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COMMITTEE ON HEALTH AND HUMAN SERVICES
February 9, 2006
LB 1220, 1179, 1035, 1132, 1178

The Committee on Health and Human Services met at 1:30 p.m. on February 9, 2006, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB 1220, LB 1179, LB 1035, LB 1132, and LB 1178. 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: Good afternoon, ladies and gentlemen, and thank you for coming. This is the Health and Human Services Committee, and we do have a full agenda this afternoon. We have six bills to be heard and we also have with us individuals from CMS, the Centers for Medicaid and Medicare Services, and we're real happy to have Fred Schuster with us this afternoon. He was here last year, and we appreciate that he has familiarized, certainly himself, with Nebraska and from one end of the state to the other end, so it's good to have you back. Welcome.

Briefing: U.S. Department of Health and Human Services

FRED SCHUSTER: Mr. Chairman, Senator Jensen, thank you very much, members of the committee. I'm not going to take a long time. I know you have a very busy schedule. I do travel the state pretty extensively for Medicare. We went all the way out to Morrill, Nebraska, last year talking about Medicare drug plans, and so I want you to know I'm very sensitive to getting to all parts of the state. This is our fourth annual visit to the Department of Health and Human Services. CMS, as you mentioned, is part of our department. We have several speakers who will just make a brief presentation and talk a little bit about what each of us is doing, and then we would be happy to answer as many questions as we can. As I mentioned, this is our fourth annual visit to Nebraska. You've been very accommodating to having us here. I understand this is your last year because of term limits, and I wanted to show a little bit of our appreciation for you allowing us to come every year. We have a Certificate of Appreciation I'd like to present to you, if I may just quickly read this. "Presented to Senator

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Jim Jensen in recognition of your leadership in providing opportunities for the U.S. Department of Health and Human Services and the Nebraska Legislature's Health and Human Services Committee to work together for the benefit of the people of Nebraska." Even though you don't leave office until January, this was signed in February but we really appreciate all the work that you have done.

SENATOR JENSEN: Oh. Thank you very much. Appreciate it.
(Applause)

FRED SCHUSTER: We had an opportunity to meet with the Governor today and with many department heads, and we would be happy to talk a little bit today. We're going to start with the Administration for Children and Family. We'll start with Mr. Gary Allen.

GARY ALLEN: (Exhibit 1) Good afternoon. My name is Gary Allen and I work for ACF, and I work with the TANF child support programs and the Healthy Marriage Initiative. And as you know, yesterday legislation was signed, the Deficit Reduction Act, which has a great effect on TANF, child support, and funds the Healthy Marriage Initiative. I've given each of you a folder with the provisions of deficit reduction as they apply to TANF and child support, and some kind of personalized things about how we think they might affect Nebraska and some of the things you'll need to decide as things go on. I can go through the legislation or I can just answer questions, whichever you would prefer.

SENATOR JENSEN: Why don't you just briefly go through it, if you would.

GARY ALLEN: Okay.

SENATOR JENSEN: I'd appreciate that.

GARY ALLEN: For TANF, when we were talking about TANF-free authorization, we've been talking about that since fiscal year 2002. What we received is not what we expected because it came through the reconciliation process. The basic TANF funding of \$16.5 billion will continue through 2010. Nebraska's TANF block grant of \$58 million remains the same. One thing that did change is that the high performance bonus

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is being discontinued. In most years, Nebraska received its maximum of \$2.9 million. That opportunity will no longer be there. Some of the biggest changes came in the area of work requirements. The definition of work didn't change. The hours of work didn't change as it would have with some of the reauthorization proposals. One of the primary changes was with the caseload reduction credit. As you know, there are two participation rates: an all-family rate of 50 percent, and a two-parent rate of 90 percent. Those rates were reduced by caseload reduction. And essentially the way that worked was the year before whatever year you were working with was compared to fiscal year 1995, and however much the welfare caseload has been reduced, the goal was reduced. So if you got a caseload reduction of 20 percent, instead of meeting a rate of 50 percent for the all-family, you had to reach 30 percent. What this legislation does is change the comparison year from FY 1995 to FY 2005. So the caseload reduction for virtually every state will be much, much smaller because you'll be comparing 2006 to 2005, and we don't know how much the caseload will go down in that one year, but probably very little, probably very little change. So states will have to work with a 50 percent goal for all-families and 90 percent for two-parents. As you can see in what I gave you, the national caseload reduction for 2004 was 51 percent. That's obviously more than 50 percent, and that created some of the problem. There were 19 states that had a goal of 0 percent. And Congress obviously didn't want that so they come up with this new thing of changing the base year to 2005. The other big change is, when we look at the reauthorization proposals that were there before, virtually all of them eliminated the separate two-parent rate of 90 percent. It is still in existence based on this legislation. And the big change is that families in separate state programs that are counted for maintenance of effort will now be included in the participation rate calculations. For fiscal year 2004, 29 states had no two-parent families in their federal program; Nebraska was one of those states. The primary reason for not having families in that program was that the states couldn't meet the 90 percent participation rate. Now they will have to do that. That will be a challenge for Nebraska; it will be a challenge for all states. And this is something that will require some work. And there are penalties if the participation rates aren't met: 5 percent

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for the first thing on the all-family rate. It's adjusted for the two-family rate. It's usually fairly small. Nebraska actually had a penalty for FY 1999 for the two-parent families and, as you can see, it was a little over \$26,000. So that's not the primary consideration for that. One consideration, one thing that legislatures will need to consider is that there are two maintenance of effort requirements: a 75 percent and an 80 percent requirement. If the state meets the participation rates, it can go with the 75 percent requirement. If the state misses either rate, it has to go with the 80 percent requirement. Nebraska traditionally has gone a little over 75 percent, like 75.3 percent. If you miss a participation rate, you have to go to 80 percent. There's no particular penalty. The penalty is just how much you missed the rate by. And so this makes...to go up to 80 percent for Nebraska would be like \$1.8 million. We're not talking a tremendous amount of money but it is a consideration. The other effect on TANF is that there will be verification requirements of work. As you can see, there are four things that will need to be verified with procedures: determining whether an activity can be considered work, determining uniform methods of reporting hours of work, the type of documentation needed to verify reported hours, and the circumstances under which the parents will be included in rate calculations. By September 30, ACF has to come out with regulations on this. By September 30 of this year, states have to come up with a procedure on how they're going to do this. And all these things, with the participation rates, are effective with fiscal year 2007. So this is beginning October of this year, so there isn't a great deal of time. This again will be a challenge for states. We obviously haven't seen the regulations yet, so we're not sure exactly what will be involved. We will be working with your TANF officials to get through this. The rest of the TANF part is basically good news. There's \$150 million that's allocated for marriage and fatherhood. Up to \$50 million of that can go for fatherhood projects; \$2 million of it can go for special tribal child welfare projects; the remainder can go for Healthy Marriage demonstration projects. States, nonprofits, virtually anyone can put in for these grants. So that's the basic TANF legislation. There aren't a lot of provisions, but the provisions that are there will have a major effect on the states.

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SENATOR JENSEN: It would seem that way. Any questions from the committee on Gary's presentation? Yes, Senator Byars.

GARY ALLEN: Yes, Senator.

SENATOR BYARS: I think I'm understanding it. I looked at the numbers when I was in Washington last weekend, and I think Nebraska's reduction at this point because of our performance is going to be somewhat over \$3 million when you take into account the HPB and...am I correct? Is that what you've been hearing, too?

GARY ALLEN: Nebraska, for most years, has received the maximum it could on the HPB, which has been \$2.9 million, so, yes, you're pretty much on target there.

SENATOR BYARS: Right, and I think once everything was taken into consideration, our fiscal analyst said somewhere over \$3 million, and I can't remember...\$3.2 million, \$3.3 million, and I'm not sure what else was taken in to consideration.

GARY ALLEN: I'm not sure what else would have been involved there but that's close.

SENATOR BYARS: Well, I hope it's \$2.9 million. I mean, I don't want it to be \$2.9 million.

GARY ALLEN: Well, we haven't gotten to child support yet.

SENATOR BYARS: (Laugh) Okay. Thank you very much.

SENATOR JENSEN: Any other questions? Thank you.

GARY ALLEN: Okay, do you want me to go into child support legislation quickly?

SENATOR JENSEN: Sure.

GARY ALLEN: Child support legislation included in the Deficit Reduction Act isn't as immediate and probably won't have as major effects as the TANF. But as you see from the handout, one of the things that did happen was regarding

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incentive payments, which can no longer be used for a federal match. Nebraska's incentives for fiscal year 2004 were \$3.6 million, which could be used then to obtain federal match. The states will no longer be able to do that. This kind of in lieu...if you'll remember, there had been talk about legislation that would have reduced the FFP rate, the Federal Financial Participation rate for child support from 66 percent to 50 percent. That didn't happen. This will have an effect on state finances. There is also a reduction in the FFP rate for genetic testing, and we did some figuring for Nebraska. This will cost the state around \$200,000 per year. Nebraska does comparatively a pretty good amount of genetic testing...more so than some other states. So that's there for what it is. Some of these other provisions will be coming up later and won't have a major fiscal effect. There will have to be a mandatory fee for families who have not been on TANF, of \$25. There will be changes, state options, to change the way they do the assignment of child support, expansion of the federal tax refund offset program effective 2007. Also effective October 1, 2007, mandatory review and adjustment of orders for families on TANF, at least every three years; a decrease in the amount of arrearage that will result in passport revocation from \$5,000 to \$2,500; information interfaces with insurance data; and a change in the medical support requirements, which will require states to look at both parents rather than just the noncustodial parent for medical support. Any questions on child support?

SENATOR JENSEN: Any questions? Senator Byars.

GARY ALLEN: Senator.

SENATOR BYARS: I guess I'm back to thee same things. As we look at the initial major funding provisions, we earn child support incentives of \$3.6 million. Are we going to lose all of that?

GARY ALLEN: We won't lose the incentive.

SENATOR BYARS: Okay. We're just going to lose the FFP.

GARY ALLEN: Right--the ability to use the incentive to get federal matching funds.

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SENATOR BYARS: So we're going to lose another \$200,000 there?

GARY ALLEN: No. The \$200,000 is from genetic testing.

SENATOR BYARS: Oh. Okay. But we'll lose \$200,000 there somewhere on that sheet of paper.

GARY ALLEN: Right.

SENATOR BYARS: And when we look out...now with the Reconciliation Act last week, and we look at the reduction in the child support reimbursements, federal reimbursements, what's that going to do to us? We had incentives paid of \$3.6 million on 2004. What's that going to be?

GARY ALLEN: Okay, you'll still receive incentives based on the same formula. The amount of incentive you receive won't change. What changes is your ability to use that incentive to draw down more federal money. So the state will need to replace some of that.

SENATOR BYARS: Do we have any idea how much?

GARY ALLEN: The best figures we have is...your child support people here figured that in the next biennium it would be like \$2.4 million.

SENATOR BYARS: Whew. So now we're looking at about \$6 million in reductions so far from the feds in these little pieces of paper that you've given us?

GARY ALLEN: Potentially, yes.

SENATOR BYARS: Okay. All right. Thank you very much.

SENATOR JENSEN: Senator Johnson.

SENATOR JOHNSON: If ours is \$6 million, what's the highest...like California or Texas or something like that?

GARY ALLEN: Oh, I don't know. The high performance bonus, the maximum any state could get was 5 percent of its TANF

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grant. But Nebraska was one of the few states that normally received the maximum of 5 percent. But that could get into, obviously, some big money. But there is a \$200 million maximum on that, so probably the most for any state would be \$10 million or \$15 million. On the incentives, I'm not sure how much a state like California actually received in incentives. But we're talking some money here.

SENATOR JENSEN: Any other questions? Thank you.

GARY ALLEN: Thank you.

PATRICIA BROWN: Good afternoon. I'm Pat Brown with the Administration for Children and Families, and I'm the office director over all of the state, community, and tribal programs. Gary just talked about TANF and child support. Also within that office we have childcare and child welfare. We also have responsibility for Head Start and Runaway and Homeless Youth. As a part of the Reduction Act, childcare is pretty flat. It's at \$2.7 billion with only a \$200 million increase over the next five years, so I think that will be pretty challenging for the state to get more people to work and not a lot more money in childcare. So I think that's going to be real challenging for you. I don't know how that will affect you but I wouldn't be surprised if most of our states will have to go to wait lists for childcare. I know you were considering raising your eligibility back to 185 percent of poverty. So I think this can have a really strong impact.

SENATOR JENSEN: We're one of the few states without a wait list, I believe.

PATRICIA BROWN: Yes, well, I think most of the states in our region don't have one. Missouri doesn't have one, Kansas doesn't have one, and I don't think Iowa has one at this point. But I think...

SENATOR JENSEN: But most of those states are not at 185 percent either.

PATRICIA BROWN: Kansas is at 185 percent. Kansas is the only state at 185 percent. So I think this is something you will probably need to look at because it will have an

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impact. In the area of child welfare, Senator Howard, I know you had asked me some questions before about...

SENATOR HOWARD: Hi. Yes, last year. Welcome back.

PATRICIA BROWN: ...about Protective Services. There is \$20 million for states to apply to for strengthening the courts, the child welfare courts. I think each state will get \$85,000. They have to apply in each area, plus some additional money for providing training to judges and attorneys, and cross training with DHS staff along with their attorneys, and then there's another \$10 million for that, and then \$10 million for tracking of children through the Child Welfare System data, as well as analysis of that data. So there's two different pots of money that they can apply for. I think last year you asked me about preventative services for children.

SENATOR HOWARD: Oh, yes, thank you for remembering.

PATRICIA BROWN: And this year, in the Reduction Act, it's better clarification over a definition for children who are candidates for foster care. So states may claim administrative costs for children who are at imminent risk of placement but they're still in their own home and they're providing services. As long as they document that they're practicing reasonable efforts to keep those children in their own home and that they redetermine every six months that those children are at imminent risk, they can draw down administrative costs for those children. So that's an additional way that the state may get some more money and put it into preventative services for those families and prevent those children from coming into the Child Welfare System.

SENATOR HOWARD: Well, that's very exciting for me. I was able to get my bill passed last year. So thank you for getting some more money for me.

PATRICIA BROWN: Okay. But they'll be able to use that pot. And there's some small changes related to...and I don't think this will affect Nebraska very much...when children were 4-E eligible but actually in ineligible placement types...say, for example, they'd moved into a relative's

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home but the relative wasn't licensed. They can now claim administrative costs for up to a year or up until the time that the state's license that child, whichever is less. And if they're an ineligible placement type and moving to an eligible placement type...say they were in detention and then move into a foster home, the state will have up to a month that they can claim administrative costs for that particular child. So that's just a little bit more additional dollars.

SENATOR HOWARD: If I could ask a question?

PATRICIA BROWN: Sure.

SENATOR HOWARD: Would the child still have to go into a licensed facility or foster home immediately upon removal in order to qualify for...

PATRICIA BROWN: To be eligible for...yeah.

SENATOR HOWARD: So that remains?

PATRICIA BROWN: Yes. I think that's all the news I have. It's not all bad but it's not all good. Do you have any questions for me?

SENATOR JENSEN: Senator Byars.

SENATOR BYARS: Thank you, Senator Jensen. Thank you for your hard work. I appreciate it very much. I think actually we should celebrate a little bit because the original funding for childcare was substantially less than actually...

PATRICIA BROWN: Yes.

SENATOR BYARS: ...ended up in the reconciliation budget. And I think that was thanks to a lot of people telling members of Congress that this is going to do a tremendous amount of damage. Do you know in the President's budget request that he delivered Monday what he did or what the administration did as far as childcare was concerned in this year's budget request, do you know?

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PATRICIA BROWN: No. I don't.

SENATOR BYARS: Okay. I'm not sure I do...

PATRICIA BROWN: The only thing I have is what happened as a result of this reduction, which is \$2.7 billion with \$200 million annual increase each year for the next five years.

SENATOR BYARS: Okay. All right. Thank you very much.

SENATOR JENSEN: Thank you. I think that's it.

KATHRYN COLEMAN: (Exhibit 2) Good afternoon. I'm Kathryn Coleman. I'm the Medicare Prescription Drug Education Campaign Manager for the Kansas City Regional Office of the Centers for Medicare and Medicaid Services. Thank you very much for inviting us to be here this afternoon. As you all probably well know, the addition of the prescription drug benefit in January of this year was the largest, most significant change to our program in over 40 years. We've heard from a lot of people since implementation began in January, and we've learned firsthand that for many people the system is working well, but we've also heard, as I'm sure you have, too, for others it's not. I think over the past month we've all gained a deeper appreciation of what the issues and the barriers and the problems are that are out there, and we're working very hard, together with our partners and the states, to solve all of them. We've certainly gained a deeper appreciation for the work that the pharmacists across this country do each day and the struggles that they're facing in implementing this new program. As I said, I think for the majority of the people it's working. And many people who have never had prescription drug coverage before are saving money and beginning to live healthier lives. We know that pharmacists are filling more than a million prescriptions every day, and we've had more than 2.5 million people sign up for the program in just the last month. While most persons and seniors with a disability are getting their prescriptions filled, there are a few start-up issues that we've had that could be expected at the beginning of a benefit as large and comprehensive that affects millions of people all at the same time. But like I said, we're working very hard to

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identify those problems as we learn of them and fix them as quickly as we possibly can. What we've found is, since this is a new program, some people will probably experience a problem the first time they try to go and get their medicines. But we're confident that after they use the program once, things will probably go much more smoothly. Right now, the significant majority of people who are having issues at the pharmacy counter today are people who are dual eligible--those who are eligible for both Medicare and Medicaid. And it's a subset of those folks that were first auto-assigned to one prescription drug plan but perhaps chose to re-enroll in a different plan. We found that to be especially true for people who switched plans near the last two weeks of December. In most states, this problem didn't affect all of their dual eligibles but I can assure you that we are concerned about every single one that it did. To everyone who went to the pharmacy and was not able to get their prescriptions filled, it was a big problem and we're working very hard to address the issues and solve them for them. What we've learned is that one way to reduce these problems is for beneficiaries to enroll earlier in the month. And we are encouraging people, if they're going to enroll or change plans, to do so before the 15th of any month. It's much more likely that if they do that, things will go smoothly when they go to the pharmacy counter than if they enroll later in the month. Of course, they can continue to enroll at any time but we're suggesting the earlier, the better. Our message to those people that go to the pharmacy and do encounter a problem is to not leave the pharmacy without their drugs and to reassure them that there are several steps they can take to ensure they get the prescriptions they need and they don't have to pay more than they actually owe. We've taken several immediate steps to improve things. We have provided a new computer system that pharmacies can use to verify eligibility in less than a second, and that's what we refer to as the E-1 transaction system. I don't know if any of you are familiar with that. We've also established a toll-free pharmacy help line that pharmacists can check for beneficiary information, and we've increased by 400 percent the number of operators that are on that line. So right now, there is minimal or no wait time for the pharmacist. And if the pharmacist can't find the information that way for a beneficiary who is on Medicaid and has been switched to Medicare, the pharmacist can

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actually enroll them in a default plan right at the point of sale at the pharmacy counter. Finally, if all else fails, the pharmacy or the beneficiary can call 1-800-MEDICARE and ask for the assistance of a caseworker who will work to resolve their individual needs. And we've already resolved thousands of those cases and many for the residents of the state of Nebraska. We have also asked the plans to increase their customer service lines for both the beneficiaries and, importantly, the pharmacists. We acknowledge, obviously, that it's not acceptable for pharmacists, or anyone for that matter, to have to wait 30 minutes or more on the phone to get information so someone can get their prescription filled. We know that part of the reason the waits were so long initially was that the transaction system that we gave to pharmacists did not always work as it should, and we know that there was some data translation problems with some pharmacists' systems initially. We also acknowledge that some of it was due to less than adequate staffing of the call lines, and that some of the plans were just not prepared for the volume of calls that they received. So we have taken some steps to address that, both at our own call center and those at the plans. And we've already seen some improvement at the plans but we expect all of them to get their wait times down, and we're actually tracking that ourselves on an ongoing basis and providing feedback to the plans as to what we've learned. Clearly good service is a requirement of participating in the Medicare drug program, and we're pleased that many of the plans are now meeting our expectations. Pharmacists across the country and right here in Nebraska have clearly worked heroically over the past month and a half to handle the new system and the enrollment of all these beneficiaries but we know we need to do more to support them. Just last week we launched a new training initiative for them. We hosted a first in a series of conference calls for pharmacists so they could share information and best practices with one another, as well as have our contractors on these conference calls so pharmacists in the field can ask questions directly and share feedback about what's not working. We hosted them three times a day on Tuesday, and then we actually record them so pharmacists that are busy at the counter when the calls are going on can listen in at a time that's convenient for them. We've asked the plans to honor the requirement of the law that the beneficiaries get the drugs they need

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during the transition period, and just last week we notified the plans that the initial 30-day transition coverage period is now in effect for another 60 days. We continue to work closely with the states including Nebraska. We know that some of data transmission hasn't been as perfect as it could have been, and there are some imperfections that we need to straighten out, and we work with them on a regular basis to figure out what's going on and how we can perfect the transfer of the data. This doesn't apply to the state of Nebraska but last week we announced a temporary reimbursement program for states that were interested in stepping up as the payor of last resort to ensure their dual eligibles got access to drugs that they needed. As I said before, adding a prescription drug benefit to Medicare is the biggest change in our history and it's all happening at once. You can imagine when millions of people are enrolled at the same time, there are bound to be some transition problems but I want to assure you that we've dedicated a number of staff at the regional office and across the country to work with beneficiaries, their pharmacies, and their plans to resolve any outstanding issue. But I also think it's important that we not lose sight of the fact that many, many people who have never had coverage for their medicines before have it today, and we're confident that it will be a success for the millions of Americans who are going to save money, stay healthier, and gain new peace of mind. We are strongly urging those who have signed up to spread the word among their family and friends. There are many ways for people to get information and education about the drug benefit. We've worked really hard over the past year and a half to set up partnerships across the country, and Nebraska has done a just outstanding job of working with many, many partners at the state and local level. We're very proud of the work of the SCHIPs and the AAAs in this state and the statewide coalition that was formed here. And I know Fred has held it up as a national model with his peers, and I have done the same, that we just have not seen that kind of collaboration anywhere else in the country, so we're very proud of what you've done. We do acknowledge that it takes some time to enroll. As you can see, over the past month there are some issues. You may find some issues when you use the coverage for the first time but many seniors will tell you, including my own mother, that it's worth it. As Secretary Leavitt said recently: I think the

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measure of our success isn't whether the program is perfect on the first day but it's a few months from now when millions of people are getting drugs that they never got before with little or no problem. I know we have more work to do and I'm happy to answer your questions.

