be the bank employee who believed that borrowing money from his employer to gamble was okay, as long as he put it back when he won. Prior to being introduced to gambling, these people were the people next door, or the family member that had never done anything wrong. There is just something about gambling that sucks people in, chews them up, drastically alters their life, and then spits them out. At HFS, Heartland Family Service, we not only provide treatment for pathological gamblers, but we also provide treatment for their spouses, parents, and even the young children who have been negatively impacted by a family member's gambling behavior. Those affected by the gambler encounter high personal, financial, emotional, and social costs. They will often seek help because of the staggering consequences created by the gambler. They will reach out to pastors, family, or insurance. And unfortunately, most of these sources don't help a whole lot, because they don't understand the depth of the problem associated with the gambling. The only way many of these gamblers, of these individuals, can receive treatment is with the aid provided by the Gamblers Assistance Program that currently exists in the state of Nebraska. By the time a gambler or those affected by gambling come in for

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treatment, the financial consequences are fairly devastating and very few can actually afford to pay \$75, \$85, \$95 an hour for treatment. And very few insurance companies will help pay for treatment of problem gamblers. Last year 152 gamblers and those affected by gambling contacted Heartland Family Service seeking help. The average time between the actual call for help and the evaluation is six working days. Now that's a pretty good turnaround in most cases, but by the time a gambler or those affected by gambling call, the crisis is usually so huge that six days seems like an eternity. Of the 152 that contacted HFS, one-third failed to follow through on the evaluation. One of the things that shows us is that six days is too long, and the only reason we have to put them off for six days is because our schedules are full. We don't have waiting lists, but we do have to schedule them in where we can. We can't bump other gamblers to bring more gamblers in. I will not go into the statistical aspects of the costs of treatment for addictive gambling in Nebraska. Those will be catalogued in the Gambler Assistance Program's annual report for 2004 and in the handouts that you have there. What I will say is that the current trends indicate that even without legalized casinos, addictive gambling is on the increase in Nebraska. With the increasing popularity of Internet casinos and other forms of Internet gambling, and celebrity Texas "hold-em" tournaments appearing on almost every channel on TV--I recently did an interview with the Papillion Times on how the Texas "hold-em" commercials are influencing teenagers after school. Instead of going to a job, instead of engaging in a sport activity, many teenagers are now getting together and having Texas "hold-em" tournaments. Last year Heartland Family Service exhausted its allotted funding for 2003/2004 in 11 months. This year we are on track to fully utilize 12 months of funding in 10 months. You now have an opportunity to address and enhance an underfunded Gamblers Assistance Program. Right now I am issuing an invitation to each one of you. If any of you would like to talk to the gamblers in our program, please feel free contact me and an opportunity to sit in on one of our group sessions can be arranged. Earlier I mentioned some of the reasons why people seek treatment. The 16-year-old that stole prized possessions from his grandmother, now he's 20, and he recently joined the National Guard. The 67-year-old retired teacher, after a

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lot of work, has re-established a bond of trust with his wife, and they are enjoying their retirement together. The bank employee, he was arrested, spent time in prison, completed his treatment process after release from prison, and is currently rebuilding his life without quick fixes. The 55-year-old housewife? She completed treatment on a successful basis. Approximately six months after her discharge, I received a call from her husband. He told me that she had recently died of a fast growing cancer. He went on to say that the last five months of their life together was the richest that they'd had for a long time. He was very thankful for the help that she received at Heartland Family Service and the help that the Gamblers Assistance Program provided. In closing, I would like to read you a short letter I recently received in the mail. The writer of the letter had been in treatment on two separate occasions, but dropped out of treatment both times. It said, "Dear Harlan: I trust this letter finds you and your staff in excellent health and humble spirit. Listen, there's no hope for me with regards to gambling. I won't be wasting your time. Thanks for your caring and please continue to grow in this field. I lose." And then he signed it. Unfortunately, despite all our efforts, some gamblers continue to find trapdoors when they believe they've hit bottom, and they continue to gamble. Thank you for your time, and if there are any questions, I'd be glad to attempt to answer them.

SENATOR JENSEN: Well, first of all, thank you for your testimony. Thank you for the work that you've been doing for some time in the Omaha and Iowa area. We really seem to have a, almost an epidemic going on. I did read in the paper that on-line gambling will reach \$8 billion now.

HARLAN VOGEL: Um-hum.

SENATOR JENSEN: And of course, anyone that has access to a computer, whether you want it or not, it pops up, at least sites to go to.

HARLAN VOGEL: Right.

SENATOR JENSEN: And then I also did read where the proliferation, particularly on the poker issue that's on

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three channels on our television, and I also understood that young people...and if you go to some stores, why, they've got the card tables or the tables they lay out and everything else, and this is really becoming a...is there any end to that, or do we just keep going more and more?

HARLAN VOGEL: Senator Jensen, that's a question I've asked myself. Ten years ago when I started working with pathological gamblers, the cyclical nature of the process appeared to be 10 to 15 years. Now we're 10 years into it, and it seems to continue to be on the upswing. And just the types of gambling that you talked about, 10 years ago weren't even thought of. And it just seems that every time we turn around there's another form of gambling that all of a sudden has been popularized. Ben Affleck wins at a big Texas "hold-em" tournament, so boy, it's the thing to do. You know, so I don't know if there's an end; all I know is that from my end and from the therapists I work with, all we want to do is help the people get the help that they need to pull their lives back together and make things work for them.

SENATOR JENSEN: Is your program therapy and then do you follow a 12-step program like they do in alcohol addiction?

HARLAN VOGEL: Sure. There are occasions when we incorporate pieces of the 12-step program, but what we find is that a combined mental health addictions approach--it's fairly hybrid, you know--works the best. There is no set time frame for individuals in our program, because like mental health, you know, it's hard to say. You've been gambling for 20 years, you've got all the consequences, you've got all the contributing factors. We can't fix that in 12 months. Part of our treatment is helping develop abstinence, it's helping develop the awareness of why the gambling addiction began to establish itself, it's addressing contributing factors, what we term as core belief systems, and then it's developing the healthier tools, and then helping them to use the tools so they don't continue to create new consequences.

SENATOR JENSEN: I don't mean to prolong this, but I...

HARLAN VOGEL: No, that is fine.

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SENATOR JENSEN: ...also...there's indications that individuals that do gamble, there is actually a brain function or a pleasure that comes from a high risk activity. Is that...do you follow that line of thought, or...

HARLAN VOGEL: I sure do. And one of the things that we address with clients is we spend a lot of time working with them on creating that awareness, that that's one of the things that they crave is the high, the emotional shift that occurs when they're in action. And actually it starts well before they ever get into action. It starts with the manipulation to get the money. It starts with creating time. It starts with creating opportunity. And for many gamblers, the actual act of gambling is often anticlimactic. So you know, it's a whole process and now when they leave the casino, there's an extreme depression, frustration because, if you're a pathological gambler, even if you win, you lose because you continue to gamble until the point of financial exhaustion. So it's a very cyclical thing, and when they leave the casino and they're feeling very desperate, very anxious, the only way they believe, at that point, they can break that process is by starting to plan, how do I create another opportunity? We use a simple acronym, you create TOM--time, opportunity, and money. Most of the time, then, gamblers will act out somewhere.

SENATOR JENSEN: Well, any other questions? Senator Johnson?

HARLAN VOGEL: Yes, sir.

SENATOR JOHNSON: Well, yeah, you got me to thinking about this as well. You've gone through it pretty well. Are there any common traits that you find in these groups that are susceptible? I know you went through all of the different people and so on, but are there any psychological traits or something like that, that's...

HARLAN VOGEL: That's a very good question. When we look at problem gamblers, we look at two types, primarily. We look at the action/aggressive gamblers, which are the individuals that, getting back to what Senator Jensen said, seek and crave the high, the mood change that goes along with it, and

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studies do show that that high is comparable to what a cocaine addict can get. On the other side of the coin, we have what we call the passive/escape gamblers, and they're the types of gamblers, they don't chase the high, they chase a mood change that takes them away from whatever depression or anxiety or frustration or uncomfortable feeling they are experiencing. They just want to avoid and escape life. And so when dealing with gamblers, it really takes an educated therapist in the field of gambling to determine, what am I dealing with? It's real easy to clump gamblers in together and say, they're all pathological gamblers, so this is what we need to do. Well, no. What we've found, what I've found in the 10 years I've been working with gamblers is that each one has to be treated as an individual. That's where the mental health approach comes in. But there are several commonalities that we look at.

SENATOR JOHNSON: One short follow-up question.

HARLAN VOGEL: Sure.

SENATOR JOHNSON: You're located in Omaha and Council Bluffs. Sounds like that you are short of staff here. How about outstate and what percentage of people that you see are from, shall we say, outside of Douglas County?

HARLAN VOGEL: Sure. We primarily work with individuals in Washington County, Douglas County, Sarpy County, and I've even had some clients from Cuming County. Most of the...that's one of the nice things about the Gamblers Assistance Program, and I'll put a caveat in here for the way Tim Christensen runs the program. I think he's done a great job at providing services for the out counties, the rural areas. The problem that he runs into is that, unlike the metro area, the Omaha metro area and the Lincoln area, where we have agencies that can address this issue, in western Nebraska he has to rely on individual therapists. And the greater distances, there's a great degree of...it's a lot more work to help people out in rural Nebraska, just because of the unique situations that they all face. And mileage is one of the big ones. And so the therapists out in western Nebraska...I know he's got programs in Norfolk, there's a...and if you just go west, I know he's got programs all over the state. And so he's put a lot of

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effort...in fact, Mr. Bauerkemper can talk about the trainings that we use to train therapists for treatment of pathological gamblers. And he starts in the west and he'll work east, and then he'll start in the east and he'll work west. And you know, they go to great extent to make sure that trainings are available.

SENATOR JOHNSON: Thank you.

SENATOR JENSEN: One last question. Is there a correlation between an alcoholic or a propensity for somebody to gamble, who is also in alcohol or drugs or even smoking?

HARLAN VOGEL: Um-hum. Sure. What we recognized in many cases...I've worked with several alcoholics that were recovering through AA, Alcoholics Anonymous, and they've got several years of sobriety. But it seems like once they get involved with the gambling process, it catches them off guard, and they start redeveloping those addictive behaviors and those addictive tendencies, but they don't believe they're being sucked in, because they're not drinking. They have a real hard time correlating an activity--well, I'm not drinking, I'm not shooting, I'm not sniffing, I'm not doing anything. I'm not taking a substance in. But all this is happening to me, and I don't know why. It's really very confusing. If I can relate one quick story. One such individual came into my office, 10 years of sobriety through Alcoholics Anonymous. He'd started creating consequences, financial consequences, and his wife saw what was happening. She saw the addictive, alcoholic behavior starting to re-emerge, even though he hadn't been drinking. He sat across from my desk after we had done the evaluation that showed that a pathological gambling diagnosis was warranted, and sat across from my desk and said, okay, you convince me how an activity is like getting drunk. And so we used the first eight sessions to address the commonalities. And at the end of eight sessions, I looked at him and I said, now it's up to you to decide if you want to pursue what we're offering you, so that you don't fall prey to other addictive behaviors, or else you can go back to what you were doing. And he says, you know, I like what you're offering me; it's really broadened my thought process. I want more. And I know that individual right now, his life is so much better than he could have ever imagined it was, just because he

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broadened his thought process to a point where...and these are his words, he goes, I'm not just an alcoholic, I'm not just a pathological gambler, I've got an addictive approach to life. And that is often what we address with our clients, is their addictive approach to life.

SENATOR JENSEN: Wow, thank you. Any other questions? We thank you for your testimony.

HARLAN VOGEL: Thank you, and I'll leave some brochures to be passed around, as well as my testimony. Thank you.

SENATOR JENSEN: Next proponent, please?

DEB HAMMOND: (Exhibit 1) I definitely am not Jerry Bauerkemper. My name is Deb Hammond, H-a-m-m-o-n-d, and am a state certified gambling counselor, and the director of Choices Treatment Center in Lincoln, Nebraska. Harlan Vogel just alluded to numerous different incidences where he sees the problem of pathological gamblers and their families. I would like to read to you the definition, so that we are all on the same page as far as what this disorder is characterized as. Compulsive pathological gambling--a progressive disorder characterized by continuous or periodic loss of control over gambling; a preoccupation with gambling and with obtaining money with which to gamble; irrational thinking and a continuation of the behavior, despite the adverse consequences. Senators, I could have filled this room this afternoon with individuals who could testify to you and give you horror stories from the effects of the problems of pathological gambling that they experience. Their spouses, their children, extended family members and employers are all suffering. This addiction does not care who, what, when, where, or why. This addiction has no boundaries--blue collar, white collar workers are standing side by side seeking help. They share a common bond; they are powerless over a gambling addiction that has turned their world upside down. One thing the vast majority of these individuals have in common is that they did not know where to seek help or how to seek help. They didn't even know that treatment existed. I have worked with problem gamblers and their families since 1989, and those 16 years I have observed several different types of gambling, including illegal sports gambling, horse track wagering, stocks and

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commodities, keno, lottery, casino, and the current craze that is sweeping the United States, gambling on the Internet and Texas "hold-em." I have seen a shift from a clientele of mostly male problem gamblers to what is now a 50/50 split of male and female. On a daily basis I see families who are affected by problem gamblers. I help them cope with their finances, the breakdown of the family, the health risks, the criminal activity, the mental illness that accompanies this addiction. The majority of these clients I have seen have had suicidal thoughts. They fight the desperation stage of this addiction. It is an addiction that can drive depression to the lowest level. In the past many mental health counselors have been unwilling to treat or identify the problem gambler. Immersed in an already mentally draining and time consuming occupation, they do not want to take on another expertise. I have trained individuals on a state and national level, and the vast majority do not want to work with the problem gambler or treat them, due to the nature of the illness and the amount of work that it takes to treat this individual. This addiction cannot be fixed within a few sessions or with a pill. According to the 2002 Health and Human Services report, 47 percent of the 40,000 Nebraskans affected by problem gambling presented for mental health and substance abuse treatment one year prior to the treatment of problem gambling. Treatment success cannot be expected in 90 days. Long term treatment is the only way to restore a healthy, productive lifestyle for those affected. In working with my clients I have had to develop, educate and train referral sources from within the community centers right here in Lincoln, including legal, financial, substance abuse practitioners, mental health practitioners, medical doctors and psychiatrists. This referral source is critical to the treatment of the problem gambler in this state, and the development of an integrated treatment plan is necessary if we hope to reduce the costs involved with problem gambling. Equally critical is the development of a public health approach to the treatment of problem gamblers. I have hired a mental health counselor to integrate the mental health concerns with the addiction side of the treatment program for problem gamblers. Please refer to your handouts in your packets that will include testimony from the firm of Anderson, Creager and Wittstruck dealing with criminal activity in this city, Bernie Glaser, another attorney, John Dittman, president of Cornhusker Bank, who deals with

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financial situations on a daily basis. As you can see, the impact of problem and pathological gambling in Nebraska is far reaching. There is a definite need for education, prevention, awareness and treatment of problem and pathological gambling in Nebraska. Money spent in these areas will help preserve our families and communities, instead of reacting to the devastation that will occur if this addiction is not recognized. The testimonies you will hear today are from the individuals who have sought help for their problem. You will hear about their pain and legal issues. You will hear that they didn't know where to turn when their lives were unmanageable, and that their gambling had started to spin out of control. We need to show those who are affected by problem and pathological gambling where to seek help, and we can do this through a public health awareness approach, if we pass LB 332. I'd like to close with a poem, and you do not have a copy of this, and I apologize for this. As of recent yesterday, I had an individual who relapsed, and his 15-year-old daughter wrote this poem, as they discovered that they were \$16 in the hole in their bank account, and they had no funds to buy groceries with. "Disappointment, pain, and fear, realize that I was here. You make mistakes, you cause me pain. Now is all the hurt I can take. You roll the dice, you waste your life. When gambling you take a chance. Now I'm asking you to dance this dance. Take your right and take your left, this is a dance I won't forget. If not for me, then do it for you. There's something you can do. Now I'm asking you, drop the dice, forget the numbers. Change your life. You want a chance? Here we are, so please for us, dance this dance and drop the dice, and take the chance." I ask you to support LB 332 because of the situations that we have in our community and throughout our state with our children, who are at great risk, and because we need a protected fund. Do you have any questions?

SENATOR JENSEN: Thank you, Deb. Yes, Senator Stuthman?

SENATOR STUTHMAN: Thank you, Senator Jensen. Deb, you've been working with this program, like you stated, since 1989?

DEB HAMMOND: Yes, I have.

SENATOR STUTHMAN: Do you see a regaining on it, or are

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there more people getting addicted to gambling, or less?

DEB HAMMOND: I don't know if necessarily there's a number that's getting addicted to gambling, but I know there are problems that are surfacing as a direct result of it. And if we could educate, prevent... an outreach program of a public awareness approach so that we can reduce the number of people that present for treatment, then we're successful. And in order to do that, you have to have the funds available to do that. And we don't have those funds available. In 1992 and '93, when the original commission--and I was a commission member at that time--developed this plan, we built it and they came. And so now the problem is so far much greater that we don't have any money available to do this with, other than for treatment.

SENATOR STUTHMAN: And there are people that want treatment?

DEB HAMMOND: There are people who are seeking out now, that want treatment. Usually, there's a reason why. Nobody ends up in my office or in Harlan's office or anybody's office because they want to be there. There's usually a reason why they are there.

SENATOR STUTHMAN: Thank you.

DEB HAMMOND: You're welcome.

SENATOR JENSEN: Any other questions? Thank you, Ms. Hammond.

DEB HAMMOND: You're welcome.

SENATOR JENSEN: Next testifier in support, please?

RICHARD HEDRICK: I'm Richard Hedrick, H-e-d-r-i-c-k. Problem gambling is overwhelmed by the promoters of gambling. One of them is the state. A while back someone started a question, who would you go out to drink with? And one of the individuals was President Bush. Anyone with any sense knows that a problem drinker, as Bush admits, should not be enticed to a drink. A gambler is the same problem. The state should take a position that gambling cannot be

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stopped or should not be promoted. People who promote gambling do so for their own benefit. They receive the money directly or the money is used for their benefit. They have state projects that sound like they're doing really great things, but the main thing is they don't have to pay for it. Thank you.

SENATOR JENSEN: Thank you for coming forward. Any questions? I don't see any. Anyone else testifying in support?

THOMAS NUTT: (Exhibit 6) Good afternoon, Senator Jensen and the rest of the members of the committee. It's an honor to be here. I have a written statement. My name is Thomas L. Nutt, N-u-t-t. I'm here to support LB 332. This bill would create an office for the problem of gambling and increase funding for the Nebraska Gamblers Assistance Program. I am from Holdrege, Nebraska, in Phelps County, and I retired from the Nebraska State Patrol in 1997. I was a sergeant assigned to the Holdrege area. I was elected sheriff in 1998, and I am now in my second term as Phelps County sheriff. In 1999 I was appointed by Governor Johanns to serve on the Commission on Compulsive Gambling, and I was reappointed in 2004. At that time I was also appointed to the new HHS advisory board on mental health, substance abuse, and problem gambling. Members of the Nebraska Commission on Problem Gambling and I strongly support LB 332. We feel there is a need in the state to create the Office of Problem Gambling and increase funding available for treatment. Members of the commission feel Nebraska's needs justify a provision of a full time Office of Problem Gambling to oversee funding and treatment availability for problem gamblers. We feel a lack of provision leaves many problem gamblers to go untreated. As a career law enforcement officer I have seen many problems associated with problem gamblers. A percentage of suicides, thefts, domestic violence, juvenile crimes, and other criminal activity can be attributed to compulsive gambling. Over the past five years we've seen a sharp increase in these activities. The passage of LB 332 could have a big impact on reducing criminal activity associated with problem gambling. During the time I have served on the Commission for Problem Gambling I have witnessed an amazing success rate for those who have completed the proper treatment

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program. I have also witnessed some who have sought treatment and have been turned away, due to inadequate funding for the program. And I appreciate your time and attention to LB 332, and I wish to thank the senators responsible for creating this bill, and I sincerely hope it will advance to the next step. Thank you.