SENATOR JENSEN: Thank you. Are there any questions? I know the state has some hired some FTEs and are working diligently both training and providing services. There's an April deadline that approaches. Do you expect anything at that time different or...?

KATHRYN COLEMAN: The deadline for signing up is May 15, and anyone who doesn't sign up by then will face a penalty. We will continue our education and outreach efforts across the state and the country to remind people and encourage people to sign up.

SENATOR JENSEN: I would imagine there would be many that would wait until last week week or so...

KATHRYN COLEMAN: Well, we've been very pleased with the number of people who have signed up. I think we processed about 20,000 applications on-line each day, and there are many more that come in through the actual health plans or through the telephone or paper applications. So we've been pleased with the progress we've seen so far.

SENATOR JENSEN: Senator Byars.

SENATOR BYARS: I just...the overwhelming task...I want to compliment you and, of course, we in Nebraska want to work with you every way we can. As I looked at what is apparently like 19 million eligible people for these plans, and that takes a long time to get information disseminated and get everybody happy. We're still hearing a lot of "I don't understand" and "I'm scared and I don't know what to do." I am personally worried about the dual eligibles, but I know you're working on that and trying your best to make sure they're enrolled.

KATHRYN COLEMAN: We are and we will continue with our education campaign and our outreach campaign. And I think you'll see shortly we'll have some national...not on

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television but some print media and will continue, obviously on the regional office level, to do trainings and outreach to communities across our region.

SENATOR BYARS: Good, because dual eligibles, there's some real confusion and some fear, so please do your best.

KATHRYN COLEMAN: Sure. Thank you.

SENATOR BYARS: Thank you.

SENATOR JENSEN: There was also some changes with the clawback provisions, I believe, wasn't there with the states?

KATHRYN COLEMAN: There haven't been any changes since the Medicaid Modernization Act was passed.

SENATOR JENSEN: Well, I had understood that there was some changes that were contemplated with that.

KATHRYN COLEMAN: There was some push back from the states because the numbers are based on 2003 expenditures, and I think we got a lot of criticism that those numbers didn't perhaps reflect current level of spending, and so there was some attempts, I think, to change the years that we were using to calculate the clawback that the states would pay, but nothing was changed.

SENATOR JENSEN: Okay.

SENATOR BYARS: I'm thinking that maybe there have been some changes in clawback in the last couple of days on the part of the secretary.

SENATOR JENSEN: That's what I had thought.

SENATOR BYARS: Maybe they haven't told you guys yet.

KATHRYN COLEMAN: I guess we'll have to get back to you on that. I wasn't aware of them but perhaps there was...

SENATOR BYARS: I think I received some stuff this morning.

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KATHRYN COLEMAN: Okay.

SENATOR JENSEN: Yeah, I thought it was as late as this last week, but I could be wrong.

KATHRYN COLEMAN: We'll follow up. Sorry.

SENATOR BYARS: Thank you.

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

KATHRYN COLEMAN: Thank you.

JACKIE GLAZE: Good afternoon. I'm Jackie Glaze. I also work for CMS, and I'm the Program Services Branch Manager for the Division of Medicaid and Children's Health. I work on the policy side and we work with the state Medicaid agencies very closely with their waivers, their state plans, and managed care...those kinds of programs. And I wanted to touch briefly on some of the areas that will affect Medicaid and the Deficit Reduction Act. One of the first ones is targeting the case management, and I know that's one that really is on everyone's list to be looking at. So they are clarifying that and trying to better define it and give the states better direction on how that should be administered. Another one deals with one that I know Nebraska is very interested in and that's the state's long term care program. With this provision, it repeals moratorium on long term care partnership programs, which will allow more states to participate. I've been talking with Dick Nelson a lot about that, and that's something they're very, very interested in. So I've been making some calls to our central office to find out if we are developing templates and doing those kinds of things because I know now that it's been passed, you're ready to start moving in that area. Another area that's going to be a really big area is that they're establishing a Medicaid Integrity Program. With that, that will establish the program and it's authorizing CMS to hire an additional 100 FTEs across the country. What they'll be doing is basically solely working on protecting the integrity of the Medicaid program through assisting states in combating providers' fraud and abuse in that area. So that's something that we're looking at very closely as well.

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Another area which I know also that Nebraska is interested in is the HCBS area, and there's two areas there: one of them is Money Follows the Person Rebalancing Act. With that award states grant money on a competitive basis to encourage community-based living in the state rather than the long-term care in institutions. We look to try to work with states in that area to help them set up programs to do that, and I know that that's something that you're very interested in also. Another one is expanding access to HCBS for elderly and disabled population, and this gives states the option to provide HCBS through the state plan rather than through the 1915-C waiver. So with that, it also has a more stringent level of care on the institutional care than the HCBS services. So we look to try to place people appropriately and to use the avenue of HCBS if that would work best for them and if that's their choice. Other areas that we're looking at is the premiums and copay expansions. So this will grant states the option to access by imposing premiums and copayments to Medicaid beneficiaries that are over 150 percent of the federal poverty limit. So there are exceptions. There are certain groups that we cannot do that, which would be pregnant women, some kids, and the low-income groups, foster care, long-term care, so, of course, those would be exempt, but the adult population, the states are able to do that if they so choose to. I think I'll stop there because there's probably a lot more I can go into but if there's any that I've discussed or anything else that you would like for me address.

SENATOR JENSEN: Thank you for your testimony. As a matter of fact, yesterday we had Nebraska's Long Term Care Partnership bill that we heard 20 minutes after the President signed it, so I think we're up-to-date on that one.

JACKIE GLAZE: Great. Great. And we are looking at that as well, so we hope to help the state in that area.

SENATOR JENSEN: Any questions from the committee? We thank you for your information.

JACKIE GLAZE: Okay. Thank you.

SENATOR JENSEN: Hi.

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LINDA VOGEL: Good afternoon. My name is Linda Vogel. I'm the Regional Health Administrator in Region VII of the Department of Health and Human Services. To try to provide some bureaucratic geography for you, I report to the Assistant Secretary for Health back in Washington and am head of what, in Kansas City, is called the Office of Public Health and Science. We're not big funders. That happens from the agencies but with one exception in this region, and that is that we award and oversee the grants that are made under the Title X Family Planning Program. In the case of Nebraska, the Department of Health and Human Services is the recipient or is the grantee. That amount of money that Nebraska receives or has been receiving each year for a number of years is about \$1.8 million, and we expect that to continue. Now these are not stand-alone family planning clinics, as such, in most cases. They are existing facilities, and I think, in Nebraska, DHHS has really done a wonderful job of integrating funding from multiple sources that go toward the same clinics, hospitals that receive the Title X funds, and this has created an environment in which many poor women receive their primary healthcare services. And the state has been very supportive of these efforts, as I said, they've done a very nice job of blending these funding streams so that women have mammography, colorectal screening and other types of screening, as well as family planning services. And we expect that funding for the Family Planning Program will continue at at least the same level. There is a lot of emphasis these days also on abstinence education as part of the Family Planning Programs but also on protection of young women from sexual predators, in this instance education and identifying instances in which those problems have been identified. In these cases, the clinics that are the delegate clinics that receive the funds follow state law and procedure with respect to any reporting that needs to be done. Beyond the family planning, I would describe our office's relationship with the state as more of a partnership. We focus on women's health, minority health, HIV/AIDS...I'm going to miss an area here...in addition to the family planning, but overall health promotion efforts. This is the first year in which the Department of Health and Human Services in Nebraska has received a small grant of \$50,000 for its Minority Health Office. And I must say Nebraska has been a leader in this

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region. It was the first one to have a full-fledged minority health office. You've been having a conference every year. This year, in cooperation with both that office and the Office of Women's Health in DHHS, we are helping to support a listening session and it's part of a whole series of listening sessions that will happen around the United States trying to focus on women in particular categories. In Nebraska the emphasis is going to be on immigrants and refugees. You all have one of the largest populations of Somali refugees in the United States. The demographics in this region are changing so dramatically. And I often say to my colleagues back in Washington and at CDC in Atlanta, hey, it's not just the border anymore. We have the same issues in the Midwest and we need to be thought of in that context, and so this is part of our opportunity through this listening session. But we don't come in and do it; it's done locally. We're providing some support and framework in connection with a larger effort. I don't want to go on too long. In the HIV/AIDS area we have the capacity to make small capacity building grants to community-based organizations. Right now, the principal locus for that has been in the northeast Omaha area where there is a particular need--in that case, working closely with the 100 Black Men of Omaha as well as with the city health department. But it's important, we feel, to enhance those community-based efforts, and it complements resources that come to this state through the Centers for Disease Control and Prevention. I also want to comment on the importance of what you all are going to be hearing more about, the pandemic flu concern. I know you're going to be having a summit here in this state on February 23, and the Midwestern states, I think, have some special problems in terms of communication to your rural areas in ways that will be not frightening but also constructive in terms of how to plan and prepare--what families need to be thinking about. We've shared materials with the DHHS here, and Jackie Miller told me this morning that, indeed, they've adapted materials that we've forwarded which they are beginning to use in an outreach way. Another area which we'd worked with the state in emergency response is Nebraska, as you know, took the lead for proposing a Midwestern Mutual Aid Initiative that involves Region 7, the four states here, and Region 8, which has six states, and we have helped play a facilitating role. I think that the Mutual Aid Initiative is very important

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because, particularly on issues such as sharing of epidemiologists and sharing of laboratory capacity. I know our Centers for Disease Control and Prevention can do testing of samples, but guess what? It may take several weeks to get a response because of the huge backload they get; and here in Nebraska you've taken the initiative to help see that things are...to reach out and to try to take advantage of what's available more broadly. I do want to comment very favorably on noting that you all are planning to establish a state immunization registry for children. I notice that legislation had been introduced. I don't know exactly where it is, and maybe I shouldn't comment on pending legislation. But you know, that is a really important thing to do, and happy to see it happening. In terms of budget, I would like to speak not of anything that's happening for 2006 but what is proposed...and this is the President's budget which has just been issued, so obviously it's just going to Congress. There'll be a lot of debate; there'll be hearings. Areas that I think are of particular concern to Nebraska in the health field are, in rural health, one of the things that appears to be out of the budget is for emergency medical services in rural areas. This is an area where the National Rural Health Association has played an important role with concerned states and so on, but there obviously are issues of, does this duplicate that, should this be covered with money that's already available? I think those are the kinds of questions that only the states can really answer. Similarly, an area to be eliminated from the budget would be the preventive services block grants to states. I just learned from talking with DHHS staff here that the current preventive services block grant, which comes through the Centers for Disease Control and Prevention, actually impacts on some 30 programs and pays for the equivalent of 14 to 15 FTEs. Again, I'm not making any judgments. They have a tight call on making decisions on the budget. They're trying their best to have a more balanced budget. And obviously one thing that they look at is their redundancy from one part to another--Are these kinds of programs covered elsewhere? Again, I think it is having the knowledge that these things are on the table that gives you the opportunity to look closely at the data on what the impact is. And human interest stories that, you know, happy stories of something good that happened from the money don't do it anymore. You have to be

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able to show impact and how it has impacted, and numerically, if possible. I've talked to some of the staff about this but I would encourage some real good assessment and perhaps in cooperation with another Plains state that has similar issues. Similarly in the whole rural health area, I think there's issues of how a Plains state like Nebraska and Kansas can be competitive with other states where you have higher numbers of people in more concentrated ways and also where community health centers tend to be more stand-alone versus being connected to a hospital as they are often more likely to be, say in Nebraska or Kansas, because I've heard the same thing there. So I think there's some key issues that need to be thought about because there will be an impact on the budget at some point, depending upon how successfully and how the state prioritizes these issues. My final thing to say is the most important thing you can do for your people here, among other things in health in terms of prevention, is public policy on smoking. I know it's controversial but smoking is the single greatest preventable cause of early disease and disability, both for those who smoke and for those who are exposed to the smoke. And the cutting of costs is very important and there are some very important public policies, things that can be done. The federal government isn't going to do this. These are state issues. Limitation of smoking in public places of work, and that includes restaurants and bars, places where people work and where others are exposed, because it creates an environment that is a healthy environment, and the other thing is raising the price. Price and demand are an old economic story. And we need to keep our youth from smoking and becoming addicted, as so many people of my generation and of my parents' generation were. Thanks very much.

SENATOR JENSEN: Thank you. I appreciate that. You know, I think it was a little over a year ago maybe that Ramone Henderson who came to me and said, do you suppose there's any way to get help with an AIDS program in Omaha? And I directed him to your offices, and I'm so pleased that he was able to do that. That's a very important thing in the near north side on HIV/AIDS, and hopefully we can address that and lower those numbers. So I appreciate that.

LINDA VOGEL: Yeah, and unfortunately Ramone has left and he's...

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SENATOR JENSEN: OH, I didn't even know that.

LINDA VOGEL: ...followed his wife to Arkansas, and so we want to... You know, one key issue there is that they have an STD epidemic in northeast Omaha. It's not just AIDS; it's the whole issue of STDs. And they are reluctant to, in effect, say, publicly declare it as an epidemic, even though the Centers for Disease Control has said per capita of incidence, this is epidemic proportions. There is a concern of how it will reflect on them. It's a difficult issue. I know that DHHS is working with them and with a very fine county health officer, Dr. Pohl, I believe it is.

SENATOR JENSEN: Adi Pour?

LINDA VOGEL: Pour, yes. Adi Pour, yeah. Swiss lady, I think.

SENATOR JENSEN: Right.

LINDA VOGEL: Yeah.

SENATOR JENSEN: Senator Byars.

SENATOR BYARS: I just wanted to editorialize a little bit too. Thank you for your antismoking editorial. We all should celebrate...I didn't have the opportunity on the floor of the Nebraska Legislature this morning but we should all be celebrating the fact that for the first year in 70 years cancer deaths went down, it was announced yesterday, for the first time in 70 years. So what we're doing is having an effect. It didn't go down much but they went down. So everything that we continue to do to educate and to make good public policy, every one of the members of these legislatures are responsible for that.

LINDA VOGEL: I'm just going to quickly share a story. I was born in 1941, my sister in 1940. My mom couldn't get cigarettes. I have three younger siblings, the next one born in 1949, and then the others in the 1950s. Mom was an addicted smoker then. She was a chain smoker. The only thing different in our house was that mom was a chain smoker. My three younger siblings had terrible allergies

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and asthma as children. Younger brother has actually his breast bone is almost like a chicken breast because he had such trouble breathing. All three have compromised lung function. As adults they sit around talking about the inhalers they use. There is no doubt in my mind...I mean it was a clinical trial on most of my own household that that is why they were ill. Mom didn't smoke when my older sister and I were babies. She smoked when they were. So I think you can...I've heard so many people say, it's not proven that secondhand smoke harms people. It does. And I think for people who work in restaurants and bars are particularly vulnerable. And there's just really no safe level of smoke. This morning your governor rightfully raised the issue of alcohol--well, shouldn't we be as concerned. Yeah, we should be but with tobacco there is no safe level. With alcohol there is a presumed safe level. So there are some differences here. And we can make a difference through these public health policy approaches. Thanks.

SENATOR JENSEN: Thank you.

FRED SCHUSTER: I think that concludes our presentations, Mr. Chairman.

SENATOR JENSEN: Well, Fred, thank you very much and thank your team. It's been very informative and we really appreciate the relationship that we in Nebraska have with you and your personnel, and hope that it will continue. Thank you. And now, ladies and gentleman, we will begin the public hearing process. For those who came in late, this was a briefing from CMS out of Kansas City that we have had annually for the last four years. Again, we have six bills before us. When you came in, there is a table over here to pick up a sign-in sheet. Please do that. And when you come up to testify, drop it into this wooden box on this table. If you are speaking on your own behalf, tell us that. If you're speaking as representing an organization, also let us know that. If you have a cell phone, please shut the ringer off. These proceedings are recorded, transcribed, and so we would appreciate not having the ringer go off in the transcriber's ears. Also we hear proponent testimony first, opponent testimony, and then neutral testimony. I am going to ask you, because we have six bills before us, that if you are coming up to testify, hold your testimony to two

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pages--no more than that. And also, if you have a testimony that somebody else gave you that you want to read, I'm going to deny that. You can pass it out. We can read it but please don't read somebody else's testimony to us. With that, I'll introduce you to the senators that are here. Senator Howard was right over here but she went out to converse a little more with the members from CMS; next to her is Senator Arnie Stuthman who is from Platte Center; next to him, with a smile on his face, is Joel Johnson from Kearney, Nebraska; to my left here is Joan Warner, committee clerk. I'm Jim Jensen serving as Chairman. I'm from Omaha. Next to me is Jeff Santema who is the committee counsel; next to him is Dennis Byars who is Vice Chairman of the committee and from Beatrice, Nebraska. Doug Cunningham was here and he left but he'll be back. Again, this is bill introduction time clear across the Capitol, and so there are people who are introducing bills there. If somebody gets up here and leaves, please don't feel offended. They're probably introducing a bill somewhere else. With that, the first bill that we have is Senator Byars' bill, LB 1220.

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SENATOR BYARS: Thank you, Senator Jensen, members of the Health and Human Services Committee. I am Senator Dennis Byars, B-y-a-r-s, representing the 30th Legislative District. Since we're early in the hearings, that definitely is the "Caring and Sharing District." You noticed yesterday I even deleted that from my testimony, Dr. Johnson.