SENATOR JENSEN: Thank you, sheriff. Any questions for Sheriff Nutt?

THOMAS NUTT: Any questions?

SENATOR JENSEN: I don't see any. Thank you for coming up today.

THOMAS NUTT: Okay, thank you. You bet.

SENATOR JENSEN: Next testifier in support, please?

MARLA BRUDER: Good afternoon, senators. Thank you in advance for allowing me this opportunity to share with you my story. I'm sorry if I don't get through this. My name is Marla Bruder, B-r-u-d-e-r. My address is 129 County Road 2500, Denton, Nebraska 68339. I'm a 44-year-old wife, mother of two daughters, and I'm also a compulsive gambler. I was married at age 21, and I started gambling in my late 20s, playing pickle cards. My husband and I started going to casinos on New Year's Eve in the late 1980s with other couples. In 1993 when the lottery was legalized in Nebraska, I began playing the lottery and continued to go to the casinos. I'm unsure when my gambling got out of control. After entering treatment, I found scratch-off tickets shoved under the seat in my car, and the floor of my car was black from the scratch-offs. I was so infatuated with Powerball. I knew I had to play the same numbers every drawing because if I didn't, I thought that my numbers would come in and I would lose out. I would watch the news to see what the numbers were. If I missed the news, I would call the 800 number, and if the line was busy, I would check on the Internet for the numbers. I always thought that I was going to make enough money to pay off my debt, as well as take care of everyone in my family for the rest of their lives. That's why I kept going and playing the lotteries, to get out of debt. Somewhere around 1996 I had gambled

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away the household finances, I had fell behind on household bills and the mortgage. I would leave work early to go home and get the mail before my husband saw it or to erase the messages on the answering machine from creditors, so that he didn't know we were behind. I started having credit statements mailed to my office so that he wouldn't see them. All of our bills were at least two months' past due. And I started to think of any way to come up with some money to get them current so that my husband wouldn't find out how much money I had lost. I continued to gamble without thought of what was going to happen, because I always felt I was going to win enough to pay the bills. I didn't know what to do; I didn't know there was any treatment for gambling available. I eventually committed illegal acts to fund my gambling problem. I am due to be sentenced next Friday, on February 18, on a federal felony charge. I lost my job of 25 years as a state employee. I was unemployed for one month. I started working as a vocational specialist at Labor Solutions, working with the mentally disabled on May 31 of 2004, and was promoted to a vocational manager two weeks later. I had been told regardless of what happens, I will remain employed with my current employer, and should I go to prison, my job will be available upon my return. No one knew about what I had done and how bad my gambling was. In all my years gambling, I never recall, not even at the convenience store where I purchased all my lottery scratch tickets from the same clerk every day at \$50 to \$100 a day, anyone ever displaying or handing me anything that said, if you have a gambling problem, call this number for help. My greatest fear was getting caught and how bad this was going to hurt my family. I went through pain struggling fear and a feeling of being alone with no one out there, and no one to help me. Since entering treatment I've realized that the biggest obstacle wasn't my fear, but the embarrassment of what I'd done. I've learned through treatment that I am a compulsive, pathological gambler, and that there are consequences for my behavior, and that I had other problems in my relationship before. As a direct result of the consequences of my behaviors, I have been depressed. And with the help of my counselors at the treatment center and my medical doctor, I have now been put on an antidepressant and have been able to continue to work and remain in treatment. My husband, daughters, and I are learning how to be a better family, how to openly communicate, and how to

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heal the deep hurt that my addiction has caused. I have completed 10 of the 12 steps in my workbook and have made as many amends as possible to current date. There's been many times over the last 10 months that I have felt I couldn't go on and face another day. When those times have occurred, there's been a counselor there to talk to, either by my side or on the telephone. I didn't know that treatment was available until I saw my Employees' Assistance Program and an attorney. It is because of the referral to treatment that I am able to function and develop a better way of life to start restoring the trust with my family, and beginning to process the healing and forgiving myself. The counselors have helped me to see that I am not alone, I am not a horrible person, and that I can make amends to those I have hurt so badly, while also trying to forgive myself for everything I have done. They have spent countless hours at no cost, helping my family through understanding my addiction and how their wife and mother could have done the hurtful things I did. I admit now that I lost control and financially destroyed my family. There are a lot more details and a lot more pain we don't have time to get into today. That's all the more reason why LB 332 needs to be passed so that we can create a prevention awareness program that is easily accessible for problem gamblers and their families, to continue to fund treatment. The counselors have watched me suffer, cry, and laugh, and I don't know how I would have done it without them. I would not be there today without their treatment.

SENATOR JENSEN: Thank you very much, and the courage. Any questions? Thanks again.

MARLA BRUDER: Thank you.

WANDA SWANSON: My name is Wanda Swanson, S-w-a-n-s-o-n. I'm a state certified counselor at Choices Treatment Center here in Lincoln. I was asked to read a letter from a family member that was written to her parents. "Mom and Dad, let me start out by saying that I love you, and that's why I'm here. It's obvious that you are having financial problems because of your gambling habits. We're not here to gang up on you; we're here because we love and miss our mom and dad, who taught us about responsibility, discipline, hard work, love, and that family is most important to us all. Please

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don't be ashamed; we are here to help you and provide support, as long as you are once again committed to your family, and most important, taking good care of yourselves. Ever since I knew you were having trouble, probably why mom took the job at the truck stop, which I was totally against, I have really been angry and knew that the reason mom took the job was to pay your gambling debts. I know as well as you do that gambling destroys lives. Even though it may have gone too far, it's not too late to do something about it, which again, is why we are here. We love you. Every time that I went through an interview and they would ask me who my hero was, I would always tell them it was my mom and dad. Dumbfoundedly, they would look at me and ask why. I would tell them it was because my mom and dad instilled responsibility, hard work, and love all throughout my life. It would be hard to say that, not knowing you don't be things that you taught us--typo error--excuse me. Every day I look at the paper and the first thing I turn to is the bankruptcy section, wondering when I'm going to see your names in there. I shouldn't be ashamed when I hear people talk about people they know in Nebraska City who are in deep because of the casinos. It's really hard living with myself, knowing that I voted for something that is killing my mom and dad. Let's face it, mom and dad, you haven't been the same for a very long time. You know how people talked about others. How would you feel, knowing that they were talking about you? You're probably wondering what right we have, sitting here reading these letters to you, right? Simple--it's because we love you and care about you and hope to have you around a lot longer. I have a good friend that I would love to bring home to have him sample some of mom's cooking, but I'm really embarrassed to bring someone here to the house, because it is falling apart. I'm really concerned that your behavior is going to ruin the chance for my brother and his boys to make a living doing what they love to do and what they know best. I hope that this relieves you both of the pressure that you are under. I shouldn't have to feel guilty every time you buy your grandkids something, or take us out for dinner. Matter of fact, if you don't get things under control, I won't allow them to have anything you buy for them. Then you can tell them why. I would never take them away from you, because I know that they love you just as much as you love them. The hardest thing for a gambler to do, just like an alcoholic,

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is to admit that they have a problem. Do it and know that we are here to lean on as you did for us growing up. Please--is it really that hard a decision, choosing between your family and the casinos? We love you both." And this family member could not be here today.

SENATOR JENSEN: Thank you, Wanda.

WANDA SWANSON: Thank you.

SENATOR JENSEN: Any questions? Thank you for coming forward. Anyone else testifying in support?

JERRY BAUERKEMPER: (Exhibit 7) I think I'm it. My name is Jerry Bauerkemper; I'm the person they were talking about, and B-a-u-e-r-k-e-m-p-e-r. And I'm the executive director of the Nebraska Council on Compulsive Gambling. You've heard some stories about gamblers and family members, and you've heard stories about the pain of the gambling addiction. What I want to concentrate on is the issues that are going to come up in the opponents' piece of this. We know that 47 percent of the people who...in 2001, 47 percent of the people who came into our treatment programs had been into a mental health or substance abuse treatment program prior to coming in. They hadn't gotten the services they needed, and yet when they come into our services, there's a tremendous reduction in the services they need, after they come to see us. Many of them will go out of our programs--they will come in \$30,000 to \$50,000 in debt on average, and they will go out of our programs with a plan and a process, and they will be debt free, and they will have paid back their bills. Now no substance abuse program and no mental health program can say, we work with their finances. With gamblers, that's a primary piece. Our counselors learn about that, they work with the financial piece, they get them to pay back their bills, and I know this isn't popular--even the bookies get paid back, because they are a bill. And primary and first on that list is paying back families, because they're the first people that get paid. Many of them come in with having taken their family's...children's education fund, their retirement fund, and they've borrowed money because they can't pay their bills, and they've borrowed money off their house, and many of them are losing their house. You're going to hear

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testimony against this, and you're going to hear about a 2001 study by Dr. Loreen Rugle, and Dr. Loreen Rugle happens to be a gambling researcher, and you're going to hear a lot about the co-occurring disorders with gambling. And that's true, and there are a lot of co-occurring disorders with gambling. But when I saw the testimony and the letters that were submitted, I called Dr. Rugle and I said, what do you think about this? And I want to give you a letter that she just faxed me. And she says in that letter--if I could keep a copy--she says that treatment for problem gambling needs to be segregated, needs to be separated, and needs not to find its way into other funding sources and other funding pieces, simply because it is a disorder that needs specialization. And I'll let you read that. But the argument that's being made, that it's such a high occurring disorder and that it needs to be folded in, and there doesn't need to be an office, I challenge that. I challenge the fact that there should be a designated office for problem gambling. Senator Stuthman, you asked, are we gaining on it? And the answer is no, we're not gaining on it. We're losing the battle. We have come before the body several times in the last 10 years asking for additional dollars. Each time we've gotten bandaid dollars. And we're up to \$750,000. Let me suggest to you that \$750,000, if we were talking about alcohol and drug abuse, you'd laugh at us, because you get \$13 million for alcoholism, and then you get insurance on top of that. And you get federal dollars as part of that process. There are no federal dollars for problem gambling. There's no insurance reimbursements for problem gambling. All we have is you. We have people coming in in so much debt they can't pay their house bill, their utilities, let alone give us \$5. And yet we work on budgets and we get them to pay it all back, but you know, that takes time. That takes effort, and it takes money. And I'm not suggesting that we are...that our disorder is as prevalent as alcohol and drug abuse. They'll talk about 10 percent of the population having a problem, and we talk about three. But \$13 million to \$750,000 doesn't make sense to us. In addition to that, we're talking about a bill that is revenue neutral. We're talking about a bill from gamblers putting in money and using that money to help pay for treatment for gamblers. Now the lottery has testified that there will be a loss of revenue. Well, you know, forgive me for being callused to that process. Our people

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are the ones paying it. You heard a story about a lottery player putting thousands in, thousands and thousands of dollars. And if she were to tell you how much that had absconded from the state institution, you would be amazed. And where did that money go? It's our people putting money into the lottery. It's also other people. Now I admit that the vast majority of the people playing the lottery are not going to have a gambling problem, but our people do. And we would like to see those services used. The lottery is talking about if the dollars go away, then there will be a reduction in services and you'll lose educational funds and et cetera, et cetera. Let me suggest to you that last year the Appropriations Committee took \$5.6 million out of that fund, and their losses were less than bingo lotteries, which was eight percent losses. They lost eight percent from previous years-- well, 7.8, and pickles were 8.07, and they hadn't taken any money out of those accounts. And the lottery was down 5.6 percent after you all took \$5 million out of that account. So they've been doing without those additional dollars for a year, and they lost five percent of their dollars, five percent of their revenue. Other people lost more. Why do we need these funds? Because there is no insurance, there is no awareness for services. How many of you know about 1-800-BETSOFF? Have you seen those commercials--1-800-BETSOFF? They're the Iowa help line. They spend \$1.2 million telling you that. We have nothing to tell our people about our help line, and still we get 2,500 calls a year. And we have no awareness of that. We have no prevention message. Prevention...the only message that you're going to hear about gambling at this point is, you can't win if you don't play. We don't think that's an appropriate message for children. And we don't think that's an appropriate message about the inherently dangerous problem of gambling. And when I say the words "inherently dangerous," that isn't my term, that's the American Medical Association's term. And we think there's got to be another message, a message of abstinence for children. You know it's illegal for children to gamble, and yet the HHS survey talks about 65 percent of 10-year-olds gamble for money. That's long before they drink; it's long before they smoke. Now I know it's illegal and you know it's illegal, but somebody should tell them that. And there's no prevention message. We're asking for that money. We're asking you to talk to children about the fact that there are alternatives

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to gambling, that you don't have to go home and play Texas "hold-em." I was recently in a home where a single mom--she had three children--one of her children came up and said, Mom, I need five dollars. And she said, What do you need it for? He says, We're playing Texas "hold-em" downstairs. There were 18 children down there playing Texas "hold-em." He was 11. And when I said, Are you sure you want to do that? She said, Well, it's better than drinking. And that's why we need a prevention message. Recently I got a phone call from a lady in Maryland. Now I don't normally get calls from a lady in Maryland, but it just so happened that her mother was having a gambling problem. I was on the help line--well, I wasn't on the help line, but the help line people called me--and she was an 80-year-old. And she was about ready to lose her house, she was not using her medications, she was in poor health. And this lady, who happened to be a lawyer, and her sister, who happened to be a doctor, were on the phone talking to me. And what was interesting about this was the thing that kept her from seeking treatment was the fact that she was a pioneer politician, female politician in the state of Nebraska. And she was about ready to lose her house. She had no money to eat, and what kept her from going to treatment was pride and embarrassment. This is not unusual. This happens all the time for us. But it's one of you; it's one of you. And it was a groundbreaking politician, a female, back when females were not politicians. In closing, one of the things that is really truly interesting about this process was last year, you all went through a gambling debate. And there was an anti-gambling group, and there was a pro-gambling. And they were all talking about the problem gamblers, and all the devastation or lack of devastation, et cetera, et cetera, et cetera. I challenge you to look out in the audience to say, how many of them are there when the gambling bill, for problem gamblers, are still here? There is still problem gambling; it's not political any more. There's nothing that the anti-gambling people are saying, well, we need to come and support this bill, and there's nothing the pro-gambling people are going to support in this bill. It's just the people who don't have a voice, which are the problem gamblers. And that's why we're here. And we'll be here. If you don't do it this year, we'll be back, because problem gambling is something we're not gaining on right now. More people are needing us than we can serve, and we have a

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generation that's coming up, stigma free of gambling. And I fear for our generation, because there are no breaks for our kids, and there are no breaks for our older adults. And with that, I will close. Thank you.

SENATOR JENSEN: Thank you, Jerry. Any questions from the committee? Why do you feel you need a separate office for problem gambling?

JERRY BAUERKEMPER: Yeah, because we have a history in the United States--and I used to work in Iowa--and what happened is that funds that go into problem gambling get siphoned off, and it's easy to siphon that process off, even with laws. In the state of Iowa there was a law that allowed about \$5 million to go to problem gambling. It sounds like a great plan, except for 40 percent of it was siphoned off before it got there, and another 20 percent found its way into other programs, and by the time that it got there, by the time it got to the services, there was barely enough services to cover the need for the people that were there. The second reason is because there needs to be a focal point for problem gambling, and an office that says, this is important. This is a health issue, a public health issue, and the state of Nebraska needs to see it as a public health issue and so does its citizens. If we fold it back into the mental health, the LB 1083, and I'm not...we're not against LB 1083. Please hear that. But we are saying that, you know, at some point, we're too fledgling, there's not enough public outcry to keep it segregated, and we need an office, an administrator, someone who is going to be a caretaker and a person for the citizens to go to, when they have problems. Not all of the people that are served by problem gambling treatment are satisfied with their services, and not all the people are satisfied with other aspects of things. We need citizens much like your consumer affairs division office. We need those kinds of things, places where people can go, and a protector for the message. And that's why we need that.

SENATOR JENSEN: Any other questions? First of all, I do believe that gambling...problem gambling and gambling addiction should be paid for by gamblers. I also feel that alcoholics and substance abusers should be paid for by the alcohol industry. But the bill I introduced last week in

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the Revenue Committee to do that...well, they did wait until I got out of the room before they killed it (Laughter) but not long thereafter. So we'll see where we go with this. Thank you for your testimony.

JERRY BAUERKEMPER: Thank you very much.

SENATOR JENSEN: Anyone else wish to testify as a proponent? Anyone in opposition?

KORBY GILBERTSON: Good afternoon, Chairman Jensen, members of the committee. For the record, my name is Korby Gilbertson, that's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n. I'm appearing today as registered lobbyist on behalf of Intralot USA, which is one of the lottery vendors, in opposition to this piece of legislation. I need to preface my statements by saying we're not opposed to gamblers' assistance money at all. The problem that we see with this legislation is in one specific part of the funding, and I need to give you a little background in order to explain this. For those of you who weren't here in 2002, a bill was passed, LB 791, which in part provided...changed the percentages that went to these different beneficiaries. Part of that discussion during that piece of legislation was, well, what if those beneficiaries don't continue to get the same amount of money? Somehow we need to protect them. The thought at the time was that sales would be able to increase enough to keep those contribution levels at a level number. But there was a concern that if sales went down, those beneficiaries could lose money. So part of the agreement at that time was to put into law a hold harmless provision. And that hold harmless provision is in Section 9-812, and until January 1, 2008, there is a hold harmless provision for the beneficiaries of the lottery proceeds, and the funds that are to be used to pay that hold harmless amount is the unclaimed prize fund. So the problem with taking the money out of the unclaimed prize fund is that money isn't necessarily there, just sitting around waiting to be spent. It is also used for other things such as retailer payments for retailers who cash tickets, and other prize-associated things with the scratch tickets. And I will note for the record that Intralot does the Powerball contract, not the scratch ticket contract. So when you look at LB 332 and you see that currently there's about

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\$1.75 million that would need to come from that fund, you need to look at the amount of money that goes in there. And it's about two to three percent, on average, if you look clear back through the history of the lottery, two to three percent of prizes are unclaimed. So at any given time, the amount that goes in there is less than \$1.7 million. So that is where the problem lies. We're not saying that we think this is a bad idea. We're just saying that we think that the funding in the unclaimed prize fund needs to be protected, at least until that hold harmless provision is no longer operative. And with that, I'd be happy to answer any questions.

SENATOR JENSEN: Thank you. Any questions of Ms. Gilbertson? I don't see any.

KORBY GILBERTSON: Thank you.

RICHARD DeLIBERTY: (Exhibit 8) Good afternoon, Senator Jensen, members of the Health and Human Services Committee. My name is Richard DeLiberty, D-e-L-i-b-e-r-t-y, the administrator of the Division of Behavioral Health Services within the Department of Health and Human Services. I'm here to testify in opposition to LB 332. The remarks that you have I will not go through all of them, because a lot of them are a repetition of what you've heard before by the proponents. Last year the Legislature passed LB 1083, also known as Behavioral Health Reform. This landmark legislation set a direction for the state in terms of developing comprehensive continuums of care for Nebraskans. In creating a Division of Behavioral Health Services, rather than separate offices of mental health, addictions, and problem gambling, I believe that the Unicameral gave recognition to the fact that these issues are interrelated and often co-occurring. I am quoting Dr. Rugle. The March 2001 issue of "Beyond the Odds," a letter on problem gambling, reported on a presentation by Dr. Rugle. She reported that in people diagnosed with pathological gambling, the following diagnoses can be expected: Anxiety disorders, 10 to 35 percent of the time; attention deficit disorders, 20 to 35 percent of the time; personality disorders, 20 to 93 percent of the time; substance abuse disorders, 25 to 63 percent of the time; trauma, 5 to 30 percent; affect disorders, 50 to 80 percent of the time.