SENATOR JOHNSON: I noticed.

SENATOR BYARS: (Exhibit 1) I want to thank you very much for hearing LB 1220 today. I think it is a continuum of something that's been happening but I'm not sure we're all totally aware of the impact of what has been going on in rural behavioral health training, but I'll talk to you about it a little bit. I think it's a continuum of Senator Jensen's fantastic work in establishing knowledge about the lack of rural behavioral health services and what we can do as far as moving people into an appropriate environment to receive the type of treatments that are necessary for those

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who are mentally ill. The reason for the bill: LB 1220 establishes the Rural Behavioral Health Training and Placement Program Act that addresses behavioral health professional shortages in Nebraska's rural areas. Currently, 88 of Nebraska's 93 counties are classified as having mental and behavioral health shortages by the Nebraska Department of Health and Human Services and by the Federal Health Resources and Services Administration. Seventy-four percent of the state's mental and behavioral health professionals are concentrated in metropolitan areas, leaving the remaining one-quarter of licensed professionals to cover 72,000 square miles of rural Nebraska; 38 of the counties in the state have one or no licensed behavioral health professionals. I knew the shortage was serious. I didn't realize that it was this critical. To address these problems, the Munroe-Meyer Institute at the University of Nebraska Medical Center developed a model six years ago. They've had it in use for six years. That incorporates behavioral health into the primary healthcare...that's the pediatric and family medicine delivery system...by integrating behavioral health specialists into practice with physicians. For the past six years, they have received federal funding to Munroe-Meyer that placed mental and behavioral health professionals...those are psychologists, social workers, marriage and family therapists, psychiatric nurse practitioners and counselors, interns, fellows, and graduate students in the underserved areas of the state. During the past four years, the program has provided over 5,500 annual patient visits...that's on an annual basis...to families in over a 140 Nebraska cities and towns. And upon completion of their schooling, more than half of these interns, fellows, and graduate trainees are staying and practicing in the rural areas. This is a huge plus for the state of Nebraska. Despite the success of the programs, federal budget cuts, unfortunately mean additional funding sources are needed to sustain the programs. Without financial support, over 3,500 rural patient visits will be unavailable on an annual basis. What we're doing in LB 1220 is proposing an appropriation of \$200,000 per year to support, 1) increased outreach faculty positions and their clinical and training activities, 2) internship stipends for behavioral health interns and postdoctoral fellows, and 3) training and service provision expenses to include travel to rural clinic sites, equipment, clinic space, patient

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record management, scheduling, and telehealth supervision as well. There has been some question about whether we should specifically name Munroe-Meyer Institute in statute and whether this should be more generic and have more of a competitive opportunity for others that may wish to provide these services. We will be working on an amendment to clarify that to make sure we're putting appropriate language in statute. But Munroe-Meyer is the one who has developed the model. They have practicing it for six years and are the people at the Med Center who have brought this legislation to me. As I said in my opening, Senator Jensen, this is a continuum, I feel, of what we established in moving toward establishing rural health services for persons with mental and behavioral health problems. And I certainly hope, as we approach this issue, that you will see it appropriate to move it to the floor of the Legislature, and I want to thank you very much.

SENATOR JENSEN: Thank you. Any questions of Senator Byars? Thank you for your testimony. Anyone wishing to testify as a proponent, please come forward. I do have a proponent letter from the Nebraska Women's Health Advisory Council also. (Exhibit 1) That will be placed in the record. Good afternoon.

JOSEPH EVANS: (Exhibit 2) Good afternoon. My name is Dr. Joseph Evans and I'm the director of pediatric psychology at the University of Nebraska Medical Center, and I'm part of the Munroe-Meyer Institute. Thank you, Senator Jensen and members of the Health and Human Services Committee, for providing me the opportunity to speak to you today about the need for LB 1220 and my support for it. I'm testifying in support of LB 1220 because it addresses a crucial need in meeting the mental health needs of Nebraska children, adolescents, families, and adults, particularly in rural areas. As noted in the bill and mentioned eloquently by Senator Byars, there is a significant shortage of behavioral health professionals with approximately three-fourths practicing in the Omaha and Lincoln areas. Behavioral health providers with specialty preparation in working with children, youth, and families, is also even more crucial when it comes time for rural practice. To address these issues, a program of integrating behavioral healthcare into primary care was started in 1998 with funds

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obtained from three grants from the Federal Health Resources and Services Administration. This model is designed to attract, to recruit, to train, to place and retain behavioral health professionals in underserved Nebraska towns, particularly in rural areas. The internship training program has emphasized a learning through service model to the point where we now have provided annually over 5,000 patient visits by the faculty and trainees of the program in towns including Hastings, Kearney, Columbus, Chadron, Plattsmouth, Gordon, Nebraska City, and Crete. We conducted a survey in 2002 which indicated that we had at that time four clinics, and we had people from 87 different towns receiving services. We re-analyzed the data in 2005 and found that there were 11 rural clinics now and this is serving over 156 Nebraska towns where individuals, families, and children have come from. Over the past six years, 79 trainees from nearly every behavioral health training program in the state, including the University of Nebraska at Lincoln, Kearney, and Omaha, as well as interns and counseling from Wayne State, Chadron State, and Doane College have participated in the internship program. Of this number, a significant proportion, 56 percent, have been retained in rural practice. With drastic reductions in federal funding, the two grants that currently support this effort are being reduced by 55 percent and 66 percent. LB 1220 would allow internship training to continue and for students to be placed in underserved areas of the state. Without some kind of continuation, families will not be able to receive these services, and we project that between 3,500 and 5,500 patient visits could be lost. The integrated behavioral health and primary care model was originally established for a population of children and adolescents but we recently had to expand this because of demand in the community, and now we have added in marriage and family therapists, counselors, psychologists, social workers to work with adults and the elderly. Our plan is to create future internship training hubs at strategic places around the state, which would allow adjunct faculty who have been trained in the model to provide services and at the same time coordinate overall curriculum with the University of Nebraska Med Center. The integrated behavioral health program has a significant track record for increasing numbers of behavioral professionals in the state. The program is at a significant crossroads if their momentum for

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activities of the training program is to continue. The outcome of LB 1220 can eventually lead to increased accessibility to behavioral health professionals for many rural Nebraskans, children, adolescents, adults, and families across the state for whom these services have not previously been available. That's my testimony. Are there any questions?

SENATOR JENSEN: Thank you, Dr. Evans. Any questions from the committee? Yes, Senator Erdman.

SENATOR ERDMAN: Thank you, Mr. Chairman. And I may have missed this; Senator Byars may have pointed this out. The grants that are scheduled to be reduced, what is the amount that we are talking about?

JOSEPH EVANS: We are looking at \$200,000 cuts in federal funding, up to \$400,000.

SENATOR ERDMAN: So essentially this is...

JOSEPH EVANS: We know that the minimum will be \$200,000, and the potential is that because the formula has not actually been worked out at the federal level. It could totally be wiped out altogether.

SENATOR ERDMAN: So the total grant now is \$400,000?

JOSEPH EVANS: Correct, the total of the two.

SENATOR ERDMAN: And that is over a year? That's annually?

JOSEPH EVANS: Per year. Right.

SENATOR ERDMAN: Thank you.

JOSEPH EVANS: If you look on the last page of the handout, that gives a visual of where actual patients have come from. If you notice, for example, as far away as Emmet, Nebraska, people were traveling from Emmet all the way to Hastings to get services because, even though it was 180 miles, it was still much closer than 400, 450 miles driving to Omaha or to Lincoln.

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SENATOR JENSEN: Senator Stuthman.

SENATOR STUTHMAN: Thank you, Senator Jensen. Dr. Evans, in your map, in my district you've got a lot of the smaller communities, and Columbus is at the hub, and you've got pediatric behavioral health patients that come from Clarkson, Halsey, Humphrey. Do they all come to Columbus then? Is that what this says?

JOSEPH EVANS: Yes, they do at this point.

SENATOR STUTHMAN: That's where they go.

JOSEPH EVANS: And one of our goals is eventually to try to not only have people at a hub but also some outreach clinics visit smaller communities where people wouldn't have to travel as far. That would be down the road, and we think that that's an achievable goal. So maybe a day a week we might have a clinic open in Howells, Nebraska, for example.

SENATOR STUTHMAN: Do you have any of that now?

JOSEPH EVANS: We have a day clinic that we're doing in Valley, Nebraska, so we have someone that travels up to Valley one day a week. And that seems to be helping meet the needs of that smaller community.

SENATOR STUTHMAN: Thank you.

JOSEPH EVANS: Okay.

SENATOR JENSEN: Any other questions? Thank you very much for your testimony.

JOSEPH EVANS: Thank you.

SENATOR JENSEN: Anyone else wishing to testify as a proponent, come forward, please. And we do have empty chairs up front, so if you want to testify please come up to one of those chairs and we'll have a very short transition. Thank you. Welcome.

CATHERINE JONES-HAZLEDINE: (Exhibit 3) Good afternoon. My name is Catherine Jones-Hazledine. I'm a licensed

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psychologist. I'm currently employed with the Munroe-Meyer Institute at the University of Nebraska Med Center. I want to thank you, Senator Jensen and the members of the Health and Human Services Committee, for the allowing me the opportunity today to speak with you about my support for LB 1220. I'm testifying today as a citizen of Nebraska and not as a representative of the Munroe-Meyer Institute. I'm especially honored to have the chance to speak with you today because this is a bill that I feel very strongly about and I've traveled some distance to be here to speak with you about it. I personally come from several generations of Nebraskans, and I graduated from Rushville High School in Sheridan County of Nebraska. As many of you know, Sheridan County is quite an isolated area of this state, and it's one in which traditionally very few behavioral health services have been available. For a long time now, I've been really interested in returning to that area to live, and I've been especially interested in being able to provide some mental health services to individuals from that area. I even completed my doctoral dissertation at UNL on the topic of mental health services to rural populations. So it's been a long-time passion of mine, especially. As an intern at the Munroe-Meyer Institute, I was very fortunate to receive some excellent training in providing behavioral health services within a primary care setting. And with the support of the Munroe-Meyer Institute, I was able to relocate back home a year and a half ago and to establish several behavioral health clinics along Highway 20. Those clinics are now located in Crawford, Chadron, Rushville, and Gordon, but they actually provide services to a number of underserved counties including Sioux, Dawes, Sheridan, Cherry, Grant, Box Butte, and Scotts Bluff counties, as well as some others. Since the establishment of those clinics out west, we have been able to provide services to well over 150 children and adolescents, for a total of over 950 now scheduled visits for mental health and behavioral health reasons. We have worked with families, we've worked with physicians, and we've worked with schools to be able to provide specialized mental health services that were not available previously in many of those communities. Attached on to my testimony, I included a couple of letters that were just given to me in the last couple of days by some school officials in that area of the state who have particularly appreciative of our presence there. This all could not have

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been done without the support of the Munroe-Meyer Institute's Behavioral Health Outreach Program. Their support has been not only financial for these clinics but it has also included ongoing consultation and training with nationally recognized experts in fields of child mental health. It's included telehealth supervision, clerical support, and much more. The literature on rural mental health tells us that it is often difficult to recruit, and particularly to retain, mental health professionals in rural service. And that can be due to issues of provider dissatisfaction, isolation, ethical dilemmas, a whole variety of problems. Many of those issues can be minimized by proper preparation, training, and the ongoing support such as that that's provided by this program. Life in rural areas can be very challenging for many families, and I've learned that many families learn to do without many things in order to live in rural areas. I respectfully submit that behavioral health services should not be one of those things that families should have to do without. So I strongly support LB 1220 to allow the continuation of the important work in training and placing professionals that's done by this program in areas of the state that most need those services. Thank you.

SENATOR JENSEN: Thank you, Doctor. Any questions? Yes, Senator Stuthman.

SENATOR STUTHMAN: Thank you, Senator Jensen. Doctor, who would be the group or who recommends patients to you for psychiatric help? Parents, schools, or where do they come from?

CATHERINE JONES-HAZLEDINE: The original idea of the model is that we're based in primary care settings, and so originally many of our referrals come from the physicians within the practice. Research has found, especially in pediatric practices, large numbers of children that are seen in pediatric practices are actually there for behavioral health issues: sleep issues, toileting issues, temper tantrum issues, or depression or anxiety. And so physicians refer a large number of the kids that we see. But what we've discovered in particularly these farther out clinics, is that once the folks find out that we're there, the referrals start coming in from other sources. So I work

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probably at this point as much with the schools as I do direct referrals from physicians. And then families can also independently find out that we're there and refer themselves for services. So at this point, referrals come from kind of all over the place.

SENATOR STUTHMAN: And do you feel that you're accomplishing your goal with these children or do you ever get them to where they're normal again and get them back into society?

CATHERINE JONES-HAZLEDINE: That's a great question. I think Mr. Tuma had addressed that because he's a superintendent who often refers children in the school. And I think that the goals really vary, depending on what the presenting problems are. And there are many kids that we see for just a few visits and we're able to work with the families and do some parent training. A lot of what we do has a lot to do with providing families and parents with strategies that they can take home, then, and use to help with problems, so that it's not just once a week in our clinics but those changes are continuing at home, which I think is really important. And so very often we see kids who go back completely to their normal lives and the problems were met. Sometimes in more chronic and serious cases, that kind of support needs to be ongoing but at least we're able to provide the families, and often the schools as well, with strategies to help in that ongoing care of those kids as they get older.

SENATOR STUTHMAN: Okay. Thank you.

CATHERINE JONES-HAZLEDINE: Thank you.

SENATOR JENSEN: Yes, Senator Howard.

SENATOR HOWARD: Here in, I suppose you could say "the states," we're quick to prescribe medications. And in Nebraska we have a high percentage of state wards that are on behaviorally altering drugs, medications. Do you feel that the services that you provide can offset that drug use, can be used instead of that drug use?

CATHERINE JONES-HAZLEDINE: Absolutely. And one of the things of the American Academy of Pediatrics model, for

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example, for ADHD care involves a conjoint use. When stimulant medications or other medications are required, they recommend a conjoint use of behavioral health services, particularly working with families and working with schools to implement programs in that setting. And we do an awful lot of that. And one of the really fortunate things that I've found is that there are many physicians, even out in Alliance and Hemmingford, and those areas of the state, who are very, very open and interested in being able to provide their patients with alternatives so that either they won't have to be on medication or they could be on lower doses of medication or shorter terms. So they're very open to working with us to try to offset some of that use of medication.

SENATOR HOWARD: Well, thank you. I think all those attempts to work that way are very good. Thank you so much.

CATHERINE JONES-HAZLEDINE: Okay.

SENATOR JENSEN: Any other questions? Thank you, Doctor.

CATHERINE JONES-HAZLEDINE: Thank you.

SENATOR JENSEN: Next proponent, please?

EMILY WARNES: (Exhibit 4) Thank you, Senator Jensen and committee members. My name is Dr. Emily Warnes. I'm a pediatric psychology fellow at the Munroe-Meyer Institute. I'm currently providing behavioral pediatric services at the Physician's Clinic at Crete Area Medical Center in Crete, Nebraska. I'm testifying today as a citizen of Crete and not as a representative of the Munroe-Meyer Institute. I feel very passionately about LB 1220. I am from a rural community in Kansas. I was born and raised in a small community in Kansas, and did my graduate work in psychology here at the University of Nebraska-Lincoln. I was fortunate enough to have an internship at the Munroe-Meyer Institute, and during my internship was a part of the rural behavioral health training. I worked closely and collaboratively with physicians in Plattsmouth, Nebraska, to provide behavioral health services to children, adolescents, and their families. I also had the opportunity to work with several school professionals in the provision of services for these

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children. Upon completion of my Ph.D., I was interested in furthering my education and furthering provision of services for children in rural communities. My husband and I were very interested in going to rural Nebraska and being able to deliver services to those who most need it. So upon completion of my internship, I took a postdoctoral fellowship through the Munroe-Meyer Institute, and I currently receive one hour of supervision via telehealth through the behavioral outreach training grant. In my work in Crete I provide behavioral health services through the Physicians Clinic. The physicians there have been very receptive and very excited about having me in the clinic. They appreciate the opportunity to provide their families with behavioral health services and have a behavioral consultant in their practice. It's nice for families, when they're seeing their physician and issues come up such as bed wetting and tantrums and things like that, the physician can just say, well, we have Dr. Warnes who can introduce herself and link them with a behavioral health provider right in their office. And so they really appreciate that opportunity. Many of my referrals come from the physicians in the community, not only the physicians in that practice but physicians in other practices in the community. I also have several referrals from physicians in neighboring communities: Friend, Nebraska, Geneva. I've seen families in the brief time that I've been in Crete, since September of 2005, I've seen families from Geneva, Daykin, Dorchester, Friend, just to name a few. So families are coming from many small rural communities to Crete to receive services. In addition to providing services for these families in my clinic setting, I have done a significant amount of work with schools not only in Friend but in nearby communities to consult with teachers and provide services in that context. I feel very strongly that quality behavioral health services are something that are not the...often behavioral health services are seen as the extras and not the necessity for families of rural communities because they're not service providers readily available. And I feel very strongly that they deserve quality services. And I urge you to support this bill.

SENATOR JENSEN: Thank you, Dr. Warnes. Any questions from the committee? Thank you. Thank you for coming to Nebraska.

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RACHEL VALLELEY: (Exhibit 5) Good afternoon. I feel like, listening to everybody, if you build it, they will come. My name is Dr. Rachel Valleley and I'm a psychologist at Munroe-Meyer Institute, University of Nebraska Medical Center. Thank you, Senator Jensen and members of the Health and Human Services Committee, for providing me with the opportunity to speak to you today about the impact of LB 1220 and my support position. It is important to note that I am not testifying in my capacity as an employee or representative of UNMC. I also completed my internship training at Munroe-Meyer Institute between the years of 2000-2001. During that training, I participated in a rural behavioral outreach clinic in Columbus for a six-month rotation. That training experience was pivotal in steering me toward providing psychological services to children and their families in rural communities of Nebraska. So I sought a postdoctoral position at Munroe-Meyer Institute that would allow me to provide behavioral health services in Hastings. Once I completed my training, I joined the faculty at MMI and continued to provide those services in Hastings for two days a week. As a faculty member at MMI, I provided training experiences to students in the primary care clinics in rural Nebraska, with many of these students moving on to these communities. Specifically, I was able to recruit Dr. Stephanie Cooper as a postdoctoral fellow who had also trained as an MMI intern in rural Nebraska. She now has moved to Hastings in 2002 and has continued to provide behavioral health services in the community. In January of 2005, Dr. Cooper was hired by the Hastings Children and Adolescent Clinic as a permanent member of their staff. I also trained Dr. Kate Jones-Hazledine in the Hastings Clinic in 2004 where she was an intern. Since then, she has moved to Rushville as you heard and provides the behavioral health services in Chadron, Crawford, Gordon...to name a few. Furthermore, I provided supervision to Dr. Nancy Foster who has been a trainee in 2004 in Kearney. Dr. Foster has continued her training with us in Kearney as a postdoctoral fellow. In this program's first years, the behavioral health clinics were operated by two Monroe-Meyer faculty who traveled to these distance clinics in Hastings and Nebraska weekly, although we recognized very early that we needed to add that training component throughout Nebraska. So we have added training interns, as

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well as training master's level students in these communities and have been able to place them. Over the past two years there has been continued interest and expansion to these primary care practices across the state including Grand Island, Blair, Norfolk, and Beatrice. Practices have approached us expressing this interest. Physicians are extremely receptive to having behavioral health services in their office, given the number one problem presenting in primary care, being psychosocial, because parents first turn to their primary care physician when a problem arises. In Omaha, there are numerous mental health professionals available, so physicians can simply refer the family. However, in rural communities services are sparse so they often have to provide the behavioral health services themselves while having inadequate time and training to do so, thus the physicians we've found in these rural communities are particularly interested in adding behavioral health clinics to their settings. I just wanted to mention that all of the work that we have been doing at Munroe-Meyer in terms of training and then placing students in these communities has seen just incredible growth and expansion. and I wanted to just give my support for this bill.