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Given this kind of overlap or dual diagnosis, and an overlap of services and providers, a common organization of systems of care is necessary. As these services are developed, mental health, substance abuse, and addiction services will be included. Expending funds to create a separate position or to create separate systems is not an efficient use of funds or coordination of care to address all consumer needs. My testimony goes on to talk about services that you've already heard about. While we appreciate Senator McDonald's obvious commitment to improving gambling addiction services, we believe that the approach in LB 332 is not the best policy or direction to take, given the infancy of the LB 1083 reform effort. I'd be happy to answer any of your questions.

SENATOR JENSEN: Thank you. Mr. DeLiberty, are you saying that we don't need any more money in treatment of gambling addiction?

RICHARD DeLIBERTY: No sir, I think that's a legislative decision, whether we need more money or not.

SENATOR JENSEN: Okay. All right. Any other...yes?

SENATOR STUTHMAN: Thank you, Senator Jensen. Mr. DeLiberty, you stated that this is not the direction to go. What would be the direction to go?

RICHARD DeLIBERTY: I think we need to work within the Division of Behavioral Health to do the kinds of things for these kinds of needs that you've heard about, to create that system of care. My concern is that I have one-and-a-half staff now, as you heard, that are dedicated to the problem of gambling. Frankly, I don't have any staff that are dedicated to mental health services, and maybe half a staff dedicated to addiction services, because we're working as a team, working across the system, supporting each other through developing a variety of services across the state. I have people that are working in the different regions. Those people, my staff that are working in the different regions, need to be involved with problem gambling services to make sure that I don't have one person spread across the state doing this in isolation, but a team of 15 people that are treating the three major areas that are addressed in the

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Office of Behavioral Health.

SENATOR STUTHMAN: So you feel we can accomplish what we want to get done in LB 332 with the amount of staff that we have? We can take care of it that way?

RICHARD DeLIBERTY: Yes sir, I do.

SENATOR STUTHMAN: And that we will be able to do what we've been doing with the gambling addictions, and hopefully, that we could expand it and by utilizing the staff that you have to do it?

RICHARD DeLIBERTY: Yes, sir.

SENATOR STUTHMAN: And you think that we can accomplish that?

RICHARD DeLIBERTY: I do.

SENATOR STUTHMAN: Okay, thank you.

SENATOR JENSEN: Any other questions? Senator Howard?

SENATOR HOWARD: Thank you, sir. To continue with the Senator's question, do I understand you correctly, in that you have 15 staff at this time, who are dedicated to providing this service? I heard you mention half a staff.

RICHARD DeLIBERTY: No, I have about 15 staff in the Office of Behavioral Health. That's changing a little bit, as we're adding a couple of additional staff in the Office of Consumer Affairs. I'm not sure if the number is 15, 16, right around there, is my total.

SENATOR HOWARD: Where are they located?

RICHARD DeLIBERTY: On the West Campus at...

SENATOR HOWARD: Here in Lincoln?

RICHARD DeLIBERTY: ...here in Lincoln.

SENATOR HOWARD: So these folks cover the entire state?

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RICHARD DeLIBERTY: Yes. And one-and-a-half of those is the gambling staff that we're talking about.

SENATOR HOWARD: I'm sorry. I didn't understand. Half of those are...

RICHARD DeLIBERTY: Of those about 15 or 16 FTEs, 1.5 are dedicated to problem gambling.

SENATOR HOWARD: Simply dedicated to that issue?

RICHARD DeLIBERTY: Yes.

SENATOR HOWARD: Thank you.

SENATOR JENSEN: Any other discussion or questions from the committee? Thank you, Mr. DeLiberty. Anyone else in opposition? Any neutral testimony? Senator McDonald, do you wish to close?

SENATOR McDONALD: Senator Jensen, members of the committee, thank you for the opportunity to bring you back, focused back to the real and the true reason that I introduced LB 332. Nebraska citizens have gambling options available to them in their homes, on the Internet, in their basements, in their bars, at the gas stations, and at bright, shiny casinos on our borders. More Nebraskans are gambling than ever before and at a much younger age. These are the people LB 332 will help. The Gamblers Assistance Program is doing a great job with the funding they're getting now. Unfortunately, the Gamblers Assistance Program doesn't have enough money or enough people to match the growing need for the services that they provide. Problem gamblers and their families will not get the services they need without more funding and more people to provide these services. LB 332 provides the needed funding from the gambling revenue, not from state general funds, and LB 332 provides a comprehensive structure that improves the way problem gambling services are designed and implemented. I'm also using my closing as public notice that I will not stand quietly by, if funding intended only for problem gambling is used to pay for any other behavioral health treatment programs, whether during my current administration, or any

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future administration. That money is meant for compulsive gambling only. Thank you.

SENATOR JENSEN: Thank you, Senator McDonald. Any questions from the committee? I don't see any. Thank you. That will close the hearing on LB 332. Senator Stuthman is here to introduce LB 728.

SENATOR STUTHMAN: Thank you, Senator.

SENATOR JENSEN: Excuse me, before you begin with that, I do have a letter of opposition on LB 332 from the State Department of Revenue. (Exhibit 4; See also Exhibit 9) I'm sorry. Go right ahead, Senator.

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SENATOR STUTHMAN: Thank you, Senator Jensen, and members of the Health and Human Services Committee. My name is Arnie Stuthman; that is spelled S-t-u-t-h-m-a-n, and I represent District 22. I am here today to introduce LB 728. The state of Nebraska, when needed, contracts with private providers to deliver services for children and families in Nebraska. These services are designated to protect the children in unsafe living situations, treat children and youth suffering from severe mental illness and behavioral disorders, and strengthen families. Presently, there are no functioning processes that address the cost of care and reimbursements for child welfare and child mental health services in Nebraska. This causes a gap between what the service costs to provide and what the providers are receiving for reimbursements. As a result, the Legislature is compelled to intervene in the contract agreement for child welfare and child mental health services. LB 728 would address these problems by creating an advisory committee that will develop a formula for determining provider reimbursement amounts, review the reimbursement provided for protection, safety, and treatment services, conduct a survey of providers' cost of delivering services, make reports and recommendations for rate adjustments to the Governor, and to the Legislature, and HHS. Thank you for your time, and if you have any questions, I will try to answer them, or you may wait until we have the expert

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testimony that will follow me.

SENATOR JENSEN: Thank you, Senator Stuthman. Any questions from the committee? I don't see any.

SENATOR STUTHMAN: Thank you.

SENATOR JENSEN: I do have letters of support from Nebraska Association of Behavioral Health Organizations (Exhibit 2) and The Nebraska Psychological Association (Exhibit 1) and Mary Fraser Meints. (Exhibit 3) We're ready for our first proponent. Anyone speaking as a proponent? May I see a show of hands of how many wish to testify on this measure? One, two, three, four, five, six, seven. Okay, thank you. You may fill that out after; go ahead, if you will.

BRIAN RADER: (Exhibit 4) It's a pleasure to be here. My name is Brian Rader, B-r-i-a-n R-a-d-e-r. I'm here in support of LB 728. Chairman Jensen and members of the Health and Human Services Committee, I'm Brian Rader and I'm here in support of LB 728. I am employed by Grace Children's Home of Henderson, Nebraska. However, I'm here today to testify as a representative of the Nebraska Association of Homes and Services for Children. This state association currently represents many of the agencies across Nebraska who provide out-of-home services, such as group home, treatment group home, enhanced treatment group home, residential treatment centers, and emergency shelters. Additionally, many of these same agencies provide a variety of supportive services to youth and families within their home environment. My goal today is to briefly explain to you the history of the association and its role in relation to rates and reimbursement by the Nebraska Department of Health and Human Services over the last several years. With that being said, I'm not going to bore you with a lot of the detail of history; however, I came to Nebraska in 1983 and began working in the child welfare system. What I've learned over the years is that when contracting with Health and Human Services, was happening back in the early '80s...what happened when a contract came due was that the executive director of the agencies would go directly to Health and Human Services, either to the director of Health and Human Services or their designee, and contracting and negotiations would occur between the agency and the state at

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that point. A lot of the rates that were developed at that time were agreed upon, dependent upon what kind of service was provided, maybe how good of a negotiator the particular director of an agency was, and I'm not privy to any particular protocol that was utilized at that time. There may have been, but I'm not aware of that. One of the things that resulted from that, in working with several agencies across the state, was that rates varied. Some may have been rather high; some may have been rather low. And so some discussions were, I believe, implemented at the Department of Health and Human Services, which at that time was the Department of Social Services, to talk about what are some fair and standard rates. In about 1993, '94, somewhere in there, the Department of Health and Human Services contracted with Deloitte Touche to assist them in establishing standardized rates, and then what would happen then, if we standardized rates, what are the standard expectations as agencies provided services? So together with the Nebraska Association of Homes and Services, the Department of Health and Human Services selected several agencies across the state that provided a variety of services, and they completed a pretty extensive cost of care study. To make a long story short, after much discussion--and you can read at a later time all the discussion points--some standards were arrived at. Some standard rates were arrived at, based on the cost of care. Really, one of the things that was a result of that, that was a positive by-product, was that our association and Health and Human Services, really began a partnership. And that was very effective and has continued to be the case. However, one of the things that has resulted as a by-product is that, is that negotiations or those rates, are not looked at on an annual basis, or biennial basis, which is what our contracts are currently set for. We contract every two years. What happens is the rates aren't on the table, as far as negotiating every time we recontract. And what has happened as a result of that is our association, in responding to its members' financial difficulties, basically, we have to grab the bull by the horn, because in some sense, some agencies are struggling financially, other agencies may have to close, because of financial constraints. And so our association in the past has come to Health and Human Services Committee to try to gain more funding, so that we can have a rate increase. I guess the

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bottom line is we go above their heads and we would rather work more directly with them. But because of the economy and many things that you're aware of, budgetary cuts, it just hasn't been feasible for them to ask for more money. One of the things is that we find ourself in the same situation over and over. And the Deloitte Touche was a very good way to increase rates, it was a very good way to be fair, and we believe that that is something that was beneficial. Our association, just a few years ago, we decided as we came to the legislative committee here, we decided we would replicate that study and pay for it ourselves. And we did that, and we were able to show that there was some disparity in the rates, and we brought that to the legislation's attention, and you responded positively. Our concern at this point is we keep redoing that every four to six years, and what happens is, the Department of Health and Human Services gets behind financially, and then all of a sudden, there's an effort to make kind of a catch-up, to make up the disparity. Meanwhile, agencies struggle. And on the final page, you'll see several bullets there that would be some benefits for establishing this advisory committee. I believe we wouldn't have such a maybe antagonistic relationship with Health and Human Services, because we don't have to, per se, go above their head. We want to partner with them. There would be a lot of benefits, because services would not close down or have to make cutback, or find efficiencies. And so those are the things that are benefits. And there's a lot of bullets there, and I'll allow you to read that. But this advisory committee, if you would be in support and pass this, would be...they would be in a unique position to combine data from the state and from the private sector, in an effort to identify trends in the future, for service capacity, and could also be a planning instrument for the state, as a resource to the Legislature, with the goal of getting the Legislature out of the business of determining who should get rate increases and how much. Finally, there's an underlying principle within your power to plan for appropriate rate of reimbursement structures for service contracts. The state already has plans for cost growth for many things in its annual budgeting process. Salaries and health insurance are a few of the things in your annual budgeting process that you're aware of and you can predict. Likewise, there are current service contracts which the

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state does already maintain, which includes annual increases or adjustment in the budgeting process. Services that provide the care and well-being of the youth in our state should be no exception. Therefore, I urge you to support LB 728. Thank you for your time and interest in serving the state of Nebraska. I would entertain any questions at this point.

SENATOR JENSEN: Thank you, Brian. Any questions from the committee? Yes, Senator Howard?

SENATOR HOWARD: Do you see this as a method to ensure more consistency in the contracts, because I'm aware that there's quite a variety.

BRIAN RADER: Yes, I do. I believe it would be something that would be ongoing, and we would be able to use our resources as an association, along with Health and Human Services, to talk about, I think, issues of more importance, if this would be established as an advisory committee to establish a forum, and we wouldn't have to continue to come back over and over, with the same issues. And I think we could be about more important things.

SENATOR HOWARD: Okay, thank you.

SENATOR JENSEN: Thank you, Senator Howard. Any other questions? Thank you for your testimony.

BRIAN RADER: Thank you.

SENATOR JENSEN: Next testifier in support. And again, I'm going to ask that you hold your testimony to about three minutes, please.

MARY MEINTS: (Exhibit 3) Senator Jensen and members of the Health and Human Services Committee, I'm Mary Fraser Meints, and I work at Uta Halee. Oh, I forgot to spell my name. F-r-a-s-e-r M-e-i-n-t-s. I work at Uta Halee Girls Village and Cooper Village in Omaha. We provide residential treatment continuum for about 57 boys and 60 girls at any one time, and about 300 kids annually. We also provide out-patient treatment services for about 45 kids. I'm here in support of LB 728, and I want to talk about the impact of

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this one particular level of treatment called treatment group home. You have my written letter, so I won't spend a lot of time on that, but treatment group home is 21 hours of treatment services, individual therapy, group therapy, and family therapy, and a treatment environment for kids. It allows kids to practice in the community and take their opportunities to have a job or school into the community. Brian talked about the Deloitte Touche model. Recently several providers used that model to compare the costs with the actual current reimbursement rate for Medicaid, and there's a difference of about \$45 a day, which is \$16,425 per youth, per year, and a program rate of \$197,000 difference per year, for 12 kids. That's a significant difference. This has an impact on the capacity of the service in the state of Nebraska. Treatment group home beds have been decreasing, providers have been not providing that service, and as I speak, there's a treatment group home provider in Lincoln that is closing its doors. Now why is treatment group home important? It's important because it's a level of care between hospital care and higher residential care and out-patient. So if you don't move kids in and out of residential care into treatment group home and in the community, you have a bottleneck effect. If you can't move kids from the community into treatment group home, they'll go higher. That costs the state more, and it's not good for kids. Uta Halee has a capacity for 48 higher residential care beds, but we can only afford to do 12 treatment group home beds, so you can see, even with our continuum, it causes a disparity and a bottleneck within our continuum. How would the committee help? It would review and make recommendations on the cost of providing child welfare and treatment services for kids in the protection and safety system. We can identify a means for strengthening the continuum of services in Nebraska. Currently, there's not a service delivery plan in the state, and so providers and the state respond to market trends, and this committee would be able to identify trends and respond appropriately, and there would be a plan in place for continuum of services. I would be glad to answer any questions that you might have at this point in time.

SENATOR JENSEN: Thank you, Mary. Any questions from the committee? Yes, Senator Howard?

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SENATOR HOWARD: Thank you. Mary, could you explain a bit about how your payment model fits in with the Magellan program?

MARY MEINTS: You mean are we paid through Magellan?

SENATOR HOWARD: Through Magellan, and kind of touch on that just a little bit.

MARY MEINTS: Okay. Magellan is the administrative service organization for the state, and they are the authorizer of services for Medicaid. And treatment group home is a Medicaid service, meeting the rules of Medicaid state rules. And we get paid through...actually, Medicaid pays the bills, but Magellan authorizes the treatment.

SENATOR HOWARD: True enough. Now how will this fit into the contracting, or the negotiations with the state, if it's a Magellan paid program?

MARY MEINTS: Well, what we're looking at is services for the kids in the protection and safety services system, so that would be treatment and nontreatment services, because if you look at one system and you don't look at the whole system, then you've squeezed the money out over here, and it's not affected. So if you don't address the system, then you've still got problems.

SENATOR HOWARD: So Magellan will respect the rates that are set through this negotiating process?

MARY MEINTS: Magellan is contracted with the state of Nebraska, so it would be up to Medicaid and HHS to work with them as a contractor.

SENATOR HOWARD: Okay, thank you.

SENATOR JENSEN: Thank you for your testimony.

MARY MEINTS: Thank you.

SENATOR JENSEN: Next testifier in support, please?

BRAD SHER: (Exhibit 5) Senator Jensen, members of the

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Health and Human Services Committee, my name is Brad Sher. I'm the vice president of managed care and public policy for BryanLGH Health System in Lincoln, Nebraska. I'm also a lobbyist working solely on behalf of BryanLGH. I'm here today in support of LB 728. We need facts. We need agreement on what is cost and what is payment, and the growing difference between the two on the Medicaid program, and the impact of these differences. On facts, we need to know what things costs. For example, we know that we have seen declines in payment for in-patient mental health since the tobacco money, tobacco fund came in, and we had some increase at that time, and then the budget took things away. However, we hear that HHSS claims that the "going rate" for in-patient care in other states is \$450 a day. That is not a reality for Nebraska in two important ways. First, it implies a free market and that Nebraska HHSS can go to other states and buy the product there--this is not reality. Second, just because other states underpay for services doesn't mean that we have to. I have two cases that highlight the impact of underpayment. First--these cases happened recently, and one is going on as we speak, that just happened...that are occurring, of a child that stays 90 days at BryanLGH Medical Center because of lack of coordination, lack of service, and lack of concern. The child's medical necessity ended in about 10 days, and then was parked at our facility, via administrative authorization, until a group treatment home was found--couldn't find one. We have a similar case going on now where the child is waiting for placement, and we have been told it will be at least 60 days, and we're already like two weeks into it. If you assume that treatment group homes are paid \$200 a day--being generous--and we are paid \$525, we have in these two cases wasted almost \$50,000 because they weren't moved from my place to the treatment group home in a timely manner. And that's the spread between the two of them. The impact of underpaying providers for services is lack of capacity in critical areas and the resulting overpayment for unnecessary services. We want to take care of the kids we can take care of and hand them off in an efficient and effective manner. But if there's nobody there to hand them off to, because they're not getting paid what they need to get paid to keep them open, you keep them at my place, paying a higher level than you need to. The second example is Richard Young in Omaha.

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They told everyone they needed additional money to stay open. No one did anything. The state lost an important provider of services and we're all suffering because of it. BryanLGH is in favor of this bill to make sure that we know the facts and implications of pricing policy. I'll take any questions from you.

SENATOR JENSEN: Thank you, Mr. Sher. Any questions from the committee? I don't see any. Thanks for your testimony.

BRAD SHER: Thank you.

SENATOR JENSEN: I do have a letter of support also from The Nebraska Psychological Association that will be put in the record. (See Exhibit 1) Next proponent, please?

PETE TULIPANA: (Exhibit 6) Good afternoon, Senator Jensen, members of the Health and Human Services Committee. My name is Pete Tulipana. I'm the president and CEO of Heartland Family Service in Omaha. You heard earlier from one of my staff, Harlan Vogel, in testimony on the gambling bill. Our agency is an organization that's been in Omaha for 130 years, and last year we served nearly 40,000 unduplicated individuals in a variety of human services, ranging from child welfare services, shelters, treatment group home, juvenile justice services, and behavioral health. I want to testify today at a level that I think is a critical foundation level in relation to LB 728. One of the primary services we provide is out-patient mental health services. We are if not the largest, one of the largest providers to low income families who struggle with serious mental illness, and who seek their treatment on a community basis, in the community. Individuals seek counseling from us to deal with a variety of issues, which I'm going to broadly state for you today, in three categories. First is mental health issues, and that really primarily includes depression, anxiety, and loss and grief. What's important for me to share with you today is that more than 46 percent of those who enter our service in this category come into counseling with what is identified as a severe impairment in their daily functions. And in this category, what that means is they have frequent suicidal thoughts, intense physical symptoms of anxiety, and they're essentially dysfunctional in the community, but surviving on a

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day-to-day basis. The second primary area that we serve in our counseling component is conflict and marriage relationship. Of those individuals who sought service in this area last year, 54 percent came with severe impairment in daily functioning, and that means there was serious risk of physical or emotional abuse in the relationship, and/or serious risk of termination of the relationship. The third primary area that we serve in out-patient mental health is child abuse and neglect. Of the individuals who sought treatment in our agency--and last year we served 40,000 individuals throughout the metropolitan area of Omaha, unduplicated individuals in all the various programs that we have--31 percent of those individuals came into counseling with severe impairment in daily functioning. These individuals are identified as significant risk of child abuse, severe conflict on neglect of basic needs. So when you hear the percentages of the categories of individuals who are coming in at a counseling level--counseling is the primary prevention place in the community, where individuals who are struggling with serious issues get the help they need, so that they don't have to go into some more intense level of care, whether that be a shelter, or whether that be some other higher level of care for those individuals and their families. Our cost to provide an hour of mental health counseling is approximately \$95 an hour. This is comparable or less than most providers in the Omaha community. Current Magellan reimbursement rate for an hour of counseling is \$57.32, which means that for every Medicaid client that we see in our organization, we have to cover \$37.68 per hour of counseling. Now the difference in payment versus cost is increasingly difficult for us to handle, and as a result of that, our only choice is to limit the capacity that we have for Medicaid clients to come into our organization and receive treatment. Last year 385 Medicaid clients were not served because of capacity issues. And that's only the people who got into the system. About 50 percent of the people who call our agency for out-patient mental health services do not even get into our system because of capacity issues. As the difference between reimbursement rates and costs continue to grow, organizations like Heartland Family Service will be forced to continue to limit access for Medicaid clients. Reimbursement rates for out-patient mental health services, as well as all the services provided to vulnerable children

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and families, must be addressed on an ongoing basis. We can't wait five years and have to come to the Legislature to ask for your help with regard to reimbursement rates, particularly in today's environment. Costs continue to increase in every area of our organization, and reimbursement rates have stayed stagnant. We need the legislation to provide the intent and the process for these issues to be addressed on an ongoing basis, and we appreciate your support for that. I'd be happy to answer any questions.

SENATOR JENSEN: Thank you, Peter. Any questions from the committee? Thank you for your testimony and coming forward.

PETE TULLI NA: Thank you.

RUTH HENRICHS: (Exhibit 7) Senator Jensen and members of the Health and Human Services Committee, I'm Ruth Henrichs, H-e-n-r-i-c-h-s. I'm president and CEO of Lutheran Family Services of Nebraska. Lutheran Family Services is a statewide organization. We have about 30 offices across the state. We span the state from Plattsmouth and Omaha, all the way across to Sidney and Chadron. We offer a variety of types of programming and have a lot of different kinds of contracts with the state for mental health, out-patient mental health and substance abuse, foster care, special needs adoption, urgent care, medication management, juvenile justice assessments, and family support and supervised visitation. In the recent budget building process that we just completed not long ago at LFS, we had to make some very difficult decisions to actually close out-patient counseling offices, complete offices, in Alliance and Hastings. We've also made decisions in this budget to close out-patient counseling programs in Kearney, Grand Island, and Norfolk. The Medicaid rates are just simply insufficient to keep programs operating. You know, we're not asking to make money, but we are asking to cover our costs, and the Medicaid reimbursement rate just simply does not do that. LFS has also closed family support programs in 2005 in Scottsbluff and McCook. I want to address my comments to you briefly today regarding the family support programs and supervised visitation at LFS. In 1996, our unit rate that we received for family support services was \$30.13, and in the year 2005, our family support rate has risen only to

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\$34.50, and it's been at that for several years. So over the course of nine years, the increase in the family support rate has only been \$4.34 per unit. Our costs have gone up, not unlike everyone else's, but there has been no additional revenue coming in for us to pay for salary increases, and the increase in costs of benefits that everyone else has. In 2002, all providers with signed family support contracts were required, and with no input from us, which I think is very important--the providers had no input into the decision that required that if we were going to have a signed family support contract with the Department of Health and Human Services, we were going to have to take a contract to provide supervised visitation. We could not do family support unless we signed the other supervised visitation. And the rate that we were given for supervised visitation was \$19 a unit. There was no discussion; we were just told, if you want to do family support, you'll do visitation and you'll do it for that rate. In the material that I just gave you, I quickly went back this morning and pulled some data between 2001 and 2004. Now my 2004 numbers, obviously, are unaudited; the other three years are. And over the course of those four years, Lutheran Family Services in our family support program alone, has lost \$230,000, which means that we have subsidized a state program to the tune of over a quarter of a million dollars, because the rates just simply do not keep up with what we have. I would challenge all of us, as businessmen and women, and you, to ask yourselves whether you would ever sign a contract in your own business, to build a bridge or repair a home, or whatever business you have, knowing that you were going to lose money, and that you were going to subsidize that state contract by over a quarter of a million dollars. We were able to continue to do family support in the year 2004, because we simply decided we were going to limit the number of supervised visitation referrals that we accepted. We took the position that if the state were upset with that, did not like the fact that we were limiting and really very tightly controlling what referrals we accepted and how many visitation cases we would take, that we would simply terminate our contract with the state, that we were no longer going to provide the services at the subsidy level that we had been doing. So we ended the year, as you see in our numbers--they're unaudited--but we think with that kind of control that we broke even. We probably had about a

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\$4,000 positive bottom line, and the state did not pull our contract. We simply just took control of it. We limited the number of miles we would drive, and in the Panhandle, where we've actually completely closed family support. One of the ways in North Platte and Scottsbluff to control the cost was to simply not take a referral outside of a 20- to 25-mile radius, and then it was easier, because it's just simply too costly for us to put someone on the road for two hours to drive to see a client with no reimbursement for that, yet I have to reimburse those staff. Contributing to our LFS small positive bottom line in 2004 was the fact that at LFS, we pay our family support workers a per unit rate, keeping employee hours under the amount that would make them eligible for benefits. That's an embarrassment, to have to sit here and tell you, but the only way that we can make the rates work that we are given by the state, is to not have family support workers working a full time job. If we keep them under the 30 hours a week, we do not have to provide benefits. But what we are doing is increasing the number of working poor in this state. I can cite, and could have...it was true that in the year 2002, we actually in Scottsbluff lost family support, bilingual family support workers, which are so difficult to find, to Burger King, because the Burger King in Scottsbluff, Nebraska, was paying more in 2002 than I could pay them to be family support workers in Scottsbluff. And I think, you know, for me, that's a sad commentary to think that we will pay more to flip a hamburger than we will to send someone into the home of a family, where really we were the last resort. If family support doesn't work, then the children are usually removed from the home and they go into higher levels of care. I don't know what's happening to the children in the Panhandle, since we are not delivering those family support services. But I do know from our experiences in that program that when you cannot provide that service, children do go to higher levels of care. And as you've heard in prior testimony, higher levels of care cost more. It takes...you can provide about three units or three hours of family support to a family in their home for the cost of one of my hours of in-office, out-patient, certified master's level therapy, out-patient therapy. It's three to one. So it's a very cost-effective program, and I think we have to ask ourselves why we've chosen to suffocate a program at the low end of the continuum of service delivery, when we can

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provide more and we can keep children in their homes with their parents. In many ways...and I want you to know that I want to make this statement with no cynicism included, but in many ways in the state of Nebraska, I believe that we've adopted sort of a Wal-Mart mentality of human service delivery. I hope none of you are connected to Wal-Mart. But the Wal-Mart tagline is "everything for less." And when you think about human care service delivery in the state of Nebraska, sometimes it feels like it's, we want everything for less. We pay less, and are then able to recruit less qualified employees. We as community providers add to the number of working poor, and we add to the number of the kids that are waiting for service. LB 728 proposes to form a reimbursement advisory committee. I have to tell you, I am usually a person who is opposed to creating more and more committees. I just...I'm sort of committee dead sometimes. But I support the creation of this committee and this legislation. A fair and adequate process to create a fair and adequate rate for the provision of services is good business, that will strengthen the service delivery continuum in our state. LB 728 creates this process and it enables the community and the state to work together. Partnership, we have to understand, is more than just a signed contract. True partnership has to take seriously the gathering of information from both providers and the state of Nebraska. Rates and requirements for contracts must be established through this kind of partnership. We can no longer simply have a rate and a program handed to us, without anyone asking us what the cost of our reimbursement is. I thank you for your time, and I'd be happy to answer any questions that you might have for me.

SENATOR JENSEN: Thank you, Ruth. Any questions from the committee?

RUTH HENRICHS: You're welcome.

SENATOR JENSEN: Senator Erdman?

SENATOR ERDMAN: Just a comment, Mr. Chairman. Burger King is closed in Scottsbluff. (Laughter)

RUTH HENRICHS: That was 2002.

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SENATOR ERDMAN: It just closed.

SENATOR JENSEN: Thank you, Senator Erdman.

RUTH HENRICHs: That makes a Burger King and a family support program. Thank you.

SENATOR JENSEN: Yeah, both gone. How many others wish to testify? One, two, three, four. Thank you.

LESLIE BYERS: (Exhibit 8) Good afternoon, senators. My name is Leslie Byers, B-y-e-r-s. I am the mother of a 19-year-old daughter who has experienced mental illness for over 16 years now. I'm not here to talk to you about rates today. I'm here to talk to you about the years of frustration my husband and I endured in getting the right services to meet the continual needs of my daughter's mental health, while striving to keep her in the home as often as possible. On two occasions my child's mental health needs required out-of-home placement, and on both occasions, her behavior had to reach dangerous levels before she was finally admitted for treatment. The first occasion was in May of 1996, at which time my husband and I had finally succumbed to the reality that we had to relinquish custody of our child, because our private health insurance had run out, and her needs were greater than our financial ability. So therefore we got involved in the juvenile court and the child welfare system. After the initial evaluation by my daughter's caseworker and guardian ad litem, they saw a very clear and immediate need for her to be placed in a residential treatment center, because she was considered at that time a danger to herself and others, due to her improperly treated mental illness. Unfortunately there was no space available anywhere, so my daughter was returned to our home and told we would have to wait until a bed became available. Well, 10 days later a bed did become available. During a manic-induced rage, my daughter assaulted me and I had to call the sheriff for help. Upon arrival at the home, the sheriff overheard my daughter ask her brother to kill me. All of a sudden, a bed was available. Why did it have to get that bad before my daughter received the proper help? This stay in the residential treatment center lasted six months, and at that time, she finally did receive the right diagnosis. She was 10 years old. And with proper

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diagnosis, she received the right treatment and recovered well and was returned home. In preparation for our daughter's return home, my husband and I asked for in-home family support, to aid in the transition back to the home and to support our daughter's ability to stay in the home, to help my husband and I to understand how best to support her and help her. However, we were given only six visits by an intensive family preservation therapist. Because our private insurance does not pay for in-home support, we were left on our own to fend for ourselves after the six visits were exhausted. Over time, without in-home and family support, my daughter's illness progressively worsened and at age 14, stopped taking her medications. As you can imagine, she relapsed into the cycles of mania and depression. With it came the return of the volatile outbursts and aggressive behavior, and in April of 2000, she was placed in residential care again. This time her stay lasted 27 months. I will be the first to admit that my daughter needed help, but she didn't need 27 months of residential treatment. Our case portrays an all or nothing approach, either out-of-home residential treatment--but only when things get really bad--or nothing. My husband and I wanted to be an active part of our child's treatment in order to understand how to best help her, within the natural setting of a loving family. My husband and I aren't neglectful, we aren't abusive, we aren't incompetent. We simply wanted help. I believe my daughter's treatment could have been better served with an array of in-home and community based services, had they been available, and the residential treatment stay used for short-term crisis management. But instead, Nebraska paid for 27 months of the most costly treatment, residential treatment care, for a child whose family was willing to do anything to keep her home as often as possible. Thank you for allowing me the opportunity to speak with you.

SENATOR JENSEN: Thank you, Leslie. Any questions for Ms. Byers? Thank you for coming forward.

LESLIE BYERS: Thank you.

SENATOR JENSEN: Next testifier in support? Hi.

JUDY KAY: (Exhibit 9) Chairman Jensen and members of the

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Health and Human Services Committee, my name is Judy Kay, last name spelled K-a-y, and I represent Child Saving Institute in support of LB 728. CSI is a not-for-profit child welfare agency in Omaha that provides a range of services specifically focused on the welfare of children, those who are at risk of harm, those who are suffering the results of abuse or neglect, those who have serious mental health issues, and those whose lives are complicated by mental health and substance abuse and other cultural complications. Many of our services are provided with the intent to prevent harm to our innocent citizens, or to address problems at the earliest possible moment before they become more complicated and require more extensive and more expensive intervention. And I wish I could say today that Mrs. Byers' story is unique and uncommon, but in the 20 years that I've--20-plus years that I've been at Child Saving Institute and in this field--I've heard her story far too often. And I think that's why it's important for us to sufficiently fund community based services. The purpose of community based services is to act as a preventive measure, preventing the placement of children and youth in more restrictive levels of care, and preventing the need for children and youth to become wards of the state, as another that I know that's coming before this committee discusses, to cover the cost of care. Instead, community based services provide mental health services and supportive care, either in families' homes or as close to families as possible. Unfortunately there is a significant disparity between the cost of delivering community based services and the rate paid for those services. This disparity in reimbursement results in agencies sometimes having to take desperate measures to maintain contracted services, measures such as increasing staff caseloads so that they are beyond best practice accreditation standards, limiting wages and benefits to staff resulting in high turnover rates that can negatively impact the quality of care, or in some cases, making the decision to close down a valuable service as a result of a sizeable deficit. Ultimately, the lack of quality community based services for kids results in children and youth not being able to utilize preventive or early intervention services in a timely manner, problems worsening before treatment is finally provided, as you've just heard, and the need for higher levels of care that might not have been necessary, if the issues had been

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addressed in a timely manner. Child Saving Institute provides emergency shelter care as a truly short-term emergency service, a service that assures children's safety while more permanent care, hopefully safe care in their family home, is obtained. The rate for shelter care has not been altered in five years. In 2004, the average cost per day for care in CSI shelters was \$118. Daily reimbursement from the department was \$107.50. That's a difference of over \$127,000 that needed to be subsidized by our agency, just to cover those costs. And we are not an agency that's spendthrift. We're very cost efficient and cost careful. In fact, the hourly wage for the staff that provide care in our shelters is \$9.21. In essence, those people could make more by working at Burger King. CSI must make up the difference in that true cost of care for every single child or youth, and every single day of care. In some cases, reimbursement is so inadequate that large deficits result in the closing of services, such as the case with regard to a shelter that CSI opened in Nebraska City a little over five years ago. Much lower utilization than was projected by the Department of Health and Human Services, combined with insufficient reimbursement, resulted in a deficit that was so large that the shelter had to be closed, the building sold, and the community left without that resource. Intensive family preservation services, also provided by CSI, are child and family centered, with the intent to keep children with their families, and to address those serious issues that threaten disruption of the children from the family. Both mental health and supportive services are provided in home, and in a very intense manner for a short time period. And families are involved in all aspects of planning and providing that care. Because of the state's insufficient reimbursement rates, CSI's intensive family preservation teams have had to carry caseloads that are above those defined by IFP, Intensive Family Preservation models or approved by our accrediting body, the Council on Accreditation. With a more adequate rate of reimbursement, families should be provided with better care and caseloads would be within best practice standards. The reason that we at CSI believe that LB 728 is important is because a greater level of participation and input in rate setting between the Department of Health and Human Services and the providers of service will ensure that sufficient rates are being established to meet the needs of our children. Without

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sufficient rates, providers will continue to be handicapped in assisting the department in meeting the standards that were established by the Child and Family Services Review, which Nebraska failed significantly two years ago. We believe that the systems established by LB 728 are an important step in the right direction. They will help to make certain that community based services are maintained for families like Mrs. Byers' daughter, providers are sufficiently reimbursed, kids are able to get better, and hopefully, Nebraska will be able to pass the federal standards at its next review, and maintain a strong level of federal funding for Nebraska's kids. Thank you.

SENATOR JENSEN: Thank you, Judy. Any questions of Ms. Kay? I don't see any. Thank you for your testimony. Next testifier, please? Is there anyone who wishes to testify after... I'm going to ask again, please hold the testimony to about three minutes. We've got three other bills besides this one ahead of us.

TOM McBRIDE: (Exhibit 10) Senator Jensen, committee members, I'd like to thank Senator Stuthman for introducing LB 728. My name is Tom McBride, M-c-B-r-i-d-e. I'm the executive director at Epworth Village. I think it's important, as we look at LB 728, to identify some of the children that we're talking about within the various programs. I don't want to supply redundant testimony, but just to give you a snapshot of some of the kids. At Epworth Village, the average age of children in care right now is just over 13 years old. At the residential treatment center, which is one of the higher levels of care, our average length of stay there for children is 5.5 months. And it has been lower than that; however, there have been increases in that over the past couple of years. It was 4.4, then 4.8, due to the acuity of the children that we're seeing, and the inability to move to another level of care, due to unavailability. These children present with Access I diagnosis. In our population, 27 percent are oppositional defiant, 20 percent post-traumatic stress disorder, 14 percent depression, 16 ADHD, and the list goes on and on, bipolar, psychotic. We have several children right now, of the older kids, that have been diagnosed as paranoid schizophrenics. In 2000, just doing a quick snapshot today, looking at some of our reports, we had 14 direct assaults on

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staff by children. Two of these required staff getting stitches, one has required staff receiving on going physical therapy, and one resulted in a concussion. Just wanted to demonstrate the people that are working there, and the children they're working with sometimes are very difficult children. But, you know, they are great kids in and of themselves. Now when we started providing services in this form back in, I believe it was, 1994, '95, we provided day treatment services as well, and it was half-day treatment and full time day treatment. As we got into that process, we were notified that there would no longer be a full-day day treatment program, and that that was reduced to half day only, which also decreased the rate in half. June 1st of 2002, actually on April 22nd, all providers received a copy of this letter from Value Options, who was then the managed care organization for the state Medicaid program, that indicated that their intent was to pay less to providers as children were in care at the residential treatment. After 90 days the rate would be stepped down, after 180 days the rate would step down, after 270 it would step down, and anything beyond 271--271 days it would be reduced even further. Looking at 2004, this reduction in rate has, for our purposes, impacted us to almost \$44,000 loss in revenue. At the same time, even though those children are, you know, they're beyond the 90 days and the rate steps down, their acuity may not step down, staffing levels don't step down, and requirements of, you know...any of the requirements through chapter 32 or licensing or whatever, don't step down. Our children don't languish in care, except when there's possibly no place to move them. And in 2004, another quick snapshot was that we had three that waited two weeks finding some place to go to, five waited 30 days, one waited 45 days, and one waited over 60 days. We are currently at capacity in all of our programs. We have 14 treatment group home referrals sitting on the desk, we have 28 treatment group home beds--they're all full. We have five approved on our waiting list, and some of our residential treatment center youngsters were ready to step down, but we don't any place to move them, and it looks like the soonest probability is going to be 30 days. There will be some people that argue that providers make a lot of money, and if you look only at the FA20 that is reported at the end of the year, that doesn't really give you an appropriate picture. We have to add in

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all grants, gifts, donations, but we don't get to add in all the associated costs that go along with that. I did some looking real quickly on the Internet today, and I found three different job openings for...one is a Youth Care Specialist II at the Hastings Regional Center, same definitions, same requirements as staff that work in our residential treatment centers. Their beginning rate is \$23,316 a year. Our beginning rate is \$21,694. Additionally, for a Protection and Safety Trainee Worker, starting at \$2,141 a month equates out to about \$25,692 a year, and once again, we're back at \$21,694. There's an announcement for a Licensed Mental Health Practitioner or a provisional that begins at \$34,000...almost \$34,300 a year. We have eight therapists at work. We have one therapist that has over seven years' experience in specialized training that makes more money than that; the closest other one is fully licensed, been with us two-and-a-half years, and makes about \$800 less than that. I did some--just real quick--comparisons over, you know, looking at some of the costs, and there's a quick fact sheet on the back of this, that during this same time in 2004 to now, our salary costs increased 13 percent--excuse me. Our self-insured, and we have a self-insured healthcare plan, which allows us to provide a good benefit package and realize some savings if we have a good, healthy staff throughout the course of the year, that's increased 22 percent. Our energy costs increased 26 percent, workmen's comp increased 63 percent, our food costs increased 21 percent, and it costs 24 percent more to give a young man a haircut today than it did in 2000. Additional increases--gasoline has gone up 22 percent, milk 28 percent, apples 28 percent, and hamburger has gone up 32 percent. I really believe that LB 728, as it's introduced, would allow providers to work with the state in developing a vehicle to address cost of care and appropriate reimbursement across any administration. Together, then, we can continue not only the quality of service, but also be able to address issues of capacity for the needed services. It's in all our interests and intent to make sure that Nebraska is the good life for everybody. And I would offer my written testimony and be available for any questions.