SENATOR JENSEN: Thank you very much. Any questions? Also, if you have the opportunity to treat children at a younger age suffering from some form of mental illness, this quite often does have an effect, without being treated, into carrying over into an adult, and the problems become more severe, is that correct?

RACHEL VALLELEY: Absolutely. The number one thing that we see in these behavioral health clinics is what's called oppositional defiant disorder. These are the kids that say no when we say yes. We say green, they say red. And if this goes untreated, these kids oftentimes develop into juvenile delinquents, conduct disorders, adult criminal paths. And so if they go untreated, yes, it can become major, major problems. However we found that if you treat these kids between the ages of 2 and 7, that 14 years later when you go up and do follow up with them, they look no different than somebody that had never had this disorder in the past. So the data is very strong that we can change these kids' lives dramatically, getting them early.

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SENATOR JENSEN: That's great. Senator Stuthman, did you have a question?

SENATOR STUTHMAN: Yes. Thank you, Senator Jensen. Rachel, I'm very impressed with the internship out in the rural Nebraska. Do you feel that is a value two-fold: it gives the student experience and it also provides a service to the community?

RACHEL VALLELEY: Absolutely. One of the things, when I think about the importance of getting the training occurring when it's training out in the rural communities is that we oftentimes, where we train we don't stray too far from, so if we can get them out there and interested in the rural community in the training, they, one, start to learn more about that community in providing the service, but they're more likely to stay and continue there. And that's what we have found is that when we get people out there as interns, as postdoctoral fellows, they move out to the communities. They're loving it and they're staying. And just that opportunity to see more kids, it evolves. Dr. Cooper, when we first started in the Hastings Clinic, it was about a day or day and a half a week of service that we provide. Now she is there, hired on by the clinic five days a week and is onsite all the time when they have a behavioral health issue raised, so she can jump into the clinic room with the physician, or the referral happens and she sees them individually. That was not possible when we were just traveling there.

SENATOR STUTHMAN: Thank you very much.

SENATOR JENSEN: Any other questions? Thank you for coming today. Anyone else speaking as a proponent? After Mr. Keetle, is there anyone else wishing to testify? Thank you. Welcome.

ROGER KEETLE: (Exhibit 6) Good afternoon, members of the Health and Human Services Committee and Chairman Jensen. I'm Roger Keetle, K-e-e-t-l-e. I'm a registered lobbyist for the Nebraska Hospital Association. You've heard excellent testimony. The good news is I don't have to repeat it. Attached to my testimony you'll find the maps of Nebraska showing the tremendous shortage of professionals we

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have. From my experience for the Hospital Association, this is an excellent program that Nebraska really needs, and needs to continue, because it doesn't happen overnight to fill a shortage. With that, I would urge you to support LB 1220 and would answer any questions that you might have.

SENATOR JENSEN: Any questions for Mr. Keetle? Thank you for coming.

ROGER KEETLE: Thank you.

SENATOR JENSEN: Anyone else wishing to testify as a proponent? Opponent testimony? Neutral testimony? Senator Byars, do you wish to close? He waives closing.

LB 1179

SENATOR BYARS: Senator Jensen to introduce LB 1179, 1-1-7-9.

SENATOR JENSEN: Thank you, Senator Byars, members of the Health and Human Services Committee. For the record, my name is Jim Jensen, representing District 20, here today to introduce LB 1179. LB 1179 is a cleanup legislation related to the Nebraska Behavioral Health Services Act. It simply eliminates the State Behavioral Health Council originally established in LB 1083 in 2004. The bill would retain the State Advisory Committee on Mental Health Services, the State Advisory Committee on Substance Abuse Services, and the State Advisory Committee on Problem Gambling and Addiction Services, and would make them responsible to the Division of Behavioral Health Services instead of the council. We had those three and then we had another committee or council on top of this. It's the one on top we're eliminating. The need for legislation was brought to me by the leadership of the council and advisory committees and from various consumers of behavioral health services who said that the council was not serving its intended purpose and was taking time away from valuable work of the three advisory committees that simply wasn't needed. That's all the bill does. And I thank you for your time. Any questions?

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SENATOR BYARS: Thank you, Senator Jensen. Appreciate it. I presume you'll be staying for closing, if necessary. (Laughter)

SENATOR JENSEN: I will.

SENATOR BYARS: Thank you, Senator. Proponents of LB 1179? Eric. How many testifiers will we have in favor or opposed to LB 1179? Would you please raise your hands? One. Okay. Thank you. Welcome, Eric.

ERIC EVANS: (Exhibit 1) Thank you, Senator Byars, members of the Health and Human Services Committee. My name is Eric Evans. That's E-r-i-c E-v-a-n-s, and I'm the deputy executive director at Nebraska Advocacy Services, the Center for Disability Rights, Law, and Advocacy. I'm here today to offer our support for LB 1179. Although we testified in favor of the idea of a state behavioral health advisory council at the hearing on LB 1083, I think the experience over the last couple of years has indicated that this council is really not necessary. It's duplicative and perhaps is redundant. In fact, what you have is a group of advisory committees providing advice to a state advisory council that provides advice to the division. Maybe you don't need that bigger, more bureaucratic body at this particular time. So we think these two factors really do give strong argument for the intent behind LB 1179. And by continuing with the three committees, you still have that advisory capacity to the department. One of the things that we would like to ask you to consider, however, is making the coordination responsibilities among these three committees explicit as opposed to implicit. And we are offering some language there on page 7, line 13, we would ask that you reword item number 10 to something to the effect that, "The administrator of the division shall coordinate, encourage, and facilitate activities of the advisory committees created in Sections 71-814 and 71-816." Again, it would just be good to have very clear responsibility specified. As you know, whenever an opportunity is presented to talk about consumer inclusion and consumer-operated services, because it's a priority within our organization, I need to take advantage of it. I do have three other things that I'd ask you to consider in terms of language changes. Once you open it up, I figure it's fair game to come in with some other

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proposals. On page 3, lines 16-19, we would like to see a little bit more language added that would specify that the advice and assistance that's being provided to the division around mental health services includes a development implementation provision and funding of organized peer support services. This has been a priority within our organization for some time. There is momentum in Nebraska. There is, indeed, federal...CMHS just released an announcement of \$2.5 million available for seven projects at about \$350,000 apiece. And having language like this in a statute would be very helpful, not only for that but for future federal or other grants that might present themselves. And in term of (d) promoting the interest of consumers and their families, we would ask that you again look at maybe putting the inclusion and involvement out there in a very strong way by adding "especially inclusion and involvement in all aspects of service, design, planning, implementation, provision, education, evaluation and research." We also see an opportunity at page 5, lines 24-25, to...not only is it important that there be an Office of Consumer Affairs but it is important there be something that guides and directs the Office of Consumer Affairs. So we would like to offer language that would require the division to develop a written plan that is updated on an annual basis as to how they're going to accomplish this inclusion and involvement, and that this would not only be something that occurs at the level of the division but also occurs at the level of all the programs that the division contracts with, whether they be private providers or regional behavioral health service organizations. And finally, at page 6, lines 5-9, there is again another opportunity to put language in regarding organized peer support services. So we ask you to consider these language changes that we offer and I thank you for this opportunity to again speak before you.

SENATOR BYARS: Thank you, Mr. Evans, for being here. Any questions or comments of Mr. Evans? If not, thank you very much.

ERIC EVANS: Okay. You're welcome.

SENATOR BYARS: Next proponent testifier? Let the record reflect we have received a letter in support of LB 1179 from

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the Department of Health and Human Services from Nancy Montanez, Director. (Exhibit 2) Welcome.

SHERRIE GEIER: Thank you. Good afternoon, Chairman Jensen and members of the committee. My name is Sherrie, S-h-e-r-r-i-e, Geier, G-e-i-e-r. I am here today as a member of the Behavioral Health Council and the chairperson of the State Advisory Committee on Problem Gambling and Addiction Services to testify in support of LB 1179. Several years ago I held an administrative position with the Gamblers Assistance Program. When I resigned from that position, I was asked to continue to serve the program by accepting an appointment to what then was known as the Nebraska Advisory Commission on Compulsive Gambling. I was appointed to the commission and elected chairperson by my fellow commission members. I served in that capacity until 2004 when the Nebraska Behavioral Health Services Act was passed. As you know, the act created the Behavioral Health Council and renamed and attached to the council three previously existing advisory groups: the State Advisory Committee on Mental Health Services, the State Advisory Committee on Substance Abuse Services, and the State Advisory Committee on Problem Gambling and Addiction Services. I was reappointed to the State Advisory Committee on Problem Gambling and Addiction Services and to the Behavioral Health Council. I believe that the Health and Human Services Committee included this new advisory structure in LB 1083 to encourage more collaboration among the disciplines. It was certainly a laudable goal but after having worked with this new structure for 16 months, I can tell you that it is not producing the desired results and, in fact, it is impeding the work of at least two and possibly all three of the advisory committees. Four times a year, the three advisory committees meet in the morning, and the Behavioral Health Council meets in the afternoon. Ten members from each of the advisory committees serve on the council. Council members are expected to report on issues addressed and recommendations made during advisory committee meetings. The council is then expected to adopt or reject the recommendations from the committees and pass them on to the Department of Health and Human Services. To date, the recommendations that have been made have shown virtually no cross-discipline collaboration and the council, sadly, has never received any feedback from Health and Human Services

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about the consideration of or adoption of any of the recommendations that it has made. An even more important issue is the inability of at least two, and possibly all three of the advisory committees to accomplish their desired or mandated responsibilities. For example, the Problem Gambling Committee that I chair has always had statutory responsibility for allocating state lottery and charitable gaming funds to treatment providers. With the passage last year of Senator McDonald's bill, LB 332, the committee now has additional money with which to reimburse providers who had provided services gratis, and they were reimbursed with that money. We also are trying to develop and implement an evaluation and prevention plan for the Gamblers Assistance Program. Several times in the past 16 months I've had to limit discussions that were critical to our decision-making responsibilities. And this has happened because our committee agenda must now devote precious time to Behavioral Health Council issues and because we must always conclude our business in time to make it to the council meetings. I've worked with boards and commissions for over 30 years. The members of the Problem Gambling Committee are the most knowledgeable and dedicated group with which I've had the pleasure to work. Since the new structure was put in place, I've heard from members that we can ill afford to lose, that they are no longer feeling that their services make a difference. I've asked them to wait and see what the Health and Human Services Committee of the Legislature decides to do with this bill. Before I close, I would like to offer two ideas for the committee to consider. First, I believe this committee needs to make it abundantly clear to the Division of Behavioral Health Services that these advisory committees serve a very important role in providing input from consumers and the general public about the division's programs and services; and second, the original name of what is now known as the State Advisory Committee on Problem Gambling and Addiction Services should be returned to its original name as it existed in 1996 in Nebraska Statute, Chapter 83, Section 162.01. The only current reference that be retained is the use of the word "problem" instead of "compulsive" which is now the nationally accepted word to define this addictive behavior. The original statutory definition of responsibility should be updated to reflect the changes in the funding sources and program activities of the Gamblers Assistance Program. Changes should always be

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given a chance to work but if they don't, the best thing to do is to accept the reality and be willing to turn the clock back. And I believe that that's what Senator Jensen and Jeff did by listening to the concerns of the chairs of the advisory committees and the council. I hope the Health and Human Services Committee will follow Chairman Jensen's lead and advance LB 1179 for debate by the full Legislature. I'll be happy to answer any questions you have.

SENATOR BYARS: Thank you for your testimony. Any questions? Senator Howard.

SENATOR HOWARD: Thank you. You gave such clear information. I really appreciate that. Was the original intent for this advisory committee to supply information on a regular basis to Health and Human Services, and then to receive feedback from Health and Human Services? You said you hadn't received anything from them.

SHERRIE GEIER: Prior to the...I was making a reference to the stated responsibility of the Behavioral Health Council to make those recommendations with the expectation that we were going to get feedback on whether or not the recommendations had been adopted or rejected. So there is a stated requirement that the Behavioral Health Council had that relationship and that responsibility. Prior to that, the give and take in the reporting of recommendations between the three independent advisory groups was far more informal. It wasn't stated explicitly.

SENATOR HOWARD: How many reports have you supplied Health and Human Services, if you know?

SHERRIE GEIER: Pardon? I'm sorry.

SENATOR HOWARD: How many reports have you supplied Health and Human Services?

SHERRIE GEIER: Well, we've met quarterly for 16 months. I would say perhaps in total we may have made one recommendation or two per meeting, so I don't do the math right but without the minutes in front of me, I'm not sure exactly how many. But I know that each time I watched the minutes to come back and see or I listened to the discussion

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at the council meetings about whether or not we've gotten any feedback. And to date I've heard and read of nothing.

SENATOR HOWARD: Thank you.

SENATOR BYARS: Thank you, Senator Howard. Any other questions or comments? Thank you very much for being here.

SHERRIE GEIER: Thank you.

SENATOR BYARS: Any other proponents? I don't think there were any. Any other proponents?

MELIA COOKE: Can I say one thing?

SENATOR BYARS: Yes.

MELIA COOKE: My name is Melia Cooke, M-e-l-i-a C-o-o-k-e. I didn't know until just now that I was going to speak but I am a proponent for LB 1179. And I would kind of like the name to be changed back to the Mental Health Planning and Evaluation Council for the State Mental Health Advisory Committee, just because all other 49 states have that name. Also, it shows more that it's about a planning group. Thank you.

SENATOR BYARS: Thank you, Melia. Any questions for Melia? She's gone. Thank you, Melia. Any other proponents? Any opponents? Anyone to testify neutral? Not seeing any, Senator Jensen waives closing. You have the Chair back.

LB 1035

SENATOR JENSEN: Thank you. The next bill to be heard is LB 1035 with Senator Synowiecki. Welcome, Senator.

SENATOR SYNOWIECKI: (Exhibit 1) Good afternoon, Senator Jensen and members of the committee. I'm John Synowiecki. I represent District 7 of the Legislature, and I'm introducing today LB 1035 for your consideration. It's a bill to change licensure requirements for alcohol and drug counselors. LB 1035 will allow licensed mental health practitioners to apply all hours of experience obtained

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while providing counseling services to individuals that are dual-diagnosed with a drug or alcohol dependency and with a mental health disorder toward the requirements needed to be licensed as an alcohol and drug counselor. Currently, only a portion of the hours obtained while providing counseling services to individuals that are dual-diagnosed can be applied toward the requirement needed to be licensed as an alcohol and drug counselor. As a public policy, we should encourage dual certifications of practitioners. Increasingly, professionals are recognizing the prevalence of co-occurring disorders. We need professionally trained counselors within our state that are prepared to be effective in treating individuals that suffer from both substance abuse and mental health disorders. The shortage of licensed alcohol and drug counselors was profoundly cited in the methamphetamine treatment study that was undertaken during the interim. Licensed mental health practitioners are highly trained professionals. LMHPs must obtain a master's or doctorate degree that consists of coursework in therapeutic mental health and includes a practicum or internship with at least 300 hours of supervised client contact. In addition, they must complete 3,000 hours of supervised experience in mental health practice with a minimum of 1,500 hours of direct client contact, and must pass a board-approved examination. I introduce this legislation to address difficulties experienced by a number of licensed mental health practitioners that were pursuing licensure as a licensed alcohol and drug counselor. Specifically, there is a question as to how the hours spent treating individuals with co-occurring disorders are divided in order to meet the requisite number of hours needed for LADC supervised clinical work experience requirements. It has been suggested that this issue may be a matter of conflicting interpretations of documentation required to have these hours recognized. I hope that we can get a concrete answer relative to this issue today at the hearing, and I urge the committee to advance LB 1035 so we can reduce the barriers to becoming a licensed alcohol and drug counselor in the state of Nebraska. Thank you, Senator Jensen and members of the committee, for your consideration.

SENATOR JENSEN: Thank you, Senator Synowiecki. Any questions from the committee? I do have a letter from Health and Human Services stating that they're not taking

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any formal position on LB 1035. (Exhibit 1) Any other questions? Seeing none, will you be here for the closing?

SENATOR SYNOWIECKI: I'll stick around.

SENATOR JENSEN: All right, good. First proponent, please, of LB 1035? May I see a show of hands for how many wish to testify on LB 1035? I see one, two. Could you please come up to the front so that we can make a quick transition? Welcome, Ms. Boye.

CAROLE BOYE: Good afternoon, Senator and Senators. My name is Carol Boye, B-o-y-e. I'm the executive director of Community Alliance in Omaha, and I come today to support this bill. I want to support the language of this bill in terms of its intent as we read it and as we've discussed it with the senator and with some of our colleagues. While I think there may be some question regarding the specific language that is in the bill versus what we need to do this, and I'm certainly going to leave any technical comments about language to people like the senator and like Jerome Barry who will speaking on this matter later...all of them are much more versed in the technicalities of this...but our support in relationship to the intent is based on two things. First, it recognizes where we are as a field, behavioral health field, where we're heading, and where we need to head. And that is recognizing dual diagnosis and dual competencies. Our profession has to go there. And we have to go there together rather than separate, sometimes equal, sometimes not equal, parallel tracks. Second, I believe that this bill is a response to what really, in all probability, is an administrative interpretation issue. And when we can't solve an administrative issue on an administrative level, we come to you for legislative intervention and legislative relief. What I mean by that, there is always a need to apply intent, purpose, and common sense when it comes to rules and regulations in the licensing and credentialing process. But sometimes it's hard to get through it even when we know that we have done everything we can to meet the intent of a standard. Let me give you an illustration that I'm actually more familiar with that Community Alliance is actually dealing with right now. Community Alliance has been providing day rehabilitation services, a behavioral health service, since

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1982. We've had it nationally accredited since 1992, well before the state mandated these services be nationally accredited. We're certified by the Behavioral Health Division to provide that service. A few years ago, and I suspect it came through this committee, we created a category called Adult Day Service, and said that these services needed to be licensed. The intent of that legislation was to license elderly adult day services. However, the way it was written, and we certainly didn't object to it, while it was focused towards the elderly and the regulations are focused toward the elderly, it was applied to all behavioral health day rehabilitation programs, including ours. The regs say for adult day services that there will be deemed status, meaning that we would be found to be in compliance with the regulations if we were nationally accredited. The program was, by CARF or JCAHO or a similar national accreditation. For three years now, Community Alliance has been denied deemed status for this program. The administrative interpretation of the regulations is that it's deemed status for people accredited at adult day services. Well, in the behavioral health world or in the CARF world, it's called psychosocial rehabilitation. Now we can't seem to apply common sense, interpretation, and intent to this. The result: We have duplicated oversight, duplicated audits, duplicated costs, and use of resources that we all know are scarce. Our alternative in this case is that we can appeal administratively, which we have done and not been successful. We could get accredited under adult day services as an elderly program and then get deemed status, but that's not the intent nor does it meet our professional standards, and so we've declined to do that. Or we could seek legislative remedy. Sometimes that's the only alternative available to us. My hope, with what Senator Synowiecki has introduced here, is that: a) it's recognized as a real one; b) we continue to move forward in terms of recognizing that we have got to move to dual diagnosis, co-occurring recognition within our field and within all of our rules, regulations, licensing, and credentialing; and that the issues that are being faced by practitioners out there, that we address them and that we hopefully can address them administratively. If not, we'll continue to support the last remedy known to us, which is legislative relief. Thank you for listening to me.

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SENATOR JENSEN: Thank you, Carol. Any questions of Ms. Boye? Thank you for your participation. Next testifier in support, please? Any other proponents to LB 1035? Opponents to LB 1035?