SENATOR JENSEN: Thank you, Tom. Any questions of Mr. McBride? Thank you for coming forward.

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TOM McBRIDE: Thanks.

SENATOR JENSEN: Anyone else in support? Opposition testimony?

MARY STEINER: (Exhibit 11) Okay, I've edited it down. The unabridged version is in print, to keep this moving. Good afternoon, Senator Jensen and members of the Health and Human Services Committee. My name is Mary Steiner, S-t-e-i-n-e-r. I'm the interim Medicaid director for the Department of Health and Human Services Finance and Support. I'm here today to testify in opposition to LB 728. The Health and Human Services System continues to work under the guidance of last year's LB 1083, which increases community based services across the state, resulting in an array of appropriate services closer to the person's home community, support systems, family and friends. We are working closely with the six behavioral health regions as they work with providers across the state, on plans to develop and implement these important services. LB 1083 has created opportunities for community and provider input, along with a legislative oversight commission. This bill, LB 728, does not mention service availability as a goal. LB 728 seeks to establish a second advisory panel to the Health and Human Services System that would provide input to the system for rate setting. The advisory panel will take into consideration items that make up the cost component of services. HHS programs already have rate setting processes in place; specifically, in 1997, the Office of Behavioral Health contracted with a consultant who developed a cost model method for determining the rates paid for services. The model includes the cost of staff, we originally used state rates of pay, cost of space, and so on. Originally the estimates of these costs were based on provider input. Changes to the rates since the original rates were established were the result of legislative changes and not changes in the estimated costs. In the area of child protective services, the department and providers collaborated in October 1997 to establish standard contracts that went into effect July 1, 1998. Collaboration in making revisions to the standard contracts was done in 2000 and 2001. Being mindful of the competing priorities for time and resources for department staff as well as

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providers, an abbreviated revision process for contracts began July 1, 2002. Currently, providers identify any critical issues that they have with the programmatic language. The Medicaid in-patient psychiatric hospital rates are computed as the median of the hospitals' operating cost of providing psychiatric care by the facility. The rate is calculated as a set amount per day. Practitioners are paid on a specified fee schedule and receive rate increases as allowed or designated by appropriation. Managed care rates are included in the contracts between Magellan and the providers. The Medicaid program would need to obtain authorization and approval from the federal Centers for Medicare and Medicaid to delegate rate setting to an entity separate from the state Medicaid program. For institutional rate setting purposes, the federal requirements contain limitations such as upper payment limits. These rates may not be amenable to negotiation. The Medicaid Advisory Committee is charged with many of the same responsibilities as those identified in LB 728, including providing input on rates. The process advocated for in LB 728 would invite providers to determine their rate reimbursements based on costs. Currently, cost is only one of the criteria used to set rates, in addition to important parameters such as available funding. Therefore, if that is the approach proposed by the bill, it is a substantial policy and financial change for the state of Nebraska. As I have mentioned, we currently work closely with a number of advisory groups on issues, including payments, such as the LB 1083 Oversight Commission, advisory committees for problem gambling, addiction services and mental health, and the Medicaid Advisory Committee. We also work directly with groups of providers in the child welfare area, and will continue to do so. I'd be happy to answer any questions.

SENATOR JENSEN: Thank you, Mary. Any questions for Ms. Steiner? Thank you for your testimony.

MARY STEINER: They let me off easy.

SENATOR JENSEN: Anyone else with to testify in opposition? Neutral?

J. ROCK JOHNSON: My name is J. Rock, J. Rock Johnson, J-o-h-n-s-o-n. Thank you, Senator Jensen, and members of

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the committee. I'm providing testimony in a neutral capacity for the purpose of information. I notice that this proposal to create the Provider Reimbursement Advisory Committee does not contemplate the inclusion of any past or present service recipients, particularly former wards of the state or representatives of service recipients or advocates. Thank you.

SENATOR JENSEN: Thank you, J. Rock. Any questions for Ms. Johnson? Thank you for coming forward. Anyone else in a neutral position? Senator Stuthman, do you wish to close?

SENATOR STUTHMAN: Thank you, Senator Jensen. You have heard the testimony given here, and I want to thank all those that did testify today. I would just hope that the committee would consider all of the testimony, and hopefully, that we can move this bill out of committee, so thank you very much.

SENATOR JENSEN: Thank you, Senator Stuthman. Any questions? I don't see any. (See also Exhibit 12) That will close the hearing on LB 728. LB 606, Senator Thompson's bill?

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SENATOR THOMPSON: (Exhibit 1) Thank you, Senator Jensen. I know you've had a long day, and you're going to have a longer one, so let me trim my testimony to 10 percent, and just say, this bill does three things. It creates the Children's Behavioral Health Management Team, which is a state-level oversight of the system. At the local level it creates a health team in the regions, and it also creates within Nebraska law what 14 other states have done, and that is not require parents to give up custody of their children to get services. There are a lot of people who want to talk about this. I'm just going to give you my overview as a senator, of why I think it's important that we move forward. We...and Senator Jensen, you've led a great reform effort in the state on behavioral health. This is a piece that I think fits well and is the next step to being able to get to the children's health services and the tremendous need that is out there. The fiscal note on this one is a gagger, no

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doubt about it, and I've given you an amendment which I think would help us get to the actual costs of what this could do. And you're going to hear from people who will talk to you about ways to save money in the system by having a better way of managing the kids that have these very, very serious disorders that is money saving. But what I would suggest to do is to at least get the backbone of the system put together, which is recommended here, and which, quite frankly, is taken from a grant that the department already has received for doing this. The federal government is encouraging the states to do this. And the third section, what the amendment suggests is that this team that's created--the first action would be to review how the other states have accomplished it. I have a copy of North Dakota's form that's here on the back of your handout, but I think what they can do is look at that, the ways that other states have accomplished it, what the costs are, and bring back to the Legislature information on how this could be implemented. Clearly, we don't have room this year to be able to do this in the budget at this level. But I think it does point out the ways that, from a public policy perspective, you pay it here, you pay it there. And what we need to be looking at is what is the most effective way to be able to help these kids, help their families, but also, as legislators, help us develop a system that's effective, that has the elements...this afternoon while I was waiting, I was reading an article--and I thought of Senator Erdman--on Medicaid reform that was from March of last year in the state legislature review, maybe you give copies out, but some of the elements of that, well, what do you do that's preventative, what do you do that gets to the chronic disease elements which this does, the most seriously ill, what do you do to access your federal funds most effectively? I think all of those elements of Medicaid reform fit within this bill. And with that, I would tell you I will waive closing and chat with you afterwards if there are other issues. But I'd be happy to answer any questions that you may have.

SENATOR JENSEN: Thank you, Senator Thompson. Senator Erdman?

SENATOR ERDMAN: Just a comment. Senator Thompson, you may be aware of this, but I found the grinch in the hallway and

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he shared this information with me.

SENATOR THOMPSON: You found what?

SENATOR ERDMAN: The grinch. By year 2013, the growth in TEOSA and Medicaid only will surpass any future revenues that the state has.

SENATOR THOMPSON: Oh, well, I sit on the Appropriations Committee, and I'm aware of the trend lines there.

SENATOR ERDMAN: Well, you have to be careful about the information we share, because it scares other people.

SENATOR THOMPSON: No, that is absolutely true, but I can also tell you I have a family member who has serious mental illness. Senator Jensen and I have talked about this, and I've watched this from childhood on, and if we can do the things that could happen and prevent people who are going to be in our adult mental health system for a very, very long period of time, by being able to address and help people manage their mental illness, starting with identification at an early age, I think we can do a lot to not have the cycle that continues to repeat on the adult side. And we...these kids are somewhere. I mean, they have serious mental health disorders; they're somewhere. And without having a way for their families to get treatment without relinquishing their custody is also implying that we don't know how to do this with families. And we know from the latest research that we have--and at least my last eight years in the Legislature--that we need to work with families. We need to...kids go home to somewhere, or they don't go home at all. When they become our ward, we are the parent. There are things that we can do better and is a better use of our money. And we need to get to the front end of the system, as well as just the back end.

SENATOR ERDMAN: I agree. We can't afford to do nothing.

SENATOR THOMPSON: Yes, absolutely. Thank you very much.

SENATOR JENSEN: Thank you, Senator Thompson. You probably remember, I introduced a bill similar to this a couple of years ago.

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SENATOR THOMPSON: I didn't know that. I should have mentioned that.

SENATOR JENSEN: No, but the fiscal note continues to grow, even from when I introduced mine, which was about--I don't know--we were about \$14 million or something like that. But there's really something wrong with the system where you have to divorce your kids in order to get treatment for them. How we do that, I don't know. I'll be glad to certainly look at this and see if this is a way, or whatever.

SENATOR THOMPSON: Sure. And I appreciate that, and also the bill provides that...it isn't like that you can sign up if you've got an issue. There has to be a financial need; you have to exhaust your other resources; Medicaid is the payer of last resort under the waiver, so I mean, we would certainly take it through the steps, but it is very, very sad when this happens.

SENATOR JENSEN: Senator Howard had a question.

SENATOR HOWARD: Well, I understand the bill and I think it's overdue. Just a technical point. It isn't really relinquishment. The child is placed in the custody of...in the court custody.

SENATOR THOMPSON: Right. I'm sorry. It wasn't...I'm using the wrong language.

SENATOR HOWARD: It isn't a relinquishment or a termination. So it might be good to...

SENATOR THOMPSON: Yes, I appreciate that. It's not a termination, and I kind of mixed my language up, because I'm not from the system. It is a custody issue. Thank you.

SENATOR JENSEN: Okay, thank you. I don't see any other questions.

SENATOR THOMPSON: Thank you.

SENATOR JENSEN: May I see a show of hands of how many wish

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to testify on this? Okay. I'm really going to ask that you hold your testimony very short. I know the stories behind this are...entail a lot of years, usually, but if you would just bear with us. I'm afraid I'm going to lose some committee members--one right now--and others, if we go real late into the evening. So please hold your testimony short, tell it as quickly as you can, and we'll go from there. First testifier, please? I do have letters of support from The Nebraska Psychological Association (Exhibit 2), the Nebraska Association of Behavioral Health Organizations (Exhibit 3), and the Nebraska Medical Association. (Exhibit 4)

KATHY GAST: (Exhibit 5) I promise to be brief, Senator. My name is Kathleen Koley Gast; last name is spelled G-a-s-t. I represent the Nebraska Nurses Association and myself, and I want to thank you for the opportunity to speak with you today. I'm a psychiatric nurse, and as I said, I'm a member of the Nebraska Nurses Association, the Nebraska Psychiatric Nurses Association, and I worked at Richard Young for 19 years until it closed. During that time I worked on the child and adolescent unit. I now work as a psychiatric nurse and staff trainer at the Nebraska Medical Center, and I do community healthcare marketing for Methodist Home Health and Hospice. I'm here today to give my support for LB 606 and encourage you to pass this legislation. In my 19 years with children at Richard Young, I witnessed the frustration and the anguish of parents when they felt forced to turn their children over to the custody of the state in order to get mental health treatment for these children. Many were forced to do this after they had maxed out their mental healthcare benefits on their insurance policies and simply could not pay out of pocket for costly and lengthy mental health treatment. These parents were fearful of doing this, because they were giving up the right to make healthcare decisions on behalf of their children. They placed the welfare of their children in the hands of busy caseworkers. Parents did not always agree with the decisions which were made regarding their children, be it decisions on medication, doctors' treatment plans, care facilities or placement. It was and is a very frustrating and scary experience for parents and their children in need. Once the children were turned over to the custody of the state, the parents were no longer the

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decision makers; they may have had input or may not. As stated in LB 606, this bill will help to preserve the sanctity of the family unit and will prevent families whose children have serious emotional disorders from having to relinquish custody of their children to the state to access behavioral health services. It will also allow parents to be involved in all aspects of the delivery of services. This bill will also prevent the trauma of a child being unnecessarily removed from care in his own home. Senators, this bill has been a long time in coming. It is time to return to the parents this most important decision making power. It is the best thing for these children, best for their families, and best for our society. I hope you will turn this legislation into law. Thank you.

SENATOR JENSEN: Thank you, Ms. Gast. Any questions? I don't see any. Thank you very much.

LINDA JENSEN: (Exhibit 6) Linda Jensen, J-e-n-s-e-n, representing the Nebraska Nurses Association. I'll skip most of my testimony and just say that I have a friend who I taught in a family-to-family class this last semester. She's a nurse. Her daughter was 18 at this time, but had been placed in custody with the state three years before that, so that she could get care. She'd been in over 18 different placements during those three years. I'm sure you've heard these stories before, but this girl is still very, very disturbed, but now had turned 18, so had come back home to her mom, and just a tough, tough situation. And I can't imagine moving 18 times in three years, how disturbed anyone would be. So this has not been an successful way to take care of this problem, so if we can think about a change, it certainly would help. Thank you.

SENATOR JENSEN: Thank you, Linda. I didn't see any questions. Next testifier in support, please?

LESLIE BYERS: (Exhibit 9) Good afternoon, senators. My name is Leslie Byers. As I mentioned earlier, I have a 19-year-old daughter who has suffered with mental illness for many years. We now know that her illness began to manifest during her toddler years. As early as age three, my daughter's mood swings became severe enough that my husband and I sought guidance from a child psychologist,

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only to be told we were overreacting. At age four my daughter had been expelled from a day care and a preschool. As she entered grade school she experienced numerous suspensions every year, due to her behavior outbursts and finally, at age seven, her behavior problems became severe enough that they caught the attention of the professionals and we began receiving help through the special education and the mental health systems. My daughter's first in-patient hospitalization came at age nine. Then for a period of seven months, from October '95 through March of '96 she was hospitalized five times. At that point we had exhausted our private health insurance. Therefore, the only course of action available during a psychiatric crisis was to call the police to transport my daughter to the emergency room of the local hospital, where she was immediately given a shot of Thorazine, basically a tranquilizer that would, in effect, render her semiconscious for the remainder of the evening. And then we would drag her out to the car and take her back home, where she would be lethargic the next day, without any comment of the previous night's events. And we would pray to God that we would make it through another day. This was occurring four to five times a week. Without any access to needed mental health treatment, my husband and I began to search for whatever means we could find. But everywhere we turned, including our daughter's doctors, we were told that the only option left was state support. But as you well know, that comes at a high price, the price of relinquishing custody of your child to the state. My husband and I agonized over this decision for several months, seeking any other avenue we could turn to before succumbing to the reality that we had no other choice. Our daughter needed intensive treatment that our insurance wouldn't provide, and we didn't want her to end up in jail or worse, dead. So we placed our little girl into the hands of the state and prayed to God that things would turn out right. At the time, my husband and I thought we were helping our child by this decision, but we quickly learned that our capacity to advocate on behalf of our daughter was severely limited. However, as difficult as this decision was on my husband and I, I can't imagine...I was not prepared to have to explain to my 10-year-old daughter why we did what we did when she asked me, why did you give me away? This isn't a decision that just affects the parents. Children feel that devastation,

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that separation, and I can't imagine the agony she went through, wondering why we gave her away. No parent or child should have to experience the devastating impact of this decision. I beg your consideration in realizing how potentially harmful, on an already vulnerable situation, the issue of custody relinquishment is to children and families. And I thank you for your support.

SENATOR JENSEN: Thank you, Leslie. Any questions? Thank you for coming forward.

LESLIE BYERS: Thank you.

KATHY DUNNING: (Exhibit 7) Good afternoon. My name is Kathy Dunning, that's D-u-n-n-i-n-g, and I'd like to point out, before I read this, that this bill is not just about parents relinquishing custody in order to get the services they need, it is also about setting up a system of care that prevents children from having to go to higher levels of services, wherefore parents would not have to make that difficult decision. I have a profound empathy for families who are forced to relinquish custody to receive medical services for their children. Our family was blessed to receive wraparound services so we did not have to do so. Wraparound services reflect the same system of care principles you're being asked to consider in LB 606, family and child centered, comprehensive, promoting prevention and strength based. In wraparound, a team identifies family strengths and then brainstorms options unique to that child's strengths and cultures, to help him or her succeed in the home. Not only does this support families and communities, it is much less expensive than paying for out-of-home placement. Parents do not want themselves or the state to place their child in a residential treatment center, if a supportive home based alternative is available. I also coordinate Families First and Foremost family resource center, where families such as myself help families of youth with mental and behavioral health issues locate the services and supports available in our community. We've received several calls from parents who have been told they must make their child a state ward in order to get medical help. Insurance has run out, and they do not qualify for Medicaid, as you've heard from other people. Some of those parents spoke of debts of \$25,000 and \$40,000 and more that

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could have been avoided. Just last week I received two such calls. One call was from a mother whose daughter had been a ward of the state. Now that her child was back in her care, she says she doesn't ever want to go there again, because she lost her authority regarding choice of therapist, school, type of treatment, et cetera. Her daughter is diagnosed with schizophrenia. She needed to hospitalize her that day and would do so, not knowing where the money would come from. There are studies that show best practice models, in which persons with schizophrenia can go two to three times longer between hospitalizations. That is the type of creative intervention a system of care team might pursue. It's more beneficial to the child and family and less costly for everyone. Many parents would not have had to relinquish custody if two of this bill's proposals had been available to them--first, a supportive system of care which coordinates professionals and families coming together to create unique, strength based plans for children to develop behavioral and mental wellness, plans that strive to develop creative alternatives to expensive hospitalizations or out-of-home treatment, and secondly, if they had had a way for parents to ensure that their child can receive necessary medical treatment without relinquishing custody. And with these systems of care, supports I'm talking about, if they were in place, parents will be less likely often to seek costly, residential services. No parent should have to give up their God-given right to be a parent, just because they want their child to receive necessary medical treatment. Please vote in favor of this bill, and I have a P.S. We were talking about getting into the adult mental health system--my son went through this years ago. He's 20 years old now. He got this type of wraparound services. People said we would probably have to house him the rest of our lives; that's how severe they thought he was. He's 20 years old now. He's been a plumber's apprentice for a year-and-a-half. He works 40 hours a week; he's a tax paying citizen, and I don't believe he will ever be in the adult mental health system, because of these types of supports. Thank you.

SENATOR JENSEN: Thank you, Kathy. Any questions? Good to hear that.

KATHY DUNNING: Thank you.

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SENATOR JENSEN: Next testifier, please?

LISA BLUNT: (Exhibit 8) Chairman Jensen and members of the Health and Human Services Committee, my name is Lisa Blunt, that's B-l-u-n-t, and I am here on behalf of Child Saving Institute in support of LB 606. As you heard testimony on behalf of LB 728, Child Saving Institute is a nonprofit child welfare agency with roots in the Omaha community dating to 1892. We currently have several programs that address the behavioral health needs of children and families in the Omaha community, including an intensive family preservation program and other community and home based therapy and support services. We support LB 606 because we believe that no family should be forced to ever relinquish custody of a child in order to meet a child's behavioral health needs. And as a treatment provider, I can assure you that that is exactly how it feels to the child and to the family. It feels like an abandonment, and the emotional repercussions of the child's perception of abandonment can significantly undermine the benefits of treatment and cause irreparable damage to the lifelong ability to form and sustain healthy relationships. We also know that an emphasis on prevention, early identification, and early intervention results in more positive treatment outcomes, and is also more cost effective, oftentimes eliminating the need for future out-of-home placements. And of course, the availability of comprehensive, community based services in the least restrictive setting possible constitutes best practice in the behavioral health field. Child Saving Institute's mission supports doing what is best for children, and to this end, we are happy to collaborate with other providers and provide input to the behavioral health management team. We believe that for this endeavor to be successful, all parties must exercise creativity in identifying and providing strength based, cost efficient services to children and families, in order to preserve the family unit whenever possible. And I would like to thank you all for your commitment to serving the best interests of Nebraska's children.

SENATOR JENSEN: Thank you, Kathy (sic). Any questions for Ms. Blunt?

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BRAD SHER: (Exhibit 10) Senator Jensen, members of the committee, my name is Brad Sher, S-h-e-r. I'm here today in support of LB 606. Our greatest frustration at BryanLGH is that as the last standing provider of in-patient mental health services for children in southeast Nebraska, is how we treat our kids. And something needs to be done. I told you earlier my example of the two cases that we've got going on, where we're wasting \$50,000, and I know there's a big fiscal note with this, but we need to look at potential efficiencies in the system, as well. And Senator Jensen, you've been to our place, you've met our staff who have dealt with it. And it's cases like this and when it deals with the kids, that their greatest frustration with the system is how it just doesn't work. And I know you've tried to, you're tackling the adult side. I would just encourage you and the rest of the committee to try and do something and tackle what's going on with the kids. Thank you very much.

SENATOR JENSEN: Thank you, Mr. Sher. Any questions? Thank you for appearing.

BRAD SHER: Okay.

BRENDA FLETCHER: (Exhibit 11) Senator Jensen and members of the Health and Human Services Committee, my name is Brenda Fletcher, that's F-l-e-t-c-h-e-r, and I serve as a youth coordinator for Families CARE, which is a family advocacy organization which serves 22 counties in central Nebraska. But more importantly, I am a parent of three children, two of which have been diagnosed with behavioral health issues, and I appreciate this opportunity to testify with you regarding LB 606. My eldest child, who you're going to meet shortly, Brandon, has spent most of his life in turmoil. Beginning from the day of his birth there were constant tantrums, angry outbursts, and rages. He seemed incapable of dealing with the outside world. By the time he entered school, I was grateful to have someone finally else to deal with him, but like me, teachers were unable to understand what was causing Brandon's difficulties. In the following years, there were many diagnoses, treatments, and medications, to no avail. At only age 12, Brandon made his first suicide attempt and his first of many hospitalizations. After returning home from the hospital,

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his depressions deepened, and his behaviors at home and school got worse. The cost of his treatments skyrocketed. Soon afterward, we learned that although my husband had not switched his job, his employer had switched insurance companies and through no fault of his own or ours, we found that our new insurance company had very limited mental health coverage and would pay for very little of Brandon's ongoing treatment. We had sought help everywhere. We tried to apply for Medicaid but were turned away and told we were not eligible. We applied for SSI benefits for our child, but we were told the symptoms were not severe enough and denied benefits. We continued to fight for him on appeal. In the meantime, Brandon's bills were skyrocketing and stockpiling, and he continued to have problems at home and at school. This is when the school suggested that Brandon be placed into a foster or a group home. They indicated that if we would do this, our financial worries would be over, if we would just relinquish custody of Brandon to the state. After days of agony, we decided no matter at what cost, we would keep our son at home. We knew the best place for Brandon to get better was with the people who loved and cared about him the most. This is a decision we have never regretted, but few parents in the same situation could afford. In the following months, Brandon nearly impoverished us. His treatment cost our family tens of thousands of dollars and nearly destroyed our family. Although it was hard at times, we continued to stick by him and support him, and after 39 months of appeals, we eventually won Brandon's SSI claim, and he became Medicaid eligible. Still today, seven years later, we continue to pay his back medical bills. Despite it all, we feel we are the lucky ones. When Brandon became Medicaid eligible under SSI, we were able to access community based services and support, many of those wraparound services you just heard about. Today he still continues to struggle with his mental health challenges, but has remained at home near his family and supports. This May he will graduate from high school and soon will be attending community college on scholarship. I serve as a youth coordinator for Families CARE, a support, education, and advocacy organization for parents of children with emotional behavior challenges. As part of my job at Families CARE, I've had the opportunity to work with many families who have had to relinquish custody of their children to the state of Nebraska. I've heard their heart

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wrenching stories in making the ultimate sacrifice by giving their child up to the state in order for them to get services their child so desperately needs. Many of the youth I work with today have experienced the tragedy of parents relinquishing custody of them to the state of Nebraska. These youth do not understand why this happened to them. How can the people who are supposed to love and care about them the most give them up to total strangers? These youth feel abandoned, they have trouble trusting others, particularly authority figures. Some of them have tried to be reunited with their parents, but because of their deep emotional scars and mistrust, they have difficulty bonding with them. Many times they end up back into the foster care system, juvenile justice system, and some have attempted suicide. Relinquishing custody should not be a requirement for youth to receive necessary treatments and services in our state. Families don't deserve to be emotionally and financially destroyed because of their child's mental health challenges and needs for ongoing treatment. There must be a more humane option to keep our families together in Nebraska. I urge you to support LB 606 for our families, our youth, and our future. Thank you.

SENATOR JENSEN: Thank you, Ms. Fletcher. Any questions from the committee? I don't see any. Thank you for coming.

BRANDON FLETCHER: I am Brandon Fletcher, F-l-e-t-c-h-e-r.

SENATOR JENSEN: Thank you.

BRANDON FLETCHER: (Exhibit 12) Senator Jensen and the members of the Health and Human Services Committee, I appreciate the opportunity to testify regarding LB 606. I'm a member of the governing board of the National Youth Leadership Network, an organization of youth leaders with disabilities across the United States. I am also the founder and cochairman of Youth Encouraging Support, known simply as YES. YES is a youth led, youth run organization that is based on advocacy for young people with emotional or behavioral health challenges in central Nebraska. Most importantly, I myself am a mental health consumer. I have come today to speak upon my own behalf and the behalf of more than 100 current youth members of YES. We as members

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of YES believe the practice of relinquishing custody of a child with behavioral health challenges to the state of Nebraska solely for the purpose of getting the necessary treatment we need is barbaric. It must stop. We as youth know what helps us the best, and being with our families, at home and in our communities works the best for us. No young person should be forced to leave home without the support of their family because they are ill or need help. We should not be forced to live in a strange place with people who know nothing about us. Instead, we should be allowed, like others who are ill, to be near or at home, where we can have the love and support of our families. This is very important to us, and it is very important to helping us get better. Many of us have experienced being removed from the home and placed into foster care, treatment facilities, hospitals. Our parents are not allowed to have any decisions on what is best for us, even though they are the people who know us the best. We don't understand how a civilized society, how people could take us away from the people who know and care about us the most. Coping with our illness is tough enough, but having no support from our families is sometimes too much for us to endure. Our feelings of uselessness and abandonment make it difficult for us to trust people, because we are in fear of being hurt again. Many of us are fearful to be reunited with our parents, because we feel we will have to leave home again. It is the time to move forward, and we as youth see the need for change. We are the experts on our lives and what works for us. Whether it's going to a baseball game, movie, or weekend campout, being with our families is what is most important to us and where we really want to be, not with strangers. Families are the people who know us the best and can help us the most. All of Nebraska's children deserve to be with their families. We need to be with the people who care, love, and support, and most of all, give us hope. The state must find ways to keep youth and their families together, not break them up. There must be other options for youth to stay at home and be successful without making our parents relinquish custody. Please support this bill. It's not only important to our families, but to us, to our future as the youth of today and leaders of tomorrow. Please remember this when you are considering this bill. Thank you for allowing me to speak today.

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SENATOR JENSEN: Brandon, thank you for coming today, appreciate it. Yes, Senator Stuthman?

SENATOR STUTHMAN: Thank you, Senator Jensen. Brandon, in your group, your Youth Encouraging Support group, are they mostly kids that are at home, or you've got people that are in foster care?

BRANDON FLETCHER: We have a...we have from biological, to one-parent households, to foster care, and even in treatment homes we have people.

SENATOR STUTHMAN: So you've got all different types that are in there?

BRANDON FLETCHER: Correct.

SENATOR STUTHMAN: Okay, thank you.

SENATOR JENSEN: Any other questions? Thanks again for coming.

ROGER KEETLE: Good afternoon. For the record...

SENATOR JENSEN: Good afternoon. How many others do we have that wish to speak? One? All right.

ROGER KEETLE: (Exhibit 13) Senator Jensen, members of the Health and Human Services Committee, for the record my name is Roger Keetle, K-e-e-t-l-e. I'm a registered lobbyist for the Nebraska Hospital Association. I will be extremely brief. I have written testimony which I will give the committee. It is basically medical research provided by Dr. Pepper that basically his research in New York shows this kind of program works, and with that, I'd just submit my testimony for the record. I also have for the record the testimony of Mr. C.J. Johnson, regional administrator for Region V, in support of the bill, so Region V is also in support, plus the hospital association. That's my message. Thank you.

SENATOR JENSEN: Thank you, Roger. Any questions of Mr. Keetle? Yes, Senator Johnson.

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SENATOR JOHNSON: Is Dr. Pepper a graduate of Nebraska?

ROGER KEETLE: You know, I...there's a hook to Nebraska, but I can't remember what it was. Jeff was at the same conference. I think he's been in New York for over 30-some years, but I think he was originally from Nebraska. Do you remember? You don't, oh, okay.

SENATOR JOHNSON: Well, there was one, so thanks.

ROGER KEETLE: He's a national expert...

SENATOR JOHNSON: Yeah, okay.

ROGER KEETLE: ...and did an excellent job of talking about this issue. Jeff and I were both there.

SENATOR JENSEN: Senator Erdman has a question.

SENATOR ERDMAN: Roger, I bet we could all use a Dr. Pepper right now. (Laughter)

ROGER KEETLE: Yeah, no kidding, yeah. That's why I'm trying to keep this short, because I want to talk on the next bill, too. Thank you.

BETH BAXTER: (Exhibit 14) Hi. Senator Jensen, members of the Health and Human Services Committee, my name is Beth Baxter, B-a-x-t-e-r, and I'm the regional administrator for Region III Behavioral Health Services. I'm not going to take up any more of your time, and appreciate you sitting here and listening to the compelling testimony of families, and especially Brandon, and I couldn't say it any better than what Brandon has already told you. What I do want to encourage you to consider is that we've had two successful projects in Nebraska that demonstrates this system of care concept. We've realized cost savings in serving children; we've served additional children, and we've kept families intact in doing that. My written testimony tells you a little bit about one of those programs that we recently implemented that focuses strictly on children who are at imminent risk of being removed from their home because of a behavioral health issue. We did a pilot project last year. We served 20 children, and these are children who have very

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complex issues. Of those 20 children, we were able to keep 18, or 90 percent of those children, out of the child welfare system, at home, and they remain in their homes today. We've expanded that program through cost savings through other programs, and so I just urge you to...that money doesn't become the sole issue for allowing families to continue to give up their children. We've got creative people in Nebraska, we've got good ideas on how we can implement programs that help keep families together. Thank you.

SENATOR JENSEN: Beth, did your program kind of use a wrap-like program?

BETH BAXTER: Yes. Our program is based upon the wraparound philosophy, and we use all of the system care approaches that puts families in the driving seat.

SENATOR JENSEN: And Medicaid and whatever else you can use to supplement?

BETH BAXTER: Yes, um-hum.

SENATOR JENSEN: Good. Thank you. Any other questions? Thank you for coming today.

BETH BAXTER: Thanks.

SENATOR JENSEN: Anyone else wish to testify, please come forward. You're a proponent?

TODD RECKLING: I'm the opposition, Senator.

SENATOR JENSEN: You're in opposition. Let me just ask first. Was there any more proponent testimony? I don't see any. Fine. Please go ahead.

TODD RECKLING: (Exhibit 15) Thank you. Good afternoon, Senator Jensen and members of the Health and Human Services Committee. My name is Todd Reckling, R-e-c-k-l-i-n-g. I'm the administrator for the Office of Protection and Safety within the Department of Health and Human Services. I'm here to testify in opposition of LB 606 today. This bill is known as the Children's Behavioral Health Act. This bill

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establishes a mechanism for voluntary placement agreements by parents with HHS, with the purpose of accessing services for children with serious emotional disorders and their families. It establishes a children's behavioral health director position and...

SENATOR JENSEN: Excuse me, Todd, but in the interest of time, are you going to read the whole thing?

TODD RECKLING: Absolutely, I will get to the point, Senator.

SENATOR JENSEN: Thank you very much.

TODD RECKLING: I'll let you go through the...if I can just skip over to maybe the points of opposition and let you read through the rest.

SENATOR JENSEN: Fine. I'd appreciate that.

TODD RECKLING: Thank you, Senator. The first point, we have some issues with concerns the language in this bill. Definitions for the terms--I'm on page four at the bottom--"behavioral health services" and "serious emotional disorders" are needed to clearly define the population covered by this bill. Not defined, the term may include services for a very expansive, new population. Additionally, the role of the department is unclear. If the purpose of this bill is to expand access without placing a child in the department's custody, the voluntary placement agreement seems to be a mechanism solely to ensure payment for services. If the agreement is intended so that the department has a role in managing the care of children and family services to the family, that should be clearly defined. Finally, with respect to the language in the bill, it provides and prescribes a "system of care" strategy currently being promoted in the behavioral health field. Point number two is the fiscal impact on the system, which would be dependent upon the definition of the population, the scope of services the family could access for the child, and whether or not any limits would be provided regarding access to resources and what role the department would have. The statement in the bill would require the department to pay for all items relating to care, such as room and board,

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dental, optical, medical, along with behavioral health services. This could also be a huge expansion in the number of children for whom the state provides care. Based on the broad and vague language in the bill, there could be a significant fiscal impact. There's also no provision in the bill for high income families to contribute to the cost of care for their children. There's no reference of income guidelines or family participation in the cost of services. A number of bills have been introduced this legislative session that would expand Medicaid services. Point number three would be that the bill duplicates the advisory capacity created under LB 1083, which you've heard before, so I won't repeat that. I'd just like to note that the committee is aware of our concerns with regard to Medicaid expansion. What we believe it's time for is that we stop looking incrementally at expanding individual programs and eligibility groups and support the Medicaid reform as it is outlined in LB 709. In conclusion, we believe it is important to continue to work with families, behavioral health providers, and others to be responsive to the needs of children with mental health needs and their families. However, LB 606 may have a negative impact and far reaching impact on the public system, and ultimately, the children and families themselves. I'd be happy to try to answer any questions.

SENATOR JENSEN: Thank you, Todd. Any questions? Yes, Senator Howard?

SENATOR HOWARD: Todd, in looking at this, it seems to me it's a bit contradictory. As we both know, the majority of the children that are placed in the custody of the state come through the court system. There are very few that aren't, some voluntary placements, some interstate compact placements. So when you say this would increase the population of the children in the system, if there wasn't any court action, which would equate to the custody issue, do you see these children as still being wards of the state?

TODD RECKLING: Senator, I think that there's a couple of different potential populations. Certainly some of the children, as you describe, are probably already state wards, so if this bill would go through, they would not be required to come into the state system under the juvenile court, so

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might be a small reduction. However, there's also probably another population out there that may not be getting services now. You'll see in my testimony that we have a small program serving about 800 kids currently through the Professional Partners. Those kids are children that aren't eligible for Medicaid, so that population is getting served, but there's also a broader, expansive population, perhaps, out there with specific disorders that may qualify for this. That's why we believe the definitions are very important, to define those parameters, of what type of kids would need services. Certainly our position is that we also believe that kids shouldn't have to come into the system. And you'll see my opposition to the bill was based on several points, as I described.

SENATOR HOWARD: But if they didn't come into the system, then they wouldn't technically be state wards. They'd be served by the state, but not, per se, wards.

TODD RECKLING: I understand. Yes.

SENATOR HOWARD: I mean, am I seeing this correctly? Do you see this the same way?

TODD RECKLING: I think there are some kids currently that are state wards, as you're describing, that would possibly not be state wards because of that. I also believe that there are other populations of youth out there that may not be receiving services now, that would possibly be served under the definition of this current bill, that would be expansive, so the small number that you may take out of the state ward system under the juvenile court system, depending on how the population is defined, may also increase beyond the few that may not be in our system.

SENATOR HOWARD: I would agree with you with that, but would it be a Medicaid issue, the population that may leave would be Medicaid eligible still, probably, and this population that would be newly addressed would be Medicaid eligible? The difference would be no case management services?

TODD RECKLING: I think we'd probably see a vast array of different types of populations. Some of the kids may be eligible for Medicaid; some would not. And some, as

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described in the bill talk about...and those youth that are at risk, if they have SED of committing a juvenile, a delinquent act. As you know, probation serves about 5,000 kids, and there's also many other kids who go through the juvenile court system that may be at risk of a juvenile offense. So it can, depending on the clarification of that population, I think that it may broaden up to another group of people that may not be in the system, but would be eligible or needing services.

SENATOR HOWARD: Okay, thank you.

SENATOR JENSEN: Thank you, Senator Howard. Any other questions. I don't see any. Thank you.

TODD RECKLING: Thank you, Senator.

SENATOR JENSEN: Anyone else in opposition? Any neutral testimony? And Senator Thompson has waived closing. (See also Exhibit 16) So that will conclude the hearing on LB 606. Senator Flood is here to open on LB 618. Welcome.

LB 618

SENATOR FLOOD: Good evening. Good evening, Chairman Jensen and members of the committee. My name is Mike Flood, F-l-o-o-d, and I represent the 19th Legislative District, and I'm here today to introduce LB 618. There's no question that last year's debate over LB 1083 divided communities and our state. However, in the spirit of participating in behavioral healthcare reform, I introduce this bill which will do three things; namely, and number one, provide increased funding to community based services; number two, establish a tracking system to prevent consumers from falling through the cracks during this period of transition; third and finally, a directive to HHS to investigate Medicaid funding sources. Please do not confuse my testimony with last year's opposition to the closure of the regional centers. Given the course of behavioral health reform, I introduce this bill in an effort to help build quality, adequate community based services and behavioral healthcare that consumers in all areas of the state can rely

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upon. The first and primary provision of this bill continues an appropriation from our healthcare cash fund. Last year \$4.67 million was appropriated from this fund. Under my bill, \$4 million would be appropriated from the Health Care Cash Fund over the next two years. The very reason that I propose continuing funding was confirmed when I read the fiscal note this morning, and I quote, "Last year's appropriation was intended to provide start-up funds for the reform effort. The services initiated with these funds will be continued with general funds transferred from the regional centers and Medicaid funding." What concerns me is that there's this idea we can close a regional center on the last day of one month and then use all of that money to open community based services on the very next day. The baton cannot be passed that fast. People's lives are at stake. Consumers deserve a transition that moves slowly enough to protect each consumer from falling through the cracks. This bill recognizes that our regional centers will remain our safety net until and at which point adequate community based services are in place. The legislative intent behind last year's compromise on LB 1083 was that adequate community based services would be in place before the state discontinued services at the regional center. The people of my district understand the significance of LB 1083. However, you must understand that our regional center staff put quality, behavioral healthcare first, above any other priority. When a consumer leaves Norfolk Regional Center headed for Omaha, Scottsbluff, or Kearney, the providers at NRC want to know that that consumer will receive quality behavioral healthcare. That's why I introduce this bill. The second provision of this bill directs Health and Human Services to establish a system to track persons receiving or requesting behavioral health services, to ensure that during a period of transition, consumers do not fall through the cracks. I remain concerned that LB 1083 does not recognize the need for long-term, secure care or dual diagnosis care. This tracking system will allow Health and Human Services to better manage this transition process. The third and final provision of my bill includes a provision that would require the Division of Behavioral Health Services of the Department of Health and Human Services to contract with a national Medicaid consultant for behavioral health services, for the sole purpose of investigating whether Nebraska is maximizing

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our Medicaid funding. The way I see it, the more federal funding available, the more behavioral health services Nebraska can provide. It is important to note that this bill does not address the continued operation of our regional centers; rather, it addresses the statewide need for adequate behavioral health services. This money belongs and is intended for community based services for Omaha, for Scottsbluff. The money proposed in this bill does not go toward the continued operation of a regional center. I believe it is a proactive approach to responsible behavioral health reform on an issue that has been so dividing. I thank you and would be happy to answer any questions that you have.