JEROME BARRY: My name is Jerome Barry, J-e-r-o-m-e B-a-r-r-y. I'm here representing myself as a licensed mental health practitioner and a licensed drug and alcohol abuse counselor, and also representing the Alcohol and Drug Licensing Board...I'm the chair of that board...and also representing NABHO, the Nebraska Association of Behavioral Healthcare Organizations in opposing this bill. I want to thank you, Senator Jensen, for giving us this opportunity, and thank Senator Synowiecki for bringing this forward because, as you've heard testimony already, I think through bringing this bill forward we've uncovered some inadvertent misunderstandings and miscommunications about the licensing laws and how friendly it actually is for LMHPs to enter and become licensed as alcohol and drug counselors. And I'm going to try to point those areas out for you today. First of all, I like to always remember in my role on the licensing board and when we're considering licensing laws that the licensing laws are there to protect the public. They're for public safety and those are their primary reasons. One of my largest concerns about this bill, if it would pass, is the inadvertent consequence that it would create. And I don't believe that the senator nor the constituents that encouraged this bill understood at the time the inadvertent consequence it would cause the licensing of alcohol and drug counselors across the state. We, being Nebraska, belong to an international certification consortium. It called IC & RC, International Certification and Reciprocity Consortium. We joined IC & RC along with 44-plus other states in the United States and several countries, I believe in 1993. Our membership with IC & RC allows licensed counselors several advantages. One is reciprocity with 44-some other states and several countries, so they could, for example, go to Missouri or South Dakota and apply to be licensed there and wouldn't have to jump through the different bureaucratic hoops to become licensed in another state. The reason why we put our licensing with IC & RC in jeopardy with the passage of this bill, is IC & RC has some minimal standards that you have to meet in

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order to belong and be a member. One of the minimal standards is 2,000 hours of paid work experience specific to drug and alcohol services and care. Another thing we would lose...and I believe, based on communications with the president of IC & RC, he's the president out of Canada for the current term, he interprets this bill to mean we would probably and more than likely lose our membership with IC & RC if this passes. Other than losing reciprocity, we would also lose the benefit of the written and oral international exams that Nebraska has taken since 1993, which we believe has really improved the competency of counselors in the field. Both of those consequences of this bill I don't believe were intended. I believe they were inadvertent but would possibly put some of our licensed counselors in jeopardy as we lose our membership with IC & RC. The other reason I'm opposing this bill is I believe, as Carol indicated, I believe the licensing board and the licensing laws as they are currently written have been friendly to the co-occurring disorders, have been friendly to LMHPs, I being one of those. Counselors who apply to become licensed as drug and alcohol counselors currently do not...if they do not hold a master's degree and the license as a mental health practitioner, they currently have to have 6,000 hours of paid work experience. We have reduced that in the statutes of Nebraska down to 2,000 for licensed mental health practitioners in order to make it easier for them to get into the field and to give credit for that license. So we have reduced it from 6,000 to 2,000. Again, 2,000 is the minimum that we can go and still keep our membership in IC & RC. The other thing that we have done for the LMHPs in our current licensing laws is reduce the number of core education classes from 8 down to 3, again to give credit for the good education that's received in their master's programs. The other thing that we've done, and this is the interpretation and the communication that I think this bill has brought forward, is we currently as a board will allow licensed mental health practitioners who apply to become licensed alcohol and drug counselors, we currently allow them to claim a percentage of their time spent in co-occurring work. And I will give you an example of that: If I worked, let's say, for example, at CenterPointe here in town, that's a well-known co-occurring program, and I worked there for a year and applied for my license, all I would need is to have my supervisor attach a

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document saying what percentage of that work was specific to the drug and alcohol work. Well, typically that's about 50 percent. So we're giving a 50 percent credit towards the work experience for those practicing co-occurring programs...and again, to encourage more people to get into the field. We have seen a huge influx of licensed mental practitioners into our field over the last several years because of the accommodations we've made. And I agree, we need more counselors. We're constantly holding oral exams, written exams, reviewing applications, and there are many people coming into the field. I think that's all I want to say, and that through my communications with some of the provider colleagues in the Omaha area, I learned that some of them were unaware that they could have applied some of those hours and it could have been considered for their licensing to be approved. And I think maybe, perhaps, the licensing board and regulation and licensure perhaps needs to do a better job of communicating that information out so that we don't end up in hearings like this trying to clarify what likely should be known out there in the field. I would be happy to answer any questions.

SENATOR JENSEN: Thank you, Mr. Barry. Any questions from the committee? Thank you for your appearance. Next testifier in opposition, please?

JACK BUEHLER: My name is Jack Buehler, J-a-c-k B-u-e-h-l-e-r. I'm here representing myself as a licensed drug and alcohol counselor, and also a licensed mental health practitioner. I'm also a nationally certified addiction counselor and a certified substance abuse professional through the national NAADAC. I am currently president of the Nebraska Association of Alcohol and Drug Counselors. I'm also regional vice president for NAADAC, the National Association of Addiction Professionals. I am here testifying in opposition to LB 1035. A lot of what Jerome said I would support. I'm someone who started out as an alcohol and drug counselor, did that for many years, and then went back to school to get my master's degree in mental health counseling. I've heard a lot of people relate that in their mental health counseling programs through the colleges, they get very little training or education about alcohol and drugs, specifically treatment. And as Jerome mentioned, with the master's degree we've already given

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those people 4,000 hours credit towards their alcohol and drug license. The very minimum is the 2,000 hours that he mentioned related to the IC & RC. The dual diagnosis and the purpose of the training hours is to be able to make sure that these people have the education, training, and competency to be able to treat addiction--alcohol and drug addiction. Even though many of the people we work with are dual diagnosed, it doesn't necessarily make people competent and it doesn't mean that it's appropriate that they treat that condition. I know for myself, for many years as a counselor I worked with people that I called dual diagnosis, and some of them had all kinds of different diagnoses. One I would like to relate to would be I've worked with a lot of people that have had diabetes. I can understand that a little bit and I can be supportive and encourage them to get the services they need and to take the treatment. Certainly if I went to medical school I doubt very seriously they're going to give me credit for having worked with someone with diabetes. And I kind of relate this as the same thing. I see it that it's very important, as one person mentioned, that we have people that are dually licensed and certified. I think that's very important but that people also be proficient and competent in what they're treating, so therefore I oppose LB 1035. I'm not real sure if there is a solution to some of the problems that they have as far as the mental health people other than going through the appropriate training. And that's all I have to add. Any questions?

SENATOR JENSEN: Senator Johnson?

SENATOR JOHNSON: Just a question. How many people have both drug and alcohol problems at the same time? What percentage?

JACK BUEHLER: That's a tough question. It depends on where you do your research.

SENATOR JOHNSON: Well, give me a ballpark figure. I have no idea.

JACK BUEHLER: Depending on the program, I would say it could be anywhere from 30 percent to 80 percent. Years ago they did a study and it showed about 80-85 percent of the

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people that were in these programs had dual diagnosis, mental illness, alcohol and drug problems. The problem with that study was it was done within a regional center population, so people use that number to say all programs have that kind of percentage. But the one program...

SENATOR JOHNSON: Well, from your experience.

JACK BUEHLER: It's a tough one. I mean it depends on the program and the clientele. I work with a men's residential program here in Lincoln and within that program it's probably 60 percent of the men that we get have, let's say, meth addiction and depression--a combination of things, yeah.

SENATOR JENSEN: Senator Stuthman.

SENATOR STUTHMAN: Thank you, Senator Jensen. Jack, how long have you been a counselor?

JACK BUEHLER: Oh, my. Let's see, 28 years.

SENATOR STUTHMAN: Okay. In that length of time, how successful have you been in...do people ever graduate from the addiction? Do they ever get cured?

JACK BUEHLER: No. There's no cure that we know of.

SENATOR STUTHMAN: There's no cure, so you just continue?

JACK BUEHLER: They recover in the sense that they're able to live a productive, law-abiding, tax-paying productive lifestyle. It doesn't mean that they are cured by any means.

SENATOR STUTHMAN: They never do get, you know, get cured from the addiction?

JACK BUEHLER: The only cure we know of is death, basically, from addiction. Now it's different with abuse. And a lot of time we tend to use those words to mean the same thing...substance abuse versus substance addition, two different things. People do recover and we could say are "cured" from substance abuse, but they still have the

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ability to choose whether they drink or use drugs or not. A true addict has lost that ability and he can't really control that.

SENATOR STUTHMAN: Thank you.

SENATOR JENSEN: Any other questions? Thank you for your testimony. Anyone else wishing to testify on LB 1035 as a proponent? Opponent? Neutral testimony? I don't see any. Senator Synowiecki waives closing. Senator Price is here to introduce LB 1132. May I see a show of hands? How many wish to testify on LB 1132? Okay, I see five, six hands, I believe. Welcome.

LB 1132

SENATOR PRICE: Good afternoon, Senator Jensen. It's refreshing to be here. The Appropriations room is like you're sitting inside of a convection oven, and so...

SENATOR JENSEN: It's cool in here.

SENATOR PRICE: nice to come in here where it's really cool.

SENATOR JOHNSON: We have cool heads in here, too.
(Laughter)

SENATOR PRICE: For the record, I am Senator Marian Price. I represent the 26th Legislative District, and I'm really pleased to be here to introduce LB 1132. LB 1132 is introduced at the request of the Governor's Youth Council. I have enjoyed working with this fine group of young people since they came to visit with me this past fall, and they will follow me as the first testifiers. LB 1132 mandates that all state social services be organized as family-centered practices. That's the title: family-centered practices. Those services are for families who have a child with emotional and behavioral disorders. You will be hearing it called "wrap around." In various states, they call it "wrap around" because the focus of the family-centered practice is the family. Family centered practice is a way of providing services. It's characterized by a list of concepts that I will give to you. Whatever it

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takes. Families does the primary decision maker for their children. Individualized plans, strength-based, flexible funding, no rejection, unconditional care. And I imagine there's love in there, too. Ideally, a family-centered practice would allow the family member, usually a child or a young adult, to be served at home. This would eliminate the need for a facility, which might be local or could be very far away from home. Many tax dollars could be saved. Nebraska has a version of family-centered practice. LB 1132 would expand the requirements of present law. I will be followed by Ishma. He is a young man who contacted me initially this fall. He is passionate about this bill. And I thank you for your attention and I would be happy to answer questions at this point. I will be closing if you wish to ask me then questions then also.

SENATOR JENSEN: Very good. Any questions at this time from Senator Price? I don't see any. Thank you.

SENATOR PRICE: Thank you.

SENATOR JENSEN: May we have the first testifier in support?

ISHMA VALENTI: Hello, everybody.

SENATOR JENSEN: Welcome.

ISHMA VALENTI: Thank you, Senator Jensen and the rest of the committee. My name is Ishma Valenti. I'm a member of the Governor's Youth Advisory Council whom I'm representing today.

SENATOR JENSEN: Will you spell your last name for us, Ishma?

ISHMA VALENTI: Oh, sorry. Ishma, I-s-h-m-a, Valenti, V-a-l-e-n-t-i.

SENATOR JENSEN: Thank you.

ISHMA VALENTI: Like I said, I'm representing the Governor's Youth Advisory Council today. I'm a family-centered practice trainer for CPS Eastern Division Board in Omaha, and I was a previously an intern at Nebraska Children and

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Family Foundations. What I came here to talk about first, first of all, I would like to open up with family-centered practices, like I said or like the Senator has said before, I'm very, very passionate about this. I have a lot of experiences in this and I'm very, very convinced that it is the best way to serve our clients who have behavior and emotional problems, through social services. In lots of cases, Nebraska or the Midwest has fallen behind the curve in social services reform, as Senator Byars told me before, but sometimes we get ahead of the curve. In the last couple of years, if you look at our progress with adopting America's promise, receiving exclusive federal grants for Health and Human Services for positive youth development, and by passing the Foster Care Bill of Rights last session. We have another chance to be before this curve with family-centered practice. I was at the Governor's convention for meth and steroids in the winter of 2005. We heard stats that 11 percent of meth addicts clean up or don't relapse, which is a very, very low stat, of course. I was also at CPS trainings all last year where I heard testimony from people like Maria Gomez who shared about her success with meth addicts exclusively. She talked about turning around four consecutive meth addicts who had meth use problems, had their kids taken out of her custody and put in the state's custody, and they have turned around in a matter of three to four months--four consecutive families turn around from that were previously meth addicts and have got their kids back and are living successfully now. Just some pinnacles of family-centered practice in the field. I was also at a Washington, D.C., conference this summer. I met a lady by the name of Linda Gallagher. She's from Pennsylvania. She was telling me about the evolution of family-centered practice or "wrap around," they call it, in Pennsylvania, where actually the social worker actually now lets the family make the plan in a room, the social worker leaves, they make the family plan with the family team, and then the social worker will come back, approve it or not approve it, and then they'll make changes accordingly. But it's just showing that the evolution of family-centered practice or "wrap around" throughout the country is rapidly transforming and rapidly, rapidly happening. It's a very, very accepted practice. On the Eastern world, they have been using it exclusively in New Guinea, London... apart from the USA. So it is very, very, world accepted as well.

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Other states in the U.S. that have passed legislation toward family-centered practice or the "wrap around" process are states like New York, California, Idaho, and Pennsylvania. To give family-centered practice in a nutshell, it's a common-sense, compassionate, and effective way to plan for a family to live a more healthy, happy, and responsible life that will result in them eventually being off of the system faster. This is what we want to make sure happens. Family-centered practice is executed by getting a family team together, picked by the family, consists of people of the community, extended family, and so on. The team would determine the family's needs. Then the plan will be made to meet these needs. If the need is like transportation, then this need will be delegated to an uncle or a grandmother or active grandfather than can take care of that task so the social worker won't have to. So as the plan is put together, then the plan will be made to meet the needs of the family on a daily basis, so they can have an outline of how to live successful lives. With a system like this put in place, it will significantly help our social workers because...well, we all know they're overworked, they don't have as much time. They're at about 22 families per case worker now. They're supposed to be at about 12. We suspect that with this process in place, it will significantly cut down their time that they have to spend with every family so they can get important things done that they have to get done. It'll also include not only the community but the family more in what the family decides and what the family does and is able to accomplish. Some of my favorite components of family-centered practice are it's individualized, meaning it is an individualized plan for every single client. No two clients are going to get the same plan. As you see kind of now in our system, we have an initial assessment person and a case manager and a case worker, and then sometimes the adoption process has different people that they send out. So it's a different array of people that get all this information, so it's a barrage of information with an array of people who get this information. Well, with family-centered practice it will be more individualized so we won't get the same as some people call it "cookie cutter" system for each family that just give out services. Instead it will focus on the needs. Another thing that I really, really like is normalization. This is a big key pillar to family-centered practice. It

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normalizes the situation. I say a lot: We can't expect children and families to function in normal ways if we don't put them in normal situations. Family-centered practices will help normalize all the family situations. When I was young I can remember my mother on the phone with case workers. She'd get off feeling belittled or degraded, be crying. And I'd wonder why is this happening? Why isn't the compassion there? Well, social workers, they see a lot of the same thing every day, and so they get conditioned to what certain terms are. They say they see a single-parent mother, doesn't have a job, so they throw services at her thinking that they've seen this before, they're going to do it accordingly to how it goes. Well, with this family-centered practice process put in place, it will be individualized so where we don't just see that single-parent mother and give them services but we actually are compassionate about this to sit down and get the needs of the family, and then a team developed around the family to meet those needs. This is going to save the case worker time and, of course, the state money. I would just like to touch on in a recent issue of Nebraska Connected, Mark Mitchell, the program coordinator of Positive Youth Development for Health and Human Services, is quoted in saying that family-centered practice is the most common-sense, practical, and the most effective way for the state to serve not only behavior and emotional problems with families, but all clients. If LB 1132 is passed, it will promote and encourage the use of family-centered practice in all social services systems throughout Nebraska, which the Governor's Youth Advisory Council not only believes is definitely pivotal to youth development, as well as Health and Human Services which is in support, from the people that I have talked to, from the advisors that I have spoken with and been at meetings with and presented for, as well as case workers throughout CPS and Eastern Division boards through Omaha, which have already started implementing this process into the regular trainings. But we need to be more widespread with this implementation. That is the conclusion of my testimony. Any questions?

SENATOR JENSEN: Thank you, Mr. Valenti. Senator Stuthman.

SENATOR STUTHMAN: Thank you, Senator Jensen. Ishma, first of all, I want to thank you for your testimony.

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ISHMA VALENTI: Yes, sir.

SENATOR STUTHMAN: And I want to thank you for getting involved as a young person and that you are seeing the values of a family. That's what I really appreciate in your testimony. And you're so excited about trying to accomplish that, I just wish we could clone you. (Laughter) But it really amazes me to see a young person like yourself and you're just so aggressive...

ISHMA VALENTI: Thank you.

SENATOR STUTHMAN: ...so thank you for your work.

SENATOR JENSEN: Senator Byars.

SENATOR BYARS: Thank you, Senator Jensen. Ishma and I had the opportunity to break bread together the other day, so we became acquainted, and I also am very impressed with your passion. I might tell you, Ishma, I passed a note to the youngest member of the Legislature telling him that maybe somebody is in line to take his place. (Laughter)

ISHMA VALENTI: I would hope so. Definitely hope so.

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

ISHMA VALENTI: Thank you.

SENATOR JENSEN: Next testifier in support please?

AARON WEAVER: First of all, let me say thank you for your time, Senators. My name is Aaron, A-a-r-o-n, Weaver, W-e-a-v-e-r. I work for an organization called Visinet, as well as being a family-centered practice trainer on the Eastern Board with Ishma, and very actively involved with an organization called Foster Youth Initiative. When speaking about family-centered practice, one word comes to mind and that word being "results." This method works because of several different components that are involved with it, possibly the most important being team develop...or, I lost my focus, sorry...this is a team-developed plan made by the

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family for the family and the community resources in order to strive toward specific goals set by the family for the family that work out to bring out the strengths of the family and rectify the weaknesses. This method is also flexible when trying to achieve these goals. If the team sees that the actions that they are taking are not making the needed impact, they will re-evaluate the situation and come up with a new plan that will meet the family's ever-changing needs. I, myself, was in the system for the first six years of my life, and was very fortunate to have a very good foster home that eventually became an adoptive home. I, however, was not very fortunate in that my needs were not met in the early years of being a part of the system. I ended up being very unsuccessful in school and in the community until my adoptive family actually were the ones that took the initiative to set up the resources that I needed. If I would have had family-centered practice implemented, I would have been able to become a contributing member of society much earlier in my life because my needs would have been met. And that, I believe, is the general goal of the system to create active members of our society who give back to the community. With family-centered practice, we will be more successful, compassionate, and most importantly, we will have results. We will have less families and kids that slip through the cracks. We will have less victims who end up completing the cycle of abuse and become victimizers themselves, and most importantly, we will have families that will stay as families and have the opportunity to become nurturing, loving, and understanding environments for their children. And that's all I have to say. Thank you for your time.

SENATOR JENSEN: Thank you. Any questions of Mr. Weaver? Yes, Senator Stuthman.

SENATOR STUTHMAN: Thank you, Senator Jensen. Aaron, thank you for testifying. You are a member of the Foster Youth Council, weren't you, I think three years ago.

AARON WEAVER: Um-hum.

SENATOR STUTHMAN: Three or four years ago you came to my office, and I really appreciate that. And I appreciate that you're using your experience to help improve society in the

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future. And I thank you for that.

AARON WEAVER: Thank you.

SENATOR JENSEN: Thank you. Any other questions from the committee? Seeing none, thank you for your testimony. Next testifier in support, please? I do have a letter from the Nebraska Nurses Association in support, and that will be entered into the record. (Exhibit 1)

KATHY DUNNING: (Exhibit 2) Good afternoon, Senators. My name is Kathy Dunning. It's K-a-t-h-y D-u-n-n-i-n-g. And I run the Family Resource Center where we help families of youth with behavioral and mental health issues find resources and supports in our community, but I'm not speaking on behalf of the Resource Center. I'm speaking as an individual. I have something to read to you, and I'm still going to read it to you but I'm really pumped by those last two testimonies, so I'm going to add to it. I wasn't going to get personal into my story but I want to give you a parent's perspective. We received family-centered practice "wrap around" services for our son diagnosed when he was in fourth grade with obsessive compulsive disorder and later with bipolar disorder. We went through five years where there wasn't a day when we could hardly breath. And by the time we got the services that they're talking about, we were down to the school offering us 40 minutes a day because he was such a mess in school; professionals saying, there's not another thing we can do, he's a very difficult case. We had already called to see what the process was to make him a ward of the state because he needed residential treatment long term. We were afraid he wouldn't live until he was 18. Our son never left our home because of this type of support and service. He is now 21 years old. He's in his third year as a plumber's apprentice, a productive tax-paying citizen, and any one of you would be proud to work at his side. So I'm very much into family-centered practice. But I came to ask a favor for a little bit of a twix in the terminology in it, so here I go. As a person whose family received family-centered practice services, I am a strong proponent of family-centered practice. While I greatly appreciate the intent of this bill, I have some concerns with the descriptive language. In the future, the language in this bill could be used to interpret the definition of

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family-centered practice. So I ask the committee to consider some changes to the wording to better fit with current definitions of family-centered practice philosophy and process. I am speaking from the perspective of a parent whose child received excellent strength-based services who was empowered to have her family as key players in that process and who desires for all families to experience the positive outcomes of family-centered practices. I have attached for you documents from the National Child Welfare Center for Family-Centered Practice and a copy of state of Nebraska statutes, Section 43-535. I wish to identify suggestions for four specific changes in the language of this bill based on these documents. I gave you a copy of that. I highlighted the lines I'm looking at. On line 7 it states that the "practice promotes counseling," which is...while counseling may be one of the services identified as part of the treatment plan, family-centered practice is the philosophy and process which is utilized with all identified services. The language is restricted to counseling when one of the goals of family-centered practice is to make each plan unique to each child. Line 16 states that they shall give the family a plan, and this is my main concern. In family-centered practice a team develops a plan based on the youth's unique strengths and culture. The key element in family-centered practice is the level of family involvement. It is well stated in the child welfare handout that I have attached for you, and I'm quoting, "Families need to be actively engaged in developing, implementing and monitoring the service plan." Current practices give the family a plan. Let us please use this opportunity to clarify how things are done differently in family-centered practice. Line 19 states that the plan shall be approved by the family. I have the same concerns as I just mentioned in line 16. Please include in that line that the family is the key participant in developing, implementing and monitoring the plan. And finally, on line 24, it refers to family-centered practice as a mandatory counseling service. Family-centered practice is a guiding philosophy and a process, a way of doing business. The statute I have attached states that the treatment program shall be designed to aid each family and the family unit by utilizing counseling and any other necessary creative treatment programs which are the least intrusive on the family unit yet serve to repair and strengthen such unit. I am asking

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that the language not restrict itself to just the service of counseling, however valuable it may be. I thank you for your consideration and I wish the committee well in the advancement of this bill, which I believe will better serve youth and families in our community.

SENATOR JENSEN: Thank you, Ms. Dunning. Any questions from the committee? Thank you for your testimony.

KATHY DUNNING: Thank you.

SENATOR JENSEN: (Exhibit 3) Anyone else wish to testify in support? I also have a letter here in support here from Colleen Wuebben from NAMI. Thank you.

TODD RECKLING: (Exhibit 4) 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, and I'm the administrator for the Office of Protection and Safety within the Department of Health and Human Services. I'm happy to be here today and testifying in support of LB 1132. LB 1132 describes the Legislature's intent that all state social service systems serving children and families follow family-centered practice in our work. We agree with the bill's definition of the principles of family-centered practice and with the direction to ensure by the Legislature's statement of intent that these principles are carried out in the future. Family-centered practice is a nationally recognized approach to working with families and is compatible with family policy objectives outlined in current statute. With the direction of Nancy Montanez, Director of the Department of Health and Human Services, the department has proudly embraced the principles of family-centered practice. Over 600 of our staff have received training and approximately 80 staff statewide have been trained as trainers to ensure continued training of staff in all areas of our work, including protection and safety. Our effort to incorporate the principles of family-centered practice at this point is focused on training related to cultural competency and case planning, as well as a review and adjustment to our policies and practices. In the near future we will also begin to work with family organizations and providers to ensure that the principles of family-centered practice are incorporated into

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the department's comprehensive service delivery system. We would suggest a minor amendment to LB 1132. I have provided you with a draft of that amendment, which would eliminate lines 23-25 of the bill. That section references family-centered practice as a service. While the principles of family-centered practice impact how services are delivered, family-centered practice in and of itself is not a service. We wholeheartedly support LB 1132 and urge your support of it as well. Thank you for the opportunity to testify today, and I would be happy to answer any questions.

SENATOR JENSEN: Thank you, Todd. You know, I do have a couple questions on the bill and maybe Senator Price can answer those. There are a couple mandates in this bill that until you read it, I hadn't noticed that. On line 13, "All behavioral health personnel, including but not limited to social workers, case managers, case supervisors shall be trained in family-centered practice." I don't know that...that appears to be a mandate, and then also you are eliminating lines 22-25; that also is a mandate. "Family-centered practice shall be a mandatory counseling service to families that have family members with behavioral health problems." We have a lot of other services out there but I don't know that we mandate this practice to all of those services, do we?

TODD RECKLING: I think, as you point out, there may be some opportunity for clarification. I think you heard in the testimony prior to me that this is not a direct service. It's not a direct counseling service. It is an approach. It is a philosophy. As you heard earlier through several testimonies prior to me, those kind of 12 core values, beliefs, and principles, are a comprehensive approach that guarantees individualization, team orientation, culturally competent. So I think that I will certainly defer to Senator Price's language. But I do think that there's, as we suggest, maybe some opportunity to make sure that it's not seen as a service.

SENATOR JENSEN: Thank you. Any questions from the committee? Thank you, Todd. Anyone else wishing to testify in support? Anyone in opposition? Any neutral testimony? Yes, Ms. Boye.

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CAROLE BOYE: My name is Carole Boye, B-o-y-e, with Community Alliance in Omaha, Nebraska. I can hardly believe I'm standing up here testifying neutrally on family-centered practice. From a philosophical standpoint, this is what everything is all about. But in follow-up, Senator, to some of the comments you just made, there are some mandates in there. And one which is of concern to us is the broadness of definition of any person who receives behavioral health services. Clearly this is a child welfare bill. As we read and others have read the definition of who it applies to, it would apply to any person including adults. Clearly, adults, consumer choice says they have the right to decide the philosophy, the involvement of families, the involvement of the treatment program. So it's a technical thing that we would ask that you clarify just to avoid that administrative glitch that I referred to earlier of what the intent is. Thank you.

SENATOR JENSEN: Thank you. Any questions of Ms. Boye? And I see that is under a paragraph that says "It is the intent that the Legislature..." so this is the intent. But anyway, we'll see what Senator Price has to say about that.

CAROLE BOYE: Thank you.

SENATOR JENSEN: Anyone else with neutral testimony? Senator Price, do you wish to close?

SENATOR PRICE: Senator Jensen and members of the committee, when I first met Ishma this fall can you see why I was entranced by all of this energy? I mean, he is very, very passionate about his cause. And then Mr. Weaver as a success story, then the mother of a consumer, and the gentleman from HHS, and then, of course, the comments by Ms. Boye. I have appreciated the testimony. I feel there's been a homework assignment been given to me, and we will put some things in writing and then respond to you tomorrow.

SENATOR JENSEN: Very good. And don't get me wrong: Nebraska needs "wrap around" services...

SENATOR PRICE: Yes.

SENATOR JENSEN: ...and I really do believe in that. And

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it's a good program, been proven elsewhere, and so I don't want to say, no. It's just that when we mandate certain things, sometimes that might be a little strong too. But we'll be glad to work with you.

SENATOR PRICE: And see, I am unclear, and I will find out, you know, to what level there has to be training in order to provide assistance in the "wrap around" services. And so I will learn from this also.

SENATOR JENSEN: Good. Any other questions of Senator Price? Seeing none, thank you.

SENATOR PRICE: I thank you. Thank you very much.

SENATOR JENSEN: That will conclude the hearing on LB 1132.

SENATOR BYARS: We will now go to LB 1233. Senator Jensen to present.

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SENATOR BYARS: I might mention, as we like to remind our testifiers, it looks like we have a number of testifiers. We have a list of testifiers that has been given to us. Please try to keep your testimony appropriate. Don't be redundant. Confine it to the facts, please. And we appreciate your cooperation, and we can hear your point of view, and we take it very seriously. But we don't need to hear it more than an couple of times. Senator Jensen.

SENATOR JENSEN: Thank you, Senator Byars and members of the Health and Human Services Committee. For the record, my name is Jim Jensen, representing District 20, here today to introduce LB 1233. LB 1233 was brought to me by the Traumatic Brain Injury Advisory Council, a group of concerned citizens who want to assist persons with traumatic brain injury and their families to receive necessary services and supports. The work of the TBI Advisory Council first started as a grant-funded activity in 1999 with the passage of LB 519. I believe that was by Senator Lynch way back then, if I remember right, and the Community-Based

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Neurobehavioral Action Plan Act. Pursuant to the act, a state TBI plan and statewide needs assessment was completed. The bill contained legislative findings related to the need for further consideration of a plan and needs assessment and further integration and coordination of public and private funding services and supports for persons with TBI and their families. The bill requires that the Department of Health and Human Services and the Nebraska Traumatic Brain Injury Advisory Council to jointly provide a development of a comprehensive implementation strategy for the integration, coordination, funding, and publicly funded services and supports on behalf of persons with traumatic brain injury and their families. The strategy must be submitted to the Governor and the Legislature by December 1, 2006. The bill creates a Traumatic Brain Injury Trust Fund for the purpose of supplementing existing resources for families and supports for families with traumatic brain injury and their families to prevent the need for more intensive and more costly services and dependence on publicly funded services. The fund would be administered by the department in consultation with the council. The bill terminates on July 1, 2007. In my discussions with the leadership of the council, I have indicated that an appropriation of \$500,000 would be requested for the trust fund. I'll let others speak to the need of legislation and the purposes for which the money in a trust fund would be used. We have seen in various ways that persons with brain injuries don't always fit neatly into that particular category or surface definition--not necessarily in DD, developmental disabilities, also not in mental illness. The members have told me that it would be helpful if services were better coordinated between the behavioral health and the developmental disabilities system to better assist persons with TBI. Often their needs are very complex and involve multiple issues and various types of services. I want to thank you for your careful consideration to this legislation, and will look for the testimony of those following me. Thank you, Senator Byars.

SENATOR BYARS: Thank you, Senator Jensen. Thank you for limiting your testimony and setting a good example. We appreciate it. (Laughter) Any questions of Senator Jensen at this point? I presume you reserve the right to close. We do have a list of testifiers that has been submitted to

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us, and it is the rule of the committee that we take those individuals who have been submitted to us first. The first ones on that list will be Cindy Fisher and Mark Schultz. I see that everybody's testifying in tandem, so please come up and if you're testifying at the same time, give your names for the record and spell them so that we have an appropriate record. And I see one of my constituents is at the bottom of the list. She's going to be very upset with me, I'm sure. (Laughter) Welcome.

CINDY FISHER: (Exhibit 1) Hello, my name is Cindy Fisher, Cindy, and then F-i-s-h-e-r, and I am from southwest Nebraska between North Platte and McCook. There are several of us who are here that support LB 1233, and we are wearing green ribbons to represent growth for the survivors and family members of traumatic brain injury. I want to set the stage for this bill by telling you my story. I became involved with traumatic brain injury when my son, Michael, acquired a brain injury from an infection, which led to a stroke. He was 10 1/2 years old at this time. We as a family were comfortable in the way our lives were. Little did we know that our lives would take a really sharp detour. Even though I am a registered nurse, I found out that I really did not know anything about traumatic brain injury. When attending several workshops to learn more about brain injury, I met a large number of survivors and family members who were going through what we were. I then became involved with the Nebraska Brain Injury Association which led to the Advisory Council and then, this past year, chairperson for the Nebraska Traumatic Brain Injury Advisory Council. The road on which our family is traveling has not been any easy one. All areas of our lives as a family have been changed and continue to change. Michael's brain injury has had an outreaching effect on all of us, from us as parents, Michael's sister, grandparents, aunts, uncles, cousins, and into the community. I could tell you how Sarah, his sister, kept waiting for Michael to come back to be normal, and having to start family counseling. How frustrating it was for Michael when he reached junior high and all of his friends did not want to be around him anymore, and how Michael did not want to go to prom because "no girl would ever want to go out with me." Also the frustration of the teachers that they had when Michael would fall asleep in their classes and be too tired to do his homework. But

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Michael is doing better. I want to tell you some of the successes that Michael has had with the services he received and is continuing to receive. Michael received rehabilitation services at Immanuel in Omaha for speech, physical therapy, and occupational therapy after his stroke. And the speech continued on when we came home. Michael is able to speak plainly and has learned to adapt when he has trouble finding the words he wants to say. This is Michael's graduation picture. I invited Michael to come and sit with me but he still does not feel comfortable being in front of people he does not know, but maybe next time. Nine months after Michael graduated from high school he was able to go to Quality Living in Omaha for some more intense rehabilitation. During this time, he started to feel more comfortable around people, started to talk more to people he did not know, and gained some self-confidence. This helped because the staff was trained and knew how to deal with head injury survivors. Michael now jokes and seems to be happier with who he is. At this time, Michael is unable to live alone because he has several cognitive impairments and experiences seizures as a result of this stroke. He is now living at assisted living at Quality Living and is working four hours, two days a week, at Hy-Vee as a dishwasher. He is responsible for washing his own clothes and keeping his room picked up and clean. These successes were and are possible because Michael qualified for Medicaid and Social Security income and the services that were accessible through this qualification process, along with the disability policy on our private health insurance. And I want to thank this committee for making these services possible. Michael is now 22 years old and trying to find where his niche will be in the work force and what his future is going to hold for him. He lives 275 miles away from home. There is no other option available to him at this time to live closer to home, if he wanted to. His goal is to eventually live in his own apartment and find a job where he can be around people. His goal will only be accomplished with the further integration and coordination of public and privately funded services, and have the supports more effective and efficient. For example, the community-based services, the education of employees on traumatic brain injury, and the collaboration of our existing services. I feel that this bill would save Nebraska money in the long run by helping Michael to be a

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more self-efficient young adult and productive citizen in Nebraska. Thank you.

SENATOR BYARS: Thank you, Cindy, for your testimony. Very handsome young man.

CINDY FISHER: Yes, he is.

SENATOR BYARS: Any comments or questions? Senator Johnson.

SENATOR JOHNSON: Well, I wanted to say one thing, and I think it probably will apply to everybody. You know, one of the things that Tom Osborne, when he was a coach, always talked about was not winning the game but using what abilities you had and then getting as much out of the ability that you do have--and that's winning. I think we're probably going to see quite a few examples of that today, and obviously you two are pretty good winners in your own right.

CINDY FISHER: Thank you.

SENATOR BYARS: Thank you, Senator. Any comments for Cindy? Thank you. Mark?

MARK SCHULTZ: (Exhibit 3) Good afternoon, Senator Byars, Senator Jensen, and members of the Health and Human Services Committee. My name is Mark Schultz, M-a-r-k S-c-h-u-l-t-z. I'm director of the Assistive Technology Partnership in the Nebraska Department of Education but I'm here today as a past chair and current member of the Traumatic Brain Injury Advisory Council. Twelve years and one day ago, I was testifying before the Education Committee on the need for services for people with brain injuries. At the time, there was a lot of agreement that there is a tremendous need for services and funding for those services for people with traumatic brain injuries. We were asked, what kinds of services do you need and how many people need them? And we couldn't answer that question 12 years ago, but I'm here today to talk about the need for those services and to answer some of those 12-year-old questions. In 2000, Nebraska received some federal funds to do a statewide needs assessment and then to use that to develop a state plan for services for people with traumatic brain injury. We went

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through a survey process, interviews, public forums, and gathered a lot of information from people with traumatic brain injuries, their families, service providers, as well as key informants from public agencies. With that information, we developed a state plan. The state plan was based on three major findings. The first one was there was a lack of awareness and information about brain injury and about brain injury services that were available in the state. The second major finding was there was a lack of community-based services, people that had the trained skills and knowledge about the specialized services needed for people with brain injuries. And then third, we saw that there were a lot of people with brain injuries who were falling through the cracks of the existing system. And there were a number of reasons for that. They may qualify for services but the menu of services available didn't include those specialized services or, for the most part, they didn't fit that categorical definition of eligibility that was necessary to get those services. So knowing what those findings were, we developed 14 recommendations in the State Plan, which is in front of you, hopefully. Within that, we've made a lot of progress. A lot of the recommendations have been implemented. For example, it was recommended that we have a single point of contact so that individuals would know where to get information on brain injury services. That's been implemented through the hot line for disability services. We now have a statewide brain injury network comprised of individuals with brain injuries, as well as their family members. And they can provide information to individuals within their community, as well as share information among each other. We also have increased training to agencies and providers staff, so that they are more knowledgeable people about how to serve people with brain injuries out in the communities as well. Through all of that, there has been increased coordination of existing services primarily through the partners under the federal grant, which is Health and Human Services, and then in education, Special Populations and Voc Rehab. However, in spite of all that progress, there is still a need for funding for community-based services. In my written testimony I have a list of those services and you'll hear more information about the specific need from other testifiers so I'm not going to go into detail on that, but just to let you know, we can now answer that question, what

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are the services that we need? We know what those are, what's missing within existing programs, as well as for those individuals who aren't qualifying for those services. We also know that, just as you heard testimony earlier today on some of the mental health issues, that if early intervention is provided through, in this case, through the fund which would provide limited financial support for community-based services that can help prevent reliance on public funding and the need for long term public assistance by preventing institutionalization, homelessness, and other secondary effects of brain injury such as depression, poverty, and crime. So just as within mental health, the same kinds of issues exist for people with brain injuries, and the same solutions could exist. We also now know how many people we're talking about. In 2004, Hanna:Keelan Associates conducted a study that, in part, was to determine how many people had a need for services. And it found that 37,000, more than 37,000 people with brain injuries had a need for some level of support. Some of those individuals were receiving assistance through existing programs and were able to get their needs met. But there were 14,363 people that still had an unmet need for services, and those are the people we're talking about. It was estimated at the time that the cost of providing those services on an annual basis would be \$150 million. Now LB 1233 isn't going to be able to meet the needs of every one of those people. However, since 1994, we've come a long way and we have a lot of information. And we know a little more about who needs those services and the kinds of services that they need. LB 1233 is going to be a good first step to addressing the needs of a lot of the people with traumatic brain injuries. I would be glad to answer any questions.

SENATOR BYARS: Thank you, Mr. Schultz. Any questions? I think I remember very well back to 1994. I thought that was my last year in the Legislature. (Laughter) Now this year I think it is my last year. in the Legislature. (Laughter) Thank you very much. No further comments? Thank you for your testimony. The next testifiers: Lorie Regier and Missy Nelson. Welcome.

MISSY NELSON: Hi. I have to get my glasses adjusted.

SENATOR BYARS: Take your time.