SENATOR JENSEN: Thank you, Senator Flood. Any questions from the committee?

SENATOR FLOOD: Thank you and I appreciate it.

SENATOR JENSEN: There was a date on this, too, Mike. What was that? There's a recommendation, or the date for recommendation is September 1, 2005. But the transfer of the dollars would be \$2 million in '04-'05, and \$2 million in '05-'06; is that correct?

SENATOR FLOOD: Four million dollars each budget year, yes.

SENATOR JENSEN: Four million dollars each of those years. All right, thank you.

SENATOR FLOOD: Thank you very much. My committee is currently continuing to progress, so I'll return to that. We have executives.

SENATOR JENSEN: You're still in committee?

SENATOR FLOOD: The Judiciary Committee never sleeps. (Laughter)

SENATOR JENSEN: This is a Friday night; didn't you know that? (Laughter)

SENATOR FLOOD: We're just trying to keep pace with your committee, Mr. Chairman. (Laughter)

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SENATOR JENSEN: Oh, okay. You will not be here, then, for closing?

SENATOR FLOOD: I won't waive it at this time, but I will waive it if I'm not present. (Laughter)

SENATOR JENSEN: All right, fine. Very good. Thank you. Mayor, welcome.

GORDON ADAMS: (Exhibit 2) Thank you. Senator Jensen, members of the Health and Human Services Committee, my name is Gordon Adams; I'm the mayor of Norfolk, and here to testify in support of LB 618. We are grateful to Senator Flood and all the cosponsors of the bill for introducing this important legislation. Our community has a deep and abiding interest in behavioral health services in Nebraska. As the home of Norfolk Regional Center for over 100 years, our community has a long and proud tradition of caring for people with behavioral health needs. With the passage last year of LB 1083, we know our state is undergoing major changes in our behavioral health system. As an important part of the state's behavioral health system, we know the Norfolk Regional Center will be undergoing changes as well. We feel the Norfolk Regional Center has played a valuable and vital role in serving the behavioral health needs of thousands of Nebraskans over the years. We strongly opposed the closure of the Norfolk Regional System last year, as you well know. We continue to oppose the closure of this facility but want a positive relationship with the Legislature and the Governor. We want to continue to play an important role as the system changes over the next few years. I am here today to ask this committee, the Legislature, and the Governor to work with our community to redefine our role in serving Nebraskans in need of behavioral health services. We have approximately 300 skilled, experienced, and caring staff people who work at the Norfolk Regional System. They are a valuable resource to our state. Many have dedicated their lives to serving people with behavioral health needs. We believe they should continue to serve people in need. We need your help as the behavioral health system transitions over the next few years to find a place in the new system. We ask that the state not rush into drastic changes in the system.

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Let us take the time to make the right changes for the long-term benefit of our state and people who need behavioral health services. We can take more time if we find more funding. LB 618 calls for more funding for community based behavioral health services from the Health Care Cash Fund. LB 618 also calls for Health and Human Services to seek expert help to find more federal funding for behavioral health. We made this suggestion months ago, but the department has resisted this idea. There is much to be gained and little to be lost by being sure our current state expenditures for behavioral health services bring as much federal funding as possible back to our state. We need to ensure that changes will improve services. That is why LB 618 calls for tracking of individuals in the behavioral health system, to be sure people are receiving services and are not lost as the system changes. Thank you for your time and attention. Thank you for your patience with our concerns. LB 618 is a positive step forward to follow up on LB 1083, and the city of Norfolk asks for your support and we offer our cooperation. Thank you.

SENATOR JENSEN: Thank you, Mayor. Any questions for Mr. Adams? Thank you for coming and staying this long.

GORDON ADAMS: Thank you.

SENATOR JENSEN: Next testifier in support? And I do have letters of support from the Nebraska Nurses Association. (Exhibit 1) Welcome.

DAN MAUK: Senator Jensen, members of the committee, my name is Dan Mauk, M-a-u-k. I am president of the Norfolk Area Chamber of Commerce and the registered lobbyist for that organization. I'm here to support LB 618. The pledge I've made to my community is to ensure that mental health reform is real mental health reform, that we address the needs of the citizens of the state of Nebraska, and acknowledging that there can be some changes in the makeup of my community economically. That notwithstanding, I'm pledged to make sure that I do all I can to ensure that this transition is an actual improvement, and not a shifting of resources. The bill as presented by Senator Flood extends funding, it allows more time to develop community based services. Since LB 1083 passed, there's been moderate progress--moderate

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might be an overestimation for an exaggeration of the amount of progress of new programs that have actually been developed. It takes some time to develop those programs; it takes some funding. This extension of funding would enable more time for adequate resources to be in place in the communities to allow a reduction of force at the Norfolk Regional Center. The Medicaid maximization--there are national firms that specialize in studying Medicaid reimbursement. Some of those firms work on a percentage of what they find basis, so the fiscal note would call in question any particular costs as related specifically to Medicaid maximization. And in terms of tracking, we feel it's imperative that we have an accountability stream, so when a consumer that's placed at Norfolk Regional Center moves into community based services, that they are tracked and that the outcome is favorable, or that we can at least say we know what the outcome was. One of the following testifiers will report an incident that happened very recently, and a dismissal or placement into a community based service in Omaha, and the tracking was only there because our people were following up on it. We think that's critical to this process. I'm available for any questions from you.

SENATOR JENSEN: Yes, Senator Stuthman?

SENATOR STUTHMAN: Thank you, Senator Jensen. Dan, is Norfolk doing everything possible to try to develop your community based mental health that was enacted in LB 1083? Have you, you know, resourced all the available grant systems and programs that would help you develop a community based system?

DAN MAUK: We are, indeed. In fact, I would hold Norfolk up to the entire state for the level of development of community based services. In fact, with due respect to Senator Jensen, the folks in Omaha could take some lessons from the folks in Norfolk. We work together, our different agencies that handle different pieces of the pie, if you will, work together, meet regularly, and address the needs of the consumers. We have...we're working very hard to make sure that we can accommodate all the needs. However, I think this process will end up showing, at some point, there's going to be a broad discussion that some of the

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people that are currently being treated are so severely ill that 28 days in the Center for Excellence is not going to handle it. At some point we're going to have to have some more serious discussion about the need for some longer term care. But Norfolk is participating. We're participating on several fronts; that's one of the reasons why we're supporting this bill.

SENATOR STUTHMAN: Thank you. And you utilizing the funds from the regional mental health system, or are you going elsewhere for funds?

DAN MAUK: Well, I represent the Chamber of Commerce, so my involvement is in a lot of meetings, but I don't feel I'm qualified to answer that with any specificity. But in talking with the people that were involved with it in Norfolk, I think they're doing everything that they can.

SENATOR STUTHMAN: Okay, thank you.

SENATOR JENSEN: Any other questions for Mr. Mauk? Thanks for coming, Dan.

MORGAN KUPSINEL: Good afternoon, senators. I promise I'll talk fast. My name is Morgan Kupsinel, K-u-p-s-i-n-e-l. I'm a clinical social worker at the Norfolk Regional Center and a member of NAPE/AFSCME, our state employees' union. I come here today expressing my personal opinions, and not those of the Norfolk Regional Center or the Department of Health and Human Services. I support LB 618. We've long been concerned about the difficulty many individuals served by Nebraska's behavioral health system have in accessing services. We who work at the Norfolk Regional Center observed a noticeable difference in the severity of patients' illnesses shortly after the state moved to a system of managed care technology. Presumably this was due to the services being harder to access in the communities, and individuals decompensating before they were able to receive services. Tracking an individual's attempts to get services will ultimately improve the system and will hopefully ensure that people who need services will get them. However, we must also monitor and track people who leave programs prematurely. An individual may be discharged from a secure setting such as the regional center to an

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open, community based program, and leave before completing that program. Unfortunately, even though the statutes of the state of Nebraska allow for out-patient commitment, many counties do not have the manpower to enforce such commitments. If we do not have accurate data, these people may be recorded as successes. For example, in the last two weeks, we have become aware that two individuals recently discharged from the Norfolk Regional Center to a community based facility left practically as soon as they got there. One of them stayed less than 24 hours and the other less than 12. They literally walked in the front door and out the back. Both of these people have significant histories of homelessness. In order for behavioral health reform to be successful, we must know that these programs are effective. Thank you.

SENATOR JENSEN: Thank you, Morgan. Senator Howard?

SENATOR HOWARD: Hi, Morgan, hi. Do you know if there have been any improvements in reduction of the waiting lists, on your folks that are waiting to be discharged to get into programs, such as Community Alliance?

MORGAN KUPSINEL: Oh, the waiting list to get into?

SENATOR HOWARD: Right. Has that improved any, because the last I'd heard it was like 70 people behind.

MORGAN KUPSINEL: The people that I work with directly, some are waiting, some have gotten in. There has been movement, and Community Alliance has some open beds. I think Carol probably can talk about that; she's here.

SENATOR HOWARD: Okay, so it is looking a little better on that front?

MORGAN KUPSINEL: It always fluctuates from time to time. It might be a little better, yeah.

SENATOR HOWARD: Do you have any idea what the time frame...say, someone would be ready to be discharged. What would be the time from...

MORGAN KUPSINEL: It depends upon what kind of services that

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they needed.

SENATOR HOWARD: That's true, that's true.

MORGAN KUPSINEL: And you know, how severe they were...

SENATOR HOWARD: Sure.

MORGAN KUPSINEL: ...because sometimes someone who has less severe symptoms may be easier to handle for a community provider. So you know, there's a lot of...those waiting lists are always pretty fluid, so it's hard to say. There's not a set time.

SENATOR HOWARD: Okay. I can understand that. Thank you.

MORGAN KUPSINEL: Um-hum.

SENATOR JENSEN: Thank you, Morgan.

MORGAN KUPSINEL: Um-hum.

SENATOR JENSEN: Next testifier in support?

DANIEL STURGIS: (Exhibit 3) Senator Jensen, members of the committee, my name is Daniel Sturgis. I'm a psychologist. Currently I work at the Norfolk Regional Center. However, the comments I'm going to make do not reflect the position of my employer and should be considered my own. I've worked in academia, community mental health, and the regional center for over 30 years. I'm going to limit my meager comments so that you all can get home. LB 683 (sic) essentially deals with three issues: Improved mental health funding, developing a tracking system of the services provided to mental health consumers, and the contracting of an agency to maximize Medicaid reimbursement. While all of these are honorable endeavors, I will largely limit my comments to the second point, developing a tracking system. The reason I'm doing this is because I believe the key to mental health reform is knowing what works and what does not. It is perhaps rare to find any person in the business of providing mental health care who believes that the mental health system is adequately funded. Most of us believe the system of care we have today is underfunded, whether we're

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working in the community or in institutions. Therefore, it is essential that we have a comprehensive understanding of what happens to people, so that we know what treatment works with which patient and under what conditions, in a cost-effective way. That's what we hope the tracking system would do. I might add that this issue goes beyond the mental health system. For example, the Nebraska Department of Corrections' statistics state that 29 percent of the persons incarcerated in their system are there for drug-related offenses. Other reports are that they are up to 20 percent of the prison population taking psychotropic medications. Do we suppose that there is a connection between mental health and drug abuse services and corrections? I think we know that there is. If we can answer this accountability issue; that is, what works best with whom, cost effectively, then the additional question is that of transparency. Let's make the data available to the public, so that those who care to know how their tax dollars are being spent can see what works and what does not. Deciding public policy without good data results in poor public policy. Without transparency, it's difficult to develop public support for any endeavor. Those are my comments.

SENATOR JENSEN: Thank you, Dr. Sturgis. Any questions? Thank you for coming down. Next testifier in support, please?

KRIS BOE-SIMMONS: (Exhibit 4) Senator Jensen, members of the committee, my name is Kris Boe-Simmons, the last name is B-o-e S-i-m-m-o-n-s. I'm a licensed clinical social worker. I've worked with people who have a severe mental illness, personality disorder, and/or a chemical dependency problem at the Norfolk Regional Center for 22 years. My testimony today is not intended to represent HHS or the Norfolk Regional Center, but instead to express my own views. I support expanded funding for behavioral health services. Nebraska state funding for behavioral health is underfunded. It's so underfunded that when we recognize we need to expand service, we have to look at pulling away from one service area to give to another. If we truly want to improve our behavioral health system in Nebraska, we must add money to the system so that a comprehensive continuum of care can sufficiently provide services to people in Nebraska. Adding

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to community based services is appropriate. I would like to see this money earmarked for high level, high quality, 24-hour residential facilities. To truly improve the system, we must have complete and accurate data. The bill does identify tracking numbers of individuals requesting services, receiving services, and being denied services. But to fully understand the system needs, additional information must be tracked. And I believe the following, at least, should be included: What are the reasons for the denial of the services? Does the people not meet the diagnostic criteria? Are there multiple diagnoses or concurring illnesses that present a problem for the provider? Is the person considered too delusional or too psychotic? Does the person refuse the service, or did they go to the interview and tell the provider they're going to stop their medicine? Does the person have a violent history that's a concern to the provider? Does the person have the wrong funding or no funding source? Has the agency previously had a bad experience with this individual and they now refuse them? Does the provider believe they need a higher or a lower level of care? Is the individual not from that provider's region? I also believe outcome information about those who did receive service is important. Did they successfully attend and complete the service? When they did transition to a lower level of care, did they maintain their level of functioning? Were they asked to leave the program, and specifically, why? Did they refuse to attend the program? Did they require a higher level of service? Did they relapse? We need to remember that because of the effects of these illnesses on the brain, people with these diseases lack awareness of their illness. Therefore, individuals typically refuse to take their medicine and attend a treatment, because they do not even believe they are sick. We need to track this data fully to understand the needs of this population and to develop successful programs. Thanks.

SENATOR JENSEN: Thank you, Kris. Any questions? Thank you for coming. Are there any others who wish to testify after Mr. Keetle? Thank you, Eric. Two more.

ROGER KEETLE: (Exhibit 5) Good evening, Senator Jensen. For the record, my name is Roger Keetle, K-e-e-t-l-e, representing the Nebraska Hospital Association in support of

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LB 618, with an amendment which is attached to my testimony. The Cliff's Notes version of my testimony is as follows: One, We desperately need the statute to say there is a tracking system, so that the behavioral health is accountable. If there's one thing that should be done in statute, it's to require the accountability of the department for what's happening to behavioral health reform. I've learned from Mr. DeLiberty that he's working with the University of Nebraska to develop a tracking system. I have no idea what's in it. I think you've heard some ideas presented today, just by the previous testifier of some really good information to have. I have no idea what...I know it's a work in progress, but I haven't seen it. But data is going to be absolutely key, because the money has to follow the patient, to provide the care that is needed. The people have to know whether they are in the right level of care. If there's anything I like best about this bill is the tracking system. My amendment--research since 1939 has always shown there's an inverse relationship between the number of mental health beds and the number of people in prison with mental illness. And when we go through the research of this, if we don't keep track of the people that fall out of the behavioral health system into the prison system, we've made a terrible mistake. I've suggested to you an amendment to the Correctional Services Act; you'll find that it works pretty well. There was a bill last year--the correctional system does an evaluation. This data should be readily available from the corrections system, and there's an assessment; it fits together. So that's why this amendment is suggested. The second thing I want to emphasize is that we really don't know what the behavioral health reform is going to cost or what it's going to take to really do. I've got hospitals in Hastings that have put themselves--wherever this is--that have put themselves at risk trying to provide these new services that basically were foisted upon them, because the Hastings Regional Center was closed. And so I have no idea whether these contracts are going to result in a service that's even going to come close to be paying the cost of what the services are that are being provided. They've taken a lot of risk and done a lot of things to work with the department, and I'm always concerned that sometimes promises that were made won't be honored later. I also know that the Richard Young Hospital in Kearney has lost money for years, and I don't want to

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lose another Richard Young Hospital, but at this point, they don't know whether they can keep the doors open. And I think that's no surprise to Senator Jensen. We met on that. So they're trying to figure out whether this all works for them, too. A key provider--don't know whether they're going to be there. In Hastings, Hastings is threatened by an ambulatory surgery center that the physicians are opening, which takes away their source of cross subsidy for their mental health services. So Hastings, although a very successful hospital at this point in time, is facing the possibility of the physicians starting another hospital, just for the insured, in their own town. So that threatens Hastings' ability to continue to provide mental health services. So these services have to pay for themselves. We have to track them down. The days of cross subsidy for this service are over. So that's why that's so important. With that...the other question I have is we've done the easy ones. We haven't done the tough ones, the people with behavioral problems that will be hard to place in community based services. We need this data so that we know the system is accountable and again, people that have bad behaviors end up in prison. So we need to figure out which system is really working and where we're really at. With that, that's my testimony, and I have an amendment for the committee council to consider.

SENATOR JENSEN: Thank you, Mr. Keetle. Any questions?  
Seeing none...

ROGER KEETLE: Thank you.

ELAINE HALFERTY: (Exhibit 6) I'm going to also keep this short. Senator Jensen and members of the Health and Human Services Committee, my name is Elaine Halferty, H-a-l-f-e-r-t-y, and I'm a clinical social worker at the Norfolk Regional Center, but I'm speaking as an individual and not as an employee of the regional center. If Nebraska is to be successful with behavioral health reform, there needs to be an adequate funding for community programs to train and retain qualified staff, and to provide for the level of care needed for the successful community placement. And I just want to build on something that Mr. Keetle just said. I had recently re-read an article written a year after the state of Kansas closed the Topeka State Hospital,

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and what they found was that the level of community funding was not high enough to meet the growing needs. It was all right at first, but what happened, as the number of state beds declined and community patient loads doubled, the community centers began noticing a distinct change in the type of patients they were treating. They were seeing poor clients with more severe disabilities than before. And the result was a much higher degree of intensity of service required, at a much higher cost. We have good community programs in Nebraska, and they've been caring for the mentally ill who have been treated and discharged from the regional centers. But during the past 10 years, the staff at the Norfolk Regional Center have noticed a change in our population. The patients we are treating in an in-patient setting are sicker and have multiple problems. Fifty percent of the admissions we have are re-admissions. These are people we have had in the regional center before. They have been in the community, but they then return for medication adjustments, further education and treatment before returning to the community. These patients as they go out are going to require intense services, and the funding of community programs will need to be increased if they are expected to provide this level of care. And as we've heard in earlier testimony on other bills today, if community programs aren't adequately funded, they close. Thank you. Any questions?

SENATOR JENSEN: Thank you, Elaine. Any questions of Ms. Halferty? Thank you for coming down today.

ELAINE HALFERTY: Um-hum.

ELAINE MENZEL: Senator Jensen and members of the committee, for the record my name is Elaine Menzel, spelled M-e-n-z-e-l. I represent the Nebraska Association of County Officials, and we support LB 618 because of the additional funding that it would provide to establish community based behavioral services. And while progress is being made throughout the state, the additional resources are needed to achieve the desired outcome of LB 1083, which was enacted last year. We respectfully request that you advance LB 618, and those are my comments. Thank you.

SENATOR JENSEN: Thank you, Elaine. Any questions? Seeing

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none, Eric?

ERIC EVANS: Good evening, yet?

SENATOR JENSEN: It's evening.