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MISSY NELSON: (Exhibit 3) My name is Missy Nelson, M-i-s-s-y N-e-l-s-o-n. I'm from McCook, Red Willow County. Thank you for hearing my testimony today. Five years ago, my husband, our two children, and I were headed for Greeley, Colorado, on Interstate 76 when a passing car struck us. We spun as if we were on ice, rolling the vehicle, and landing in the median, forever changing our lives. Our 17-year-old son, Blake, who at this time continues to recover from the traumatic brain injury he sustained in the accident. Because of early intervention, it is hard to believe he has made the progress he has compared to just five years ago. The accident left him cognitively blank. It was as if somebody went in and stole his memory chips. His reading, writing, numbers, math, colors, days of the week, money, you name it--everything gone. He was also left unable to walk, talk, go to the bathroom, feed himself. It was like having a brand new baby in a 12-year-old body. After seven weeks of early rehabilitation in the hospital, we were able to take him home walking, talking minimally, feeding himself, potty trained, and from there somehow we had to figure out what to do next, as many families today do. Fortunately, because McCook has some wonderful people in it, I had two trained professionals agree to help Blake. The one was a teacher trained in the area of special education and even had prior experience with traumatic brain injuries. The other was a speech pathologist for the school system who, too, had experience with TBI. These ladies worked incredibly hard and dutiful every day from the minute he got home from the hospital. As trained professionals, they had many ideas, methods, and strategy. However, we were seeing no progress. In a year's time he was virtually the same cognitively as the day we brought him home from the hospital. So I began to search other alternatives and found a place in Ogden, Utah, called NACD, the National Association for Child Development. Now this is what I really need you to hear and know today, is in the first year of getting proper intervention for Blake, we went from this nothing state to a second grade level. And now he is currently at a sixth to seventh grade level in less than four years. This is with the same professional teachers but with the guidance and direction of a brain expert. The interesting thing is that they were using many of the same methods but we just needed to do it in a strategic way. The

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point I am here to make today is early intervention is vital to a person with TBI. Whether or not we want to face it, typically our school systems are not set up to handle this type of special need. Mr. Bob Doleman, our brain expert, has been doing nothing but studying the brain nationally and internationally for 35 years. I couldn't expect a teacher to know and have the same expertise that he has. It would be like going to a family physician and asking them to do a heart transplant on a child--it's just impossible. I know without a shadow of a doubt, Blake would not be here today if it were not for the intervention that we got for him four years ago. How many people out there today need this type of help and are deprived because of the lack of funds? Do I want Blake on public assistance for the rest of his life? No. Do you want Blake on public assistance for the rest of his life? No. It's no different than us going to the doctor or the dentist to prevent disease and cavities; it prevents the big bills later on. Let's put this thing into perspective. If we spend a little bit now to help these families, how much will we save in the future because they are able to live independently. I believe lower taxes are on the mind of every citizen. Let's give these people hope by investing in their future and allowing the Brain Injury Trust Fund to become a reality. Thank you.

SENATOR BYARS: Thank you.

MISSY NELSON: Do you have any questions?

SENATOR BYARS: Any questions? Comments?

LORIE REGIER: (Exhibit 4) I'm Lorie Regier, and I'm here testifying for the Traumatic Brain Injury Council, the Developmental Disabilities Planning Council, and also as the mother of a survivor. My son, Adrian, and my husband are right back there.

SENATOR BYARS: And Lorie, could you spell your name for the record, please?

LORIE REGIER: Sure. Lorie is L-o-r-i-e, Regier is R-e-g-i-e-r.

SENATOR BYARS: Thank you.

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LORIE REGIER: I have a letter here from the DD Council for each of you. Adrian was injured when he 17 at a high school football game. It was probably about six years ago that I was here testifying in front of most of you for a traumatic brain injury bill. I don't remember exactly which one it was. I think it was to get it started, the planning and the council and all, and I think it was about six years ago. Anyway, we have been working really hard, as Mark has told you, and I'm really excited about all the work that we have accomplished because we are ready to answer a lot of those questions like, you know, what exactly is the need and how many people are there? I want to tell you a little bit about where we've come with Adrian because I think it helps understand the needs of people who don't have what Adrian has. Adrian, of course, has a severe injury in that he cannot speak, he cannot see, and he cannot walk, he cannot feed himself. But Adrian is a very kind, compassionate, loving, intelligent, God-fearing man. And for anyone who takes the time to get to know him, he inspires everyone. He is a great blessing to all of us, and we are honored to be his parents and care for him in his home. He requires 24-hour care, and the reason we are able to take care of him at home is because of Medicaid and some health insurance--or actually, it's a catastrophic insurance through the school--and lots of prayers and a team effort of people--his grandparents, his sisters, myself and Adrian's dad, and some neighbors and friends that all help us. So it's like the perfect...well, not quite perfect but as perfect as it can be, community-based services. And I want to personally thank all of you for anything that you've done to help those kinds of resources be there because what it has done for my family is keep us together. My family is strong. We have four daughters. They're all in college. One is in master's degree and working there. The other three are all going to graduate from college and be very full, productive young ladies. So, I'm like Missy, you know, the funds it takes to take care of Adrian are a fair amount. It takes some money to take care of him but Ron and I are still working full time, and all these girls will be in...you know, it's kept our family together. We are just so thankful for all of that. We know that God has been a great part of our effort, and so along with His providing, you all and the state of Nebraska has certainly done its share. But not all families

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are so fortunate. Each person with a brain injury recovers differently, and we feel really strongly that a system needs to be put into place in Nebraska that will address each need, each person as they are. A lot of people can walk and talk and dress and feed themselves but maybe they have severe depression; maybe they can't work; they have a lot of trouble with relationships or aggressive behavior. I know a man in our local community, he sustained a brain injury three years ago. We have had him come and work for us for a short time. He is unable to work unless he has a partner right there telling him what to do and keeping him on task. His family has now been reduced to a poverty level status, and they are getting minimal services. From what I know, they're getting a little bit of help on some counseling sessions through Medicaid. His family is really struggling with how to cope. And, you know, I don't know what to tell them, what can they do. Another young man in our community...and I'm from Perkins County, so we're about 2,000 people or a little more...he sustained a brain injury when he was still in high school, a year after Adrian was injured actually, and this young man is working at a local store part-time. He would have been able to go to college and live a normal life with a good job and friends but he lives near his parents and works at a nearby town with minimum wages. He struggles to work enough hours to pay his small bills but he is exhausted before the full day is over. I talked to his mom right before we came, and she said if he could work 20 hours instead of 40, he would be so much better off. If his parents were not there helping him, living right next door to him and seeing to the rest of his needs, he would not be able to live independently. So as I think about that, I wonder how could we come alongside this young man and give him a little bit of assistance, so that he can stay living independently and develop more friends--maybe even go back to school and get a better job. I think that young man is capable of that if the right resources are in place. And at this time, this young man gets no services--not anything from anybody but his family, no SSI, nothing. LB 1233 is a bill that would enable Nebraska to start to meet the needs of many of the unserved Nebraskans with brain injury. Please consider seriously the great needs of brain injury survivors and their families and pass this bill.

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SENATOR BYARS: Thank you, very much. I appreciate your testimony, Lorie and Missy. Any questions from the members of the committee? Thank you very much. Our next testifiers are Peggy Reisher and Jo Kelly. And let the record reflect that we've received a letter from the Nebraska Planning Council on Developmental Disabilities in support of LB 1233. (Exhibit 4)

PEGGY REISHER: (Exhibit 5) Good afternoon, Senator Jensen and members of the HHS Committee. I'd like to thank you for this opportunity to speak in favor of LB 1233. My name is Peggy Reisher and it is spelled R-e-i-s-h-e-r; first name is P-e-g-g-y. I've been a social worker on the Traumatic Brain Injury Unit at Madonna Rehabilitation Hospital for the last 9 years. I have worked with hundreds of patients and families, young and old, whose lives have been completely changed by the effects of brain injury. After a severe brain injury, the simple things that we take for granted every day can be stolen in an instant. Physical difficulties range from not being able to walk across the room to use the bathroom, to not being able to stand at the kitchen sink to get a drink of water. Cognitive difficulties range from not being able to remember a headline you just read in the newspaper to not being able to make yourself a grilled cheese sandwich. Because of the many experienced cognitive deficits after a severe traumatic brain injury, it's rare to be sent home from our hospital without the need for 24-hour supervision. For many families, it's not financially feasible to quit their jobs to provide that 24-hour supervision after the patient discharges from our hospital. House payments, car payments, and other household expenses continue to stack up, even if the medical bills are initially picked up by the insurance companies. Insurance rarely covers in-home caregivers who could stay home with the patient while the family is at work. Insurance companies are shortening the amount of time a person remains in the hospital. The average time a person stays on our acute rehab unit at Madonna is 23 days. This is a week shorter than what it was just three years ago. We noticed that usually means that people are discharged home at a lower level of functioning than what they were three years ago. If LB 1233 was passed, the bridge fund could help patients and families pay for caregivers or help absorb other expenses in their time of crisis after discharge from

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the hospital. If families could afford to stay home with their loved ones for a short period of time, this would also cut down on the number of patients we have to send to skilled nursing homes because families financially aren't able to provide the supervision. Most insurance companies offer a short skilled nursing home benefit. Once the benefit is exhausted, families are faced with decisions of either taking the patient home or paying for the nursing home, privately. Most can't afford to pay for nursing homes privately, so Nebraska Medicaid becomes the primary payor source. Brain injury affects people of all income levels and all walks of life. On our unit at Madonna, the primary payor source is private insurance and Medicaid. Occasionally we have patients that don't have insurance or limited insurance coverage who are not eligible for Medicaid. This typically is middle-class Nebraskans who have worked and saved for their retirement or who have small family-run businesses such as farming. Because of Madonna's not-for-profit status, we have the limited ability to provide charity care for these individuals. This, of course, works while the patients are receiving services at Madonna but once the patient discharges to outstate Nebraska, services might stop because no insurance coverage is available. If LB 1233 passed, it may open up the opportunity for those with limited or no insurance coverage to get services for a short time in their hometown area. These are just a couple of examples of how I feel LB 1233 could benefit Nebraskans with brain injury. Thank you for your time and I ask that you pass LB 1233. Do you have any questions?

SENATOR BYARS: Thank you, Peggy. Any questions or comments from the committee? Thank you for your testimony. We appreciate it very much. I presume Jo Kelly is not here?

_____: No, Jo Kelly is...Matt Dorothy is taking his place. We're going to have Mary Ann Mertz testify first, and then his testimony will make more sense.

SENATOR BYARS: Okay. Fine.

MARY ANN MERTZ: (Exhibit 6) Good afternoon, Senator Jensen, Senator Byars, and everyone. My name is Dr. Mary Ann Mertz and I serve as director of the Brain Injured Pilot Program

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at Goodwill Industries of Greater Nebraska in Grand Island, Nebraska. I reside in Kearney in Senator Johnson's district. I am here really to speak on behalf of myself as a private citizen, someone with a long passion for working with individuals with brain injuries. For the record, my doctorate is in education with a master's in neurological nursing. Brain-injured consumers have historically not been well served through existing services as demonstrated in the state plan and state services needs assessments, which other have referenced and which is referenced in the bill. Beginning in July of 2005, two pilot programs were funded by a grant from the Department of Education in partnership with Vocational Rehabilitation to identify ways to better serve these individuals. These two pilot programs were at Goodwill Industries of Greater Nebraska in Grand Island, where I'm currently employed, and Developmental Services of Nebraska with an office here in Lincoln and services throughout the state. The purpose of the pilots is to explore what it will take in the way of services and supports for individuals with acquired or traumatic brain injuries to obtain and maintain employment, be that supported employment, competitive employment, some sort of employment. I'll reference and talk a little bit about the Goodwill program first. The Goodwill program focuses on individuals living in or desiring to live in, and I stress "desiring" to live in, a community setting and outside of a hospital where a higher level of residential service setting. The DSN program focuses on individuals currently receiving services through DSN and who also have a developmental disability. In the six months since the Brain Injury Pilot began at Goodwill, I have learned firsthand the many challenges facing the brain injured in the state of Nebraska, specifically those who live or desire to live in the more rural areas of the central or western part of the state. Having a need or willingness to work, simply is not enough. Basic services such as housing, which is necessary for prework stability, or transportation which is necessary to get to and from work, are extremely difficult if not impossible to locate. Other pre-employment needs such as transitional income and medical care can prove very difficult to acquire. Programs to provide socialization and prework day services are lacking. Should the individual somehow qualify for services within an existing system, such as Voc Rehab, Developmental Disabilities, or Behavioral

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Health, those programs are not tailored to the needs of the brain injured. Professional staff in these programs, no matter how hard they try, simply are not trained to work with the brain injured. They are trained to work with other populations. And they rarely possess the specialized knowledge and expertise, let alone the extra time it often takes to work with the brain injured in order to have successful outcomes. Many individuals and families simply give up and resign themselves to their current situation. The pilot programs will allow us to enhance services for a limited number of individuals with brain injuries for a limited period of time. In so doing, we will have a much greater understanding of what it will take to better serve these individuals and allow them to return to more productive lives through work. While both of these outcomes are very wonderful and important and can contribute much to decisions about future services, the scope of the pilots is limited in terms of dollars, clients served, and time span. Nebraska needs a more comprehensive plan for the future...and I quote from the bill..."to develop, implement, integrate, and coordinate future plans and activities." Thank you very much for taking the time to hear my testimony.

SENATOR BYARS: Thank you, Doctor. Any questions or comments for Dr. Mertz? If not, Matthew, you're next.

MATTHEW DOROTHY: (Exhibit 7) I am Matthew James Dorothy. I would like to share my story. I was riding a bike, racing, and I got ran over. I won. I was eight years old. I got a brain injury. My life was awesome before the brain injury. After the brain injury I was trying to walk, talk, and eat, and I finally did. I lived in the regional center for about 13 years. They had bad food and talked to me different. It made me feel mad. I never want to go back. Life got better when I came to DSN but I wanted a job. I had a hard time getting a job because I was sleeping. The activities weren't really what I wanted to do. I have been angry, angry, angry, so angry. Then Jo came and helped the staff better understand how to support me. Jo is the director for the Brain Injury Pilot Project at DSN. I told Jo that I wanted to be a chef so I am volunteering in the kitchen at Southeast Community College. And then I am going to get a paying job. That paying job makes Matthew smile. I want to

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live in my own house. I want a family. More support will help me do what I want to do. Please say yes, oh, please say yes to money to support brain injury people. Thank you for the time.

SENATOR BYARS: Thank you, Matthew.

MATTHEW DOROTHY: Um-hum.

SENATOR BYARS: You did an excellent job. We don't ever want you to go back either.

SENATOR BYARS: Any questions for Matthew? If not, thank you, Matthew, for your testimony.

MATTHEW DOROTHY: Um-hum.

SENATOR BYARS: Thank you, Dr. Mertz. Jo, are you going to testify or not?

JO KELLY: No, Matt took my place.

SENATOR BYARS: He did an excellent job. Eileen Currey? Not here. Pat Stear and Deb Biesecker? If I brutalized your name, I apologize.

DEB BIESECKER: Perfectly correct. My name is Deb Biesecker, spelled B-i-e-s-e-c-k-e-r. I received my head injury four years ago in a rollover car accident on my way to work. It's taken four years to finally be able to verbalize and I'm going to try to read this.

SENATOR BYARS: Take your time.

DEB BIESECKER: Finally I'm ready to tell some of the difficulties I have. First, I use this Word program to type my letters, as it helps with spelling. I wish I could find a way to verbally communicate. Actually I wish I could remember what I'd said after I said it, so it's simply much easier to be silent. I sometimes try to cook but...like last night I was cooking pork chops and I thought I needed to turn them down. Actually, I turned them up. They were very cooked by the time I looked at them. I still try to cook but only simple things. I used to be a very good cook.

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As for my relationship with my spouse, I tell him no when I mean something else, so he simply avoids me. It drives him crazy when I forget to turn off the light when I leave the room. I can turn the light on. I can let the dog out. But I forget to turn it off when I let the dog back in or I forget to let the dog in. I have become separated from my family, as my mother does not understand my feelings, so I simply do not talk to her or my aunts. The simpler my life now, the better I tolerate it. Never in a million years would I have thought I could be so lonely but that's what a brain injury truly does for you. I choose to stay home as to ask for help. That I hate to do. Trying to simply talk to people is difficult. A few days ago I was where there were some friends, I started to say something and I was told I had told them the same thing the day before. Well, I do the same thing to my spouse. I tried to tell him what I've heard and he tells me I've already told him or am I sure it's true? Like the last time I was in Grant, I came home and I told him friends had been in an accident and James Harms had been called to drive the bus. He said, "Who?" I asked who I had said, and he repeated and said. Then I told him I meant James Deaver. He said, "Now that makes sense." I sometimes forget to turn off the stove. I sometimes forget to turn off the oven or unplug my electric skillet. I was at work at the vet clinic where I work part time. I was trying to clean pet pens. I took a dog to the back room but I forgot to pick up the trash and, of course, whatever he didn't eat was all over the floor. Even a dog is at risk in my care. My poor dog, I have forgotten to feed him for days, as I can't remember to check the bowl. I've left him outside in the yard, in the hot car. Well, you can tell he's also at risk. Yes, I started I go to sleep about 9:00 p.m. and I wake in the night between 1:30 and 3:00 a.m. Sometimes it's because I have shoulder and neck pain, which I've had since the accident, sometimes I think it's because it's morning. I normally cry at least twice a day, usually in the middle of the night when there's no one to watch. Sometimes I go to bed as early as 6:00 p.m. if I'm tired. I try to sleep when I can. Yes, I'm okay because I believe that since I believe in God, he will take care of me. So whenever I get upset, I often pray. Now that's the best I can do to tell you some of the things I deal with daily. Some days are worse than others and I don't think "poor me." But I've always tried to do my best. And, yes, I saved this

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letter on the computer so that I could re-read what I had written and look for errors before mailing it. It took me four days to write this letter. Now, as for my bank account, I have copies of checks because I can't keep track of what I've paid and what I've not. And if I have cash, that complicates my bill paying because I can't remember what I've paid cash for and what I've written a check for. How it all works is really a miracle. But I seem to manage at home. I just write things down in a book that I need to remember. But when I look for the book, I can't find it. No, I shouldn't drive. It's not safe because I can't keep track of the other traffic or the truck coming at me that doesn't stop at the stop sign or the fence or the trash can or whatever else is outside my immediate vision, or to turn my blinker on when I need to turn. Most of the time, I never leave the city limits, village limits, unless I'm walking my dog. Thank God I have my feet to walk with. If I do laundry, I forget to put the clothes in the water after I've turned it on or I forget I've washed and they sit in the washer for days. I leave them in the dryer and don't turn it on or I put them in a basket or on the couch and they never get folded until they're wrinkled. And the SSI government thinks I could work in a laundry. I do not get any state help. I get started thinking of something like company coming or today I'm going to try to vacuum the house. Well, I might get the inside path vacuumed but I never get everything put away. I've put things in the trash I need to keep. I've kept things I needed to throw away. I forget that today is the 9th and the light bill is due on the 10th. Most of the time I have no idea what time it is or what the day is. If I turn the water on outside, I forget it is on. Or if I plant flowers, I forget to water them. Or if I need to weed, I think if I work in an area of 3x3, I can succeed. This is truly the length of my attention span per project. Trying to remember where I've mowed is almost impossible. Or like last year, I tried to fertilize my yard. Well, I burnt it. If I over fertilized, if I forgot to water, I'm not sure. But I do know I need to ask for help with those kinds of jobs. Now it took four years to find a way to express the difficulties I have. I have seen various doctors and counselors. Some I've found helpful but most of them truly have no clue how I can have such a positive attitude, or they tell me, thank God you have a spouse to support you, when actually I only have a

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house to live in and faith that someday will be better. And I thank you for hearing my testimony.

SENATOR BYARS: Very good job, Deb. Very good job expressing yourself.