ERIC EVANS: Good evening, Senator Jensen, members of the committee. My name is Eric Evans. I am the deputy executive director at Nebraska Advocacy Services. I really hadn't anticipated testifying on this bill today. We were going to send a letter in support, but I did want to use this time to respond to a couple of things. From some of the earlier comments, that you were given the impression that the regional centers are really a pretty good place to be, and I want to suggest that that may not be the case. And I want to make that suggestion for two reasons. In 1995 we began investigating complaints of rapes and sexual assaults at the Hastings Regional Center. We entered into a consent decree with the state. The consent decree clearly applied to the Hastings Regional Center. The state administration that was negotiating the consent decree stated that it also applied to the Lincoln and Norfolk Regional Centers. However, both--in particular the Norfolk Regional Center--was very resistant in implementing the provisions of the consent decree. There was not quite as significant resistance at the Lincoln Regional Center, and we find ourselves today with...in 2002...with 16 women who have come forward with allegations of being raped and sexually assaulted at the regional centers. That has almost quadrupled, as the result of our investigation. So it's not a problem that's just in the regional centers. This is something that we also have to be very vigilant about, as we move to community based services. And I would hope that, in looking at the reporting requirements, that there would be some way that we are also able to track, within the provider community, critical incidents such as rapes, sexual assaults, even perhaps, police contacts, regular assaults, and those kinds of things. So we are strongly supportive of the accountability and transparency that LB 618 brings and the funding that is also tied to that, and we urge that you pass LB 618. But we do have still, significant concerns about what's going on in the regional centers, as well as what is likely to occur in community programs, as we move into community based services. Thank you.

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SENATOR JENSEN: Thank you, Eric. Any questions for Mr. Evans? Thank you for your testimony. Anybody else as a proponent? We're ready, then, for opponent testimony.

NANCY MONTANEZ: (Exhibit 7) Good evening, Senator Jensen and members of the Health and Human Services Committee. My name is Nancy Montanez, M-o-n-t-a-n-e-z, director of the Department of Health and Human Services. I'm here to testify in opposition of LB 618. LB 618 asks for HHS Division of Behavioral Health Services to report on two kinds of data. We are to report on the numbers of persons requesting services from regional centers, and the numbers served and not served. This specific report will require staff to reformat information included in some existing reports. We have included a copy of an existing report on waiting lists for the three regional centers. We have also included a copy of the report on individuals in the regional centers ready for discharge and waiting for beds to open in a community based service. The division is, in fact, moving well beyond this type of general information to collecting information specific to the individuals in the regional centers and their subsequent moves to the community. Data from at least three systems are being collated into a single report that will provide current status on any individual committed to a regional center on or after January 1st of this year. That information will include demographics, current services being received, outcome information, including improvements in housing or employment, or criminal justice involvement. The division has engaged Dr. Watanabe-Galloway from the University of Nebraska Medical Center to oversee this data and to move further into qualitative analysis. Dr. Watanabe-Galloway and her staff are planning to interview patients at the regional centers, to contact community service providers, and to periodically generate reports on the well-being of patients being moved to community based services. The second kind of data includes the same information on community services: The numbers requesting services, the numbers served, and the number not served. This is a more difficult report. There will be a financial impact to the state. Community providers also may need to develop a new data collection mechanism and new methods for transferring that information to the regional authorities. This information is not

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currently available, because person requesting out-patient services are currently not entered into a data system until the first or intake appointment. The data collection system must also address a number of other issues with the collection of this information. For instance, individuals seeking services may also appear on more than one provider's wait list. To ensure accurate and useful information, providers will be required to collect identifying information, and regional authorities will be required to review the list to ensure that individuals are not counted more than once, or that they have been admitted to services with another provider. Collecting this information, communicating it to the regional authorities, and then collating that information to forward to the state for reports to the Legislature may cost upwards of a million dollars to providers and regional authorities. In regards to the provision of the bill that requires the division to contract with independent national entities to maximize Medicaid reimbursements, if the Legislature chooses to do this, we will be glad to collaborate with them. The department had a contract with a national consulting organization, the Lewin Group. That organization has expertise in health and human services issues. The Lewin Group assisted the Health and Human Services System in designing the behavioral health community based system of care. They described and evaluated the then current system of care for adults with severe mental illness, made recommendations for the community based service array, provided both a financial and an administrative overview. I would be happy to answer any questions.

SENATOR JENSEN: Thank you, Nancy. I too have always been concerned about the data, and I don't know whether the list that Ms. Simmons did present to us...but it looks to me to be fairly representative of the information that we should have. Could we get a copy of what kind of data that Dr. Watanabe-Galloway...

NANCY MONTANEZ: Watanabe-Galloway, yes. We can get you a copy of that. That won't be a problem.

SENATOR JENSEN: What that would include, so that we certainly examine that and certainly I'd be glad to get...

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NANCY MONTANEZ: Sure.

SENATOR JENSEN: ...that also to the individuals from Norfolk. And I've always hoped that we could go there. Are we currently under contract with the Lewin Group at the present time?

NANCY MONTANEZ: That was a year ago.

SENATOR JENSEN: That was a year ago.

NANCY MONTANEZ: About...approximately a year ago.

SENATOR JENSEN: Okay. Yes, Senator Stuthman has a question.

SENATOR STUTHMAN: Thank you, Senator Jensen. Nancy, maybe you can't answer this, but in the Norfolk Regional Center, or the whole, all three of them together, as of now there's 66 that are ready to be, waiting to be discharged?

NANCY MONTANEZ: Ready to be discharged.

SENATOR STUTHMAN: What percent of the the people that are there is this? Is this half of them, or is this a third of them? Like Norfolk has got 29--that is their capacity right now? Are they at 200?

NANCY MONTANEZ: You know, I think the last number I heard was 178, 180. I know they were pretty much at full capacity.

SENATOR STUTHMAN: Okay, so then they've got 30 that are really about ready to be released, but there still is about like another 150 left there, then?

NANCY MONTANEZ: Right.

SENATOR STUTHMAN: Okay, thank you.

SENATOR JENSEN: Any other questions from the committee? Seeing none, anyone else in opposition? Anyone in a neutral capacity? Senator Flood, do you wish to close?

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SENATOR FLOOD: Briefly.

SENATOR STUTHMAN: Take your time, take your time.

SENATOR FLOOD: Thank you, members of the committee. For the record, I would note that the department didn't have any specific objection to the \$4 million per year, which I think is a positive note. (Laughter)

NANCY MONTANEZ: I'm sorry. I missed it. I missed it.

SENATOR FLOOD: But I guess, on a serious note, no cost is too great to ensure that what we're doing in spending all the money on reform is working. In Lincoln last year there was a situation where there was somebody that was stabbed as the result of an individual that probably should have been receiving more of an inpatient care setting. I'd like the state to focus on the data and spend the money, so that as this reform happens and the transition occurs, we can keep our eye on what's most important, and that's the care of those individuals and, of course, the protection and safety of our citizens. With regard to the Lewin Group, there are corporations out there, it's my understanding, that perform services for states where they take a percentage and/or commission of what they locate in the way of Medicaid dollars, and that's what I was envisioning when I put that in my bill. I do greatly appreciate the opportunity to present the bill. I'm thankful for all the folks that traveled here today, and I would close with that. Thank you.

SENATOR JENSEN: Thank you, Senator Flood. Any questions for the senator? (See Exhibit 8) If not, that will close the hearing on LB 618, and Senator Erdman, I'm here to open on LB 551. I can't find my remarks; I don't need them.

LB 551

SENATOR ERDMAN: Can I see a show of hands of those wishing to testify on LB 551? I see three. I see three. I think Senator Jensen wants to testify, but somebody stole his papers. I'm going to be difficult on you, Mr. Chairman. We have a strict three-minute limit that you'll have to abide

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by.

SENATOR HOWARD: We're here for you, Senator. Don't feel rushed. We'll stay the night, if need be.

SENATOR JENSEN: I lost my...

SENATOR ERDMAN: I can read the bill to you, if you prefer.

SENATOR JENSEN: Thank you. For the record, my name is Jim Jensen, representing District 20 in Omaha, here to introduce LB 551. LB 551 does really two things. It expands into the...first of all, it's a follow up of LB 1083, and it expands the number of consumers on the behavioral health substance abuse and...well, there are three commissions that were set up by the passage of LB 1083. And what it does do, it expands each one of those with three consumers to those boards. One was alcohol and substance abuse, gambling, and one other addiction...

\_\_\_\_\_ : Mental health?

SENATOR JENSEN: Mental health, thank you. And then it also adds five more board members to the oversight commission. And we had talked about that last year, that we wanted more representation from the rural community. We also need representation of a primary care doctor. Many of our rural communities have GPs out there, that are really the first line of defense--well, not defense, but certainly the first line of individuals that approach them with mental health illness. We'd like to have somebody like that on the board, maybe a couple of consumers, and then a couple of others that also represent the western, or at least out of the metropolitan areas of Omaha and Lincoln anyway, so we have a better representation on the board. I might say that the oversight commission has been meeting since the report came down from the Health and Human Services Department, overlooking the transition. We had a meeting again today, this morning, and the commission members are doing, I think, just a very good job. They're following up and ensuring that this transition goes smoothly. With that, I'd be glad to answer any questions that you might have.

SENATOR ERDMAN: Thank you, Mr. Chairman. Any questions for

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Senator Jensen? None at all? Okay.

SENATOR JENSEN: Thank you.

SENATOR ERDMAN: Thank you, Mr. Chairman. First testifier in support of LB 551?

ERIC EVANS: (Exhibit 1) Good evening, again. I'm Eric Evans, that's E-r-i-c E-v-a-n-s. I'm deputy executive director of Nebraska Advocacy Services. I'm here today to offer support for LB 551. Many of you have been around as members of this committee and have heard consumers come before you with a phrase or mantra, "Nothing about us, without us." So that kind of summarizes my testimony. I have several points; I'm going to be real brief. One is, you use the term consumer; it's not defined. There's some ambiguity about what that means. Some people believe it includes family members; other people believe it should only include people who have a behavioral health condition. We would suggest that using the term recipients and former recipients of behavioral health services and family members of recipients and former recipients, so there is no ambiguity. You make a clear distinction and you solicit additional membership from both of those groups. Second, we are looking at the composition and we are again very supportive of specifying in statute the number of consumer representatives, and we're pleased to see three. We kind of like 50 percent, is kind of our guideline. That's something that we at Nebraska Advocacy Services use, in terms of our board composition and our advisory council composition. It's also something that the Nebraska Developmental Disabilities Planning Council has as its composition. So again, the further that we can move in that direction, the better. In terms of the state advisory council committees, those three advisory council committees Senator Jensen mentioned, the requirement there is that one-quarter of the membership be consumers, while on the statewide behavioral health advisory council, you require only that one-fifth of the composition of that entity be consumers. So at the one hand, on the lower level groups you have 25 percent composition; on the higher group, there's only 20 percent composition. And in terms of the new positions on the Behavioral Health Oversight Commission, of course we're going to say, gee, we'd like to see all five of them be

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consumers, and that you can bring consumers in and you can still achieve geographic and maybe additional ethnic representation, with consumers. Hearing Senator Jensen's comment about wanting to get a primary care physician, that seems to be very good, so you know, four out of five would be really good, as well. But that pretty much concludes my testimony. We are in support, and anything that you can do to expand, even beyond what you've been able to do here, the membership of consumers on these groups, we really appreciate it. I also have a letter in support from the Mental Health Association, so I'd like to provide that to you, so that can be introduced into the record.

SENATOR ERDMAN: Thank you, Eric. We will have that entered into the record. Any questions for Mr. Evans? Seeing none, have a good weekend.

ERIC EVANS: Thank you.

SENATOR ERDMAN: Next testifier in support of LB 551?

RICHARD DeLIBERTY: (Exhibit 2) I should say Senator Erdman, and the Health and Human Services Committee, and Senator Jensen, my name is Richard DeLiberty, D-e-L-i-b-e-r-t-y, the administrator of the Division of Behavioral Health Services, Department of Health and Human Services, and I'm here to testify in support of LB 551. And I've noticed that I've been here all day, and this is the first time that somebody from HHS has had the opportunity to be in support of one of... (Laughter)

SENATOR ERDMAN: You can see the relief on Senator Jensen's face.

RICHARD DeLIBERTY: LB 551 is simple in its function and negligible in its cost. It is, however, far reaching and far sighted in its consequences. It changes the three advisory committees that support behavioral health to include additional consumers. It expands the membership of the Oversight Commission to include more citizens, and probably more consumers. From its inception, behavioral health reform is focused on creating a better system of services for consumers, those most impacted by the change. LB 551 gives consumers the opportunity to improve the system

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by giving policy makers, administrators, and providers the benefit of their advice and life experience. It's a good thing to do. Thank you for the opportunity to testify. I would be happy to answer any questions.

SENATOR ERDMAN: Thank you, Richard. Any questions for Director DeLiberty? Seeing none, thanks for your testimony.

RICHARD DeLIBERTY: Thank you.

SENATOR ERDMAN: Prior to your arrival, the department used to take turns about who would get to testify in support and opposition. It was kind of a guess, but since everybody is coming in in opposition, you guys must be taking numbers, huh? (Laughter) Thanks for your testimony. Next testifier in support?

RON NAMUTH: I'm Ron Namuth, N-a-m-u-t-h, not to be confused with Joe, the football player. He's about the same size I am. I am representing a group called the Nebraska Recovery Network. We're a bunch of people that are recovering from alcohol or drug addiction, and we want to get the word out to other people that recovery is possible, whether it be meth or whatever, you know. There's such a fatal attitude, I guess, towards meth users, especially that they'll never recover, and we have a group of people in our organization that are recovering from meth. I've been in this business of treatment for 42 years. That's after I got sober. And so I've got a little experience in working with the various groups. But the thing I like about the bill is that it does emphasize the need for consumer input. Over those 42 years, I started a lot of programs. Many of them were successful and still going today, but if I look back at them, the reason they were successful is because we included the people that knew something about the problem--the consumer. They helped us formulate those--they said, this is what we need. So it's very important to me to see this kind of language, you know, whether we can get more consumers, that would be good. But, you know, at least we have representation of the people that...I'm assuming these are people that have either used the service in the past or are now using the service. And sometimes, I guess, people are reading this as that you have to presently be in treatment to qualify, because it says consumer services. I think

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that's one of the things he was alluding to, because I'd certainly like to be considered as one of those members, even though I haven't drank for 42 years or received any service. Well, I probably received some service, but anyway, our group supports this very strongly, and I support it very strongly. And I appreciate your doing this.

SENATOR ERDMAN: Thank you, Ron, if you want to put that sheet of paper in that box for us, the testifier sheet.

RON NAMUTH: In this box here?

SENATOR ERDMAN: Yes, sir.

RON NAMUTH: I follow instructions real well.

SENATOR ERDMAN: You do better than I do.

RON NAMUTH: That's one thing I've been able to do.

SENATOR ERDMAN: You do better than I do. Any questions for Mr. Namuth?

RON NAMUTH: Thank you.

SENATOR ERDMAN: Seeing none, make sure you say hi to Joe for us.

RON NAMUTH: Yeah, we'll help you any way we can.

SENATOR ERDMAN: Thank you. Anyone else wishing to testify in support of LB 551? Is there anyone else wishing to testify after Ms. Johnson? Great. You're batting clean-up.

J. ROCK JOHNSON: That and utility infielder.

SENATOR ERDMAN: Yeah, well, it's always good to have someone that can do more than one position.

J. ROCK JOHNSON: J. Rock Johnson, J-o-h-n-son. Senator Erdman, Senator Jensen, members of the committee. At the present time, the Behavioral Health Oversight Commission has a representation of five percent for people who have mental illnesses and addictions. In the year 2000, the National

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Council on Disability, which is a presidential appointment, generated a document called, "From Privilege to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves." And one of the core principles is that people labeled with psychiatric disabilities should have a major role in the direction and control of programs and services designed for their benefit. This central role must be played by people labeled with psychiatric disabilities themselves and should not be confused with the roles that family members, professional advocates, and others often play when "consumer input" is sought. And as I've looked around, I see that there are so very, very many people who feel empowered to speak for us, and it's difficult for our voice to be recognized, much less heard. This speaks to the additional positions on the Oversight Commission, which are five. And I think having a primary care physician is an excellent idea from a number of perspectives. One is, I would hope that we might be able to find someone with a psychiatric history who would be able to bring that experience to the table, as well as the fact that people with psychiatric disabilities in particular, die on the average from 10 to 12 years earlier than the general population. In addition to that, some of the new atypical anti-psychotics are causing diabetes, heart disease, liver disease, other failures, so there's a critical need to have someone who can look at those issues. In terms of definitions, this is a poem that was written--it's 20 years ago--by Rae Unzicker, who formerly lived in South Dakota and who passed away in 2001, having been born in 1948, called "To be a Mental Patient." "To be a mental patient is to be stigmatized, ostracized, socialized, patronized, psychiatrized." There are fewer fountains for water in this building than there used to be. That's all I can say at this point. "To be a mental patient is to have everyone controlling your life but you. You're watched by your shrink, your social worker, your friends, your family, and then you're diagnosed as paranoid. To be a mental patient is to live with the constant threat at the possibility of being locked up at any time for almost any reason. To be a mental patient is to live on \$82 a month in food stamps, which won't let you buy Kleenex to dry your tears, and to watch your shrink come back to his office from lunch, driving a Mercedes Benz. To be a mental patient is to take drugs that dull or mind, deaden your senses, make you jitter

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and drool. And then you take more drugs to lessen the side effects. To be a mental patient is to apply for jobs and lie about the last few months or years, because you've been in the hospital, and then you don't get the job anyway, because you're a mental patient. To be a mental patient is not to matter. To be a mental patient is never to be taken seriously. To be a mental patient is to be a resident of a ghetto, surrounded by other mental patients who are as scared and hungry and bored and broke as you are. To be a mental patient is to watch TV and see how violent and crazy and dumb and incompetent and crazy you are, and dangerous. To be a mental patient is to be a statistic. To be a mental patient is to wear a label and that label never goes away, a label that says little about what you are and even less about who you are. To be a mental patient is to never say what you mean, but to sound like you mean what you say. To be a mental patient is to tell your psychiatrist he's helping you, even if he's not. To be a mental patient is to act glad when you're sad and calm when you're mad, and to always be appropriate. To be a mental patient is to participate in stupid groups that call themselves therapy. Music isn't music, it's therapy. Volleyball isn't sport, it's therapy. Sewing is therapy. Washing dishes is therapy. Even the air you breathe is therapy, and that's called the milieu. To be a mental patient is not to die, even if you want to, and not cry, and not hurt, and not be scared, and not be angry, and not be vulnerable, and not to laugh too loud, because if you do, you only prove that you are a mental patient, even if you are not. And so, you become a no-thing in a no-world, and you are not." And that is why I would respectfully request, if at all possible, that those other four positions be filled by people who can come here and speak of our actual experience, speak of a system that's designed for dependency, speak of a system that has significant economic incentives to stay as it is. And even more important, to have consumers come to these tables, because the more tables we come to, the more tables we can be invited to, and to bring the ideas of recovery and self determination, and to actually transform this system along the lines of the president's new freedom commission, where we have a system that's driven by consumers and families. We have that possibility here, but there need to be more voices that can speak directly, that are in a position to be heard. I do not want to in any way

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underestimate the work and the effort and the blood, tears, toil, and sweat that has gone into this effort to this date. It's truly a remarkable thing. I know it's something I would never have thought that I would see in my lifetime in this state. But it's bringing our voices, and we know that. It's just a question of how do we do it, how do we do it better? And I appreciate the support from Health and Human Services, and I also appreciate the glass of water. Pages are good.

SENATOR ERDMAN: Thank you, Ms. Johnson. You had your own personal fountain today. Are there any questions? Seeing none, thank you for your testimony. Jill, thank you for being here as well. Anyone else wishing to testimony in support? There's a letter that has been distributed by the Mental Health Association of Nebraska, submitted by Alan Green, distributed by Mr. Evans. (Exhibit 1) Anyone wishing to testify in opposition to LB 551? Seeing none, anyone wishing to testify in a neutral capacity? I see none. Mr. Chairman, would you care to close?

SENATOR JENSEN: No, I'll waive closing.

SENATOR ERDMAN: The chairman waives the opportunity to close at this hour. That will end the hearing on LB 551. Mr. Chairman, it is your chair again.

SENATOR JENSEN: Thank you. (See also Exhibit 3) That will conclude the hearings for today and for the week, and thank you for hanging in here.