PATRICIA STEAR: (Exhibit 8) Thank you. I am Pat Stear, S-t-e-a-r. I appreciate your listening to our testimony. I'm a proponent of this bill. Five years ago, I had a traumatic brain injury, first breaking my arm on the ice and they wouldn't cast it because it was too high. So I couldn't lie down, I was sitting in a chair with pillows for a week, eight months pregnant. After a week of that, I started falling down the stairs, couldn't grab the railing. So I catapulted down and hit my head. They took my baby a month early to do surgery to remove a hematoma. Another day or so later, they realized there was still some bleeding and they did a little trimming of the right frontal lobe. This especially panicked my husband who had an aunt who was schizophrenic, and it actually catapulted him into mental illness and he became obsessive and started spending. We at the time had...well, we ended up with four houses, three were rented. We lost them all. So I was in the process of trying to heal from my injury and go through a divorce and have to move three times in four years with still four daughters, the youngest of the nine at home in four schools. Ironically, when I had my accident I had a lot of support. We had meals brought to our house literally for three months straight. When I started going through a divorce, people don't know how to deal with that, and they disappear. It's a good thing because you find out who your real friends are and who you want to have for friends. But it's been a tumultuous five years since my accident. During this time, my 25-year-old also died in a car accident. Speaking of him, Joshua is deaf, and I am very appreciative of state funds for when he was younger, we went every year to the deaf school, and parents with kids who were deaf from all over the state came. We stayed for five days. We were given food and housing. We were taken to the zoo, the Children's Museum. We had national speakers. And it was truly a "wrap around" moral support. It gave us a chance to meet deaf kids from all over the state. I have a daughter, also, who has Down's Syndrome and because of early childhood education, we had teachers in the home working with us. The

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special ed in Lincoln is magnificent. My 10-year-old is reading very well and just doing extremely well. I am glad to hear about the family-centered services and wrap around. What I have longed for in this difficult time is a case manager--a point of contact, somebody who could do the work for me to find the resources I need. And if some of that funding could be used for that sort of service, some sort of a wrap-around service for people who have traumatic brain injury, that would be absolutely magnificent. It would mean a lot. It is difficult to find that sort of stuff. I'm still trying to get settled in our home, which is older. I've had to take on all kinds of new tasks, being a single mom, learning about taxes and taking care of homes and cars, and it's a challenge. If I had someone who knew resources that I could turn to, that would just be a super help. So I hope that some of that funding could be used in that way. I appreciate you listening. Thank you.

SENATOR BYARS: Thank you for your testimony, Pat.

PATRICIA STEAR: Um-hum.

SENATOR BYARS: Any questions of Ms. Stear?

PATRICIA STEAR: Oh, and also the handout I gave...I did a little research last night and stumbled across New Mexico's project that seemed to be very thorough and helpful, and thought maybe that would give you some guidelines in developing something here. I don't know.

SENATOR BYARS: Appreciate the information. Thank you for sharing. Thank you for being here, both of you. Appreciate it very much. You sharing your personal stories is meaningful to us. Tracy Webb and Brenda Mannschreck. Brenda's a colleague of mine, so I have to give her an awfully hard time. I didn't even talk about my teacher from 45 years ago who was also my football coach, who is sitting at the back of the room and concentrating on everything that I've said, I'm sure. (Laughter) Ladies?

TRACY WEBB: (Exhibit 9) Good afternoon, committee members. My name is Tracy Webb, and for the record that is T-r-a-c-y W-e-b-b. I am originally from Scottbluff, residing in Omaha. I'm the daughter of a traumatic brain injury

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survivor and also a student in the Doctor of Occupational Therapy Program at Creighton. I've come to share with you today the perspective of a family member of an individual with TBI, as well as some of my mother's personal experiences she has shared with me. My mother sustained a traumatic brain injury as the result of a motorcycle accident that took place approximately 10 years ago. Following her accident, she was in a coma for approximately 12 days, and that followed by several months in an in-patient rehabilitation facility. She was released from the hospital and received about six weeks of outpatient rehab services, and then moved back to Nebraska to have the support system that would assist her in getting back on her feet and living independently. For the past 10 years, my mother has struggled to maintain employment in independent living, and she has dealt with high levels of anxiety and stress, depression, and has longed for social relationships and normalcy in her life. Often when services were pursued to assist my mother in these areas, the response has consistently been that she is too high functioning to qualify for services. My mother falls into the gray area that LB 1233 is working to address. Today I will talk specifically about the areas of employment and independent living. I would first like to address the issue of employment. My mother was an LPN in a skilled nursing facility before she sustained her brain injury. Her memory deficits do not allow her to safely distribute medication and keep track of a large patient caseload, people who all bear similarities in resemblance. She has compensated for this by transitioning to a home healthcare setting where she can safely utilize her skills working one-on-one with a patient. She struggles with employers not understanding her needs and the modifications that would assist her in her work setting. In over the past eight years, every time she has reached her goals of independence and gainful employment, her support systems are taken away. She will no longer qualify for medical or mental health benefits, which she needs in order to maintain that high level of functioning. The example provided within the TBI Bridge Fund that could provide a cognitive rehab to increase readiness for obtaining and maintaining employment could be very functional for her. This service could provide her with the missing link that she needs to assist her in advocating for herself the accommodations that she needs to

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increase her success on the job. With the correct accommodations, she has the capacity and drive to be a motivated and outstanding employee and a true asset to her employers and patients. Independent living is another area that she has worked diligently to maintain. Her independence and space is very important to her and this helps her to thrive. The potential outcome of the TBI Bridge Fund to provide a behavioral home health service could really benefit her by preventing her from having to go to a more restrictive or more expensive living environment and keep her living independently. Stability in her work and living situations assist her in functioning at her highest possible levels by controlling her stress and keeping it low. When she is able to function at her highest point, she is able to be an active, independent, and contributing member of society. When she experiences a lack of stability in her work or living, her depression and anxiety build and this decreases her ability to function, and she often loses her employment during these times. This obviously leaves her no choice but to fall back onto Social Security Disability and Medicaid/Medicare. Throughout her experience, it seems that the services she desperately needs are only available to her when she hits rock bottom. There hasn't been any middle ground for us. That's why we feel that LB 1233 and the establishment of the TBI Bridge Fund is to needed. It allows for services before individuals hit rock bottom, and it also decreases their chances of having to rely in public assistance funding. My mom has a strong support system between my grandmother and I; however our ability to assist her financially is very limited. My grandmother is a single woman nearing retirement, and I am a student with a husband and a 10-month-old daughter of my own. We simply do not have the financial resources to provide her with the services that will allow her to maintain her independence, thus she needs the TBI Bridge Fund to meet this need, as do many others in similar situations. Members of the committee, what I really want you to hear today is that individuals with traumatic brain injury who are higher functioning could greatly benefit from the TBI Bridge Fund. LB 1233 can provide some much-needed financial and service-related relief for the individuals with TBI in their families. These individuals desperately want to return to normalcy and be contributing, successful members of society. They simply need a few added tools to

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do so. Without these tools many will be forced back onto relying completely on the government which is, as you know, much more costly to our society and very devastating for the individuals and their families. We feel that the TBI Bridge Fund is exactly what Nebraska needs to meet this need in our state. I urge you to advance LB 1233 to General File and take the next steps in assisting these individuals to obtain the services they need. I greatly appreciate your time to hear my family's story today. I would like to answer any questions that you may have.

SENATOR BYARS: Thank you, Tracy. Any questions of Tracy? Thank you very much. Brenda?

BRENDA MANNSCHRECK: Okay. Thank you.

SENATOR BYARS: Welcome.

BRENDA MANNSCHRECK: (Exhibit 10) Thank you, Senator Byars and Senator Jensen, for allowing me an opportunity to speak. When they asked me to speak, I said I could do it really, really briefly and I will really try. And I thought, oh, wow, what am I going to talk about? Because I have been working with TBI patients now for about 25...

SENATOR BYARS: Brenda, I need to interrupt you and have you spell your name for the record.

BRENDA MANNSCHRECK: Oh, sorry. Brenda Mannschreck, B-r-e-n-d-a M-a-n-n-s-c-h-r-e-c-k.

SENATOR BYARS: Thank you.

BRENDA MANNSCHRECK: Thank you. I apologize. For the record, I'm a speech and language pathologist for the Beatrice Community Hospital and Health Center in Beatrice. I've been at the hospital for over 25 years, and I have run a traumatic brain support group through the hospital for the last 12 years. In the beginning, these individuals do not have access, when they come to our hospital, to Medicaid, Medicare. They come from the rehab centers in Lincoln, Omaha. They come to rural America. Traumatic brain injury is often--is often--the unrecognizable disability. Oftentimes these people look normal, they act normal to the

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viewer. Even physicians are not able to recognize that these people have the significant difficulties that they do have. I hope to briefly detail a picture of what families that I have worked with, just a few, go through because as I said, oh, wow, there's so many. I want to tell you about a family that previously lived on a two-person income and had small children at home. The spouse, the wife, needs to go back to work after the husband is sent back to rural America. How are they going to make ends meet? They are unable because someone needs to get the survivor to his appointments. Or how about the family that they're two healthy married individuals, and he was a professor and got hit on the head. They had a very happy family. Through getting hit on the head, the wife had to take him back and forth to different appointments. And she became ill with the stress of the life and developed fibromyalgia, and then she was put on disability because of the stress of the family that the family has gone through. Or do I tell you about the gentleman, the construction worker that was in a tree and he had his own business, and he lived here in Lincoln. He fell from the tree. During the time he was in rehab at Madonna, and then he came back to Beatrice, Fairbury, Jefferson County area, through dealings of him looking normal, people in the area took advantage of him and he lost his business. He lost his livelihood. And through some judgment and reasoning of this individual, he lost everything and there was no support or no help for him. In fact, he has moved in with his elderly parents now. He was forced to move in with his parents. He relied on his parents for transportation to appointments. Therefore, they were required to rearrange their lives; the previously independent son was back under their roof. This was emotionally difficult, especially since at this time children usually take care of the parents at this stage of life. Decreasing health benefits, shorter lengths of hospital stays, employment loss, employment, related adjustment problems for individuals with brain injuries when they are discharged from rehabilitation centers are only...and that's only the beginning of what these individuals sustain. Every situation and everyone is different, the funds for transportation, life might have been a little easier to handle. For example, there would be less financial stress, there would be less emotional stress, there would be possibly a reduced amount of depression for

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the TBI survivor. The TBI survivor may have reduced guilty feelings of taking up everyone's time. The increased independence, not having to rely only on family transportation, reduced stress on family. Family members would not have to take off time to take the survivor to his appointments. Schedules do not need to be constantly rearranged. They find someone to take patient to appointments if a family members are unable; increases the amount of treatment time for that patient; reduces the cancelled sessions of treatment time because of the lack of transportation. Other needs for transportation if no alternative ways for some survivors is to begin to drive before they are actually safe enough to be on our roads and drive. We have seen that in our area. These individuals need to have transportation to get to the support group meetings in the areas. They need support from each other. They need to know that they're not out there in the rural community or out there in the world all by themselves. A TBI does not only happen to the patient, not only happens to the person. It happens to the family. Once you have an accident, once you have a head injury, the whole family is sustaining and has had the head injury. It changes their life forever. Concerns that it would change would be they are unable to always meet their doctor's appointment because of transportation problems, they need groceries, they need to go to church, and sometimes they even need occasional outings. These people, if they do qualify for home health and they're not allowed to go out of the home situation, then the rehab potential is so very, very poor because they're kept into the home and they're not allowed to expand and to grow. They're supposed to be treated like a home health person. You cannot go out of the house if you're a home health individual. Therefore, the family...we need to have more help for the family in the rural areas for family education once they get out of the big cities, the Omaha, the Lincoln, the support groups there, they go out to rural America and the family needs support. Their life has changed. They have some support in the city. They have some support at the rehab stations. But when they come to rural America, the support is very, very thin. Survivors need to schedule treatment. They need transportation to schedule treatments. They need to do some shopping. They need to buy groceries, household needs, even personal items. And they need financial management assistance. Support

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groups, if they're not already established, we need them out there in Nebraska. Families of survivors need to connect with other families familiar with the situations. Possibly they need transportation to and from meetings. A fund would allow individuals to enable them to survive and regain some state of normalcy to their lives until they were able to qualify for other assistance or even go back to work as some do get to do. I want you to know that TBI is a long, long life effort that needs lifelong funding. One dear caregiver summed it up like this when she was discharged to our area: "Some of the things I struggle with was the financial needs of how is my house payment going to be made, my phone bill paid, electricity, gas for the car, numerous trips to Lincoln to the hospital and to the appointments? What will his employer do? College bills to be paid for Lilly. Jim always handled all the finances, so struggling to juggle my work, worry of money, paying bills, not knowing where the money would come from, the struggle with a disability, trying to get assistance for immediate needs from Human Resources was a joke. And it has been been (inaudible) have them in our support group. Oftentimes it takes six to nine months for these people to get any assistance once they're out of the hospital. Not having your insurance company come through for you, I feel Jim had to leave Madonna before he really should have because of the insurance, then to find someone to care for him at home so I could continue to work. Fortunately for me, his mother was able to stay with him. But if it had not been for her, I would have had to locate an adult daycare, which would have added to the financial burden. I was still in a state of shock for many weeks, and not having family near was difficult. My children were here for about a week but then they too had to return to their families and jobs. Such loneliness. Didn't feel there was anyone to talk to. I hope this helps a little bit. Sometimes I feel like I could write a book." Thank you. Thank you for your time. And thank you for allowing me to share with you my passion for traumatic brain injury. Thank you.

SENATOR BYARS: Thank you, Brenda. Any questions of Ms. Mannschreck? Thank you both for being here. I appreciate it very much. That's the end of our scheduled testifiers. Are there any other individuals who want to testify in favor? Kathy. Welcome, Ms. Hoell.

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KATHY HOELL: Hello. How are you today?

SENATOR BYARS: Good.

KATHY HOELL: (Exhibit 11) My name is Kathy Hoell, H-o-e-l-l. Most of you know me as the director of the Statewide Independent Living Council. First of all, let me tell you the council does support LB 1233. But in addition to that, I am a TBI'er. I am a person that had a traumatic brain injury approximately 25 years ago. And there's not a lot I can add to what has already been said but the importance of early intervention. I had a disability that resulted in both public and I did have some private resources, and I also lived back East at the time when I had my brain injury. And I was able to get services that I needed. And it was a lot easier back there. But I know back here it's different. And I was a registered nurse in my previous life, and that meant totally changing my career path. Everything in my life changed as a result of the brain injury. And the other point I wanted to make: One of the previous testifiers had made a comment about it being the hidden disability. Obviously my disability is pretty evident but I've been told repeatedly that a brain injury is not a disability. Some interesting thoughts, too. But my only concern with LB 1233 is that it does sunset in 2007. Personally, it's a person who has had a brain injury that has survived it, who is now living independently, who does have the proper support and services in place, I know that brain injury doesn't go away. So I really would encourage you maybe to rethink that if you could. Thank you for your time. If you have any questions...

SENATOR BYARS: Thank you. I appreciate your testimony. Kathy, I've known you for a long time and I learned a lot today that I didn't know. You've been keeping it a secret from me. Senator Johnson.

SENATOR JOHNSON: Well, along that line, don't run off, Kathy. How smart were you before you had your traumatic brain injury, because you're still darn smart. (Laughter)

KATHY HOELL: Actually, when I had my brain injury I was living in Spain and I spoke fluid Spanish. I now understand

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Spanish, but I can't speak it at all. I could understand English, but it took five years to learn how to speak it again. So to support our ongoing for people who have brain injuries and I suppose it depends on who you ask, as some say it's an attitude with me.

SENATOR BYARS: Thank you, Kathy. Thank you, Senator. Any other questions? Thank you very much. Brad?

BRAD MEURENS: (Exhibit 12) Good afternoon, Senator Byars, members of the Health and Human Services Committee. For the record, my name is Brad Meurens. That's M-e-u-r-r-e-n-s. I am the public policy specialist and registered lobbyist for Nebraska Advocacy Services Incorporated, the Center for Disability Rights, Law, and Advocacy. I'm here today to offer our strong support for LB 1233. As the Nebraska state plan for systemic services for individuals with brain injuries and their families, which you have in front of you, indicates, the current system for delivering services to individuals with traumatic brain injury is fragmented, uncoordinated, and compromises individuals and families' abilities to access services. As such, we fully support LB 1233's call for an implementation plan for services for persons with traumatic brain injury. We are also pleased to see that this plan will be jointly developed by the department and the Statewide Traumatic Brain Injury Advisory Council. Additionally, we support LB 1233's creation of the Traumatic Brain Injury Trust Fund. Not only are services currently fragmented but they are costly, oftentimes far outstripping the ability of or creating significant financial hardships for individuals and families to provide necessary services. Without such a fund, it is likely that many individuals and families will be forced to forego such services. We would suggest that this fund also not sunset on July 1, 2007. As Kathy points out, the need for services doesn't go away. We would also suggest that the department and advisory council look to experiences in other states that have developed such trust funds for persons with brain injuries. This is not a new idea, and Nebraska would benefit from a comprehensive approach to developing its own traumatic brain injury and trust fund. This concludes my testimony. I would entertain any questions that the committee might have.

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SENATOR BYARS: Thank you, Brad. Any questions of Mr. Meurrens? Thank you for your testimony. Any other proponents? How many more proponents do we have? We need to get wrapped up this evening and we've heard a whole bunch of very, very good testimony. I don't want to deny anybody but please keep it brief. Three more? Raise your hands again. Okay. Thank you.

ELENA RIVERA: Senators, thank you for allowing me to be here. My name is Elena Rivera, E-l-e-n-a R-i-v-e-r-a. I am originally from Honduras but Nebraska is my home. The United States is my country. I have a daughter. Her name is Tajera Rivera. She had a brain injury not from an accident but from a brain tumor. Her first surgery was almost four years ago. She already had five surgeries since she suffered a brain tumor injury. And actually, she's not here with me today because she's in the hospital. We've had to struggle a lot. I can't say first because of the language barrier because, thank God, I had learned English before I came over to the United States. I am a forest engineer. I can't work because I'm taking care of my daughter. It's so hard to be in this country and a foreign country where you have so much, and I really appreciate it and I thank God we are here, that we get so much support, but there's still a lot of things to do. My daughter is now in a rehab center...it's not a rehab center, it's rest home because she can't work and a lot of things. She's only with people who are 76 years old and on. When she's in that center, she don't want to eat. She's more depressed. She thinks that we just take her there to die. We need more support, and I'm here just to support LB 1233 because we need more people to know what TBI means, what TBI is. And I think I'm here representing not only the Hispanics, all the immigrants that we come to this country, and things happen and we don't know where to go or what to do. We don't qualify. I've been living because of the grace of God and the good things that this country has, but we need more because I am to lose my house. I almost lost my car, which is the car that drives my daughter back and forth. It's hardly working right now and who's going to take her to the appointments? Most of her doctors are in Omaha. But I'm here to tell you that I'm not here because it's a coincidence. Thank God I answered the phone yesterday because I thought a doctor was calling me. My daughter is

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very ill right now and she's coming in and out from comas and stuff. But she's still alive, and if she had support, she's going to continue living. But we need more help. We need to teach the people how more doctors and nurses and caregivers and providers and social workers and everybody to know that brain injury is not just another illness. It's something worse beyond illness that we have is a high quality disability that people get. I also think that I also need a surgery because I feel overwhelmed. I would like someone to change my brain because sometimes I can't think what else I can do for my daughter. My husband left me the same day she was having her first surgery, and then I owe a lot of people here. I didn't come to this country to (inaudible) or to beg. And I feel like I'm begging. But today I'm begging, yes, I'm begging to you guys to please support LB 1233 so we can have more of our disability families turn better and not turn to worse. Thank you. I don't know if you have questions.

SENATOR BYARS: Thank you very much for your testimony. There may be some people here that I see in the room that might be able to help, visit with you a little bit about transportation services for your daughter. So I'm sure they will get a hold of you before you leave the room and talk to you.

ELENA RIVERA: Yes, sir, thank you, yes. They have told me about transportations but they're limited, so when I need the transportation it's already booked up for two months or three months, so what I'm trying to say, we need more transportation. We need more caregivers. We need more people to be educated and have more facilities. Like my daughter's 22 years old. She said, what I'm doing here with these people? I'm going to die. So I'm trying to address, we need a lot more facilities that they have a specialty in brain injuries so they can get better attention and to make their life a better life and be more quality.

SENATOR BYARS: Thank you very much for your testimony.

ELENA RIVERA: Thank you.

SENATOR BYARS: Next proponent?

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GLEND A FERGUSON: (Exhibit 13) Good afternoon. For the record, my name is Glenda Ferguson; that's F-e-r-g-u-s-o-n. I live in Wahoo. I'm a consultant with the Traumatic Brain Injury Program for Nebraska Advocacy Services, Inc., the Center for Disability Rights, Law, and Advocacy. Under the federal protection and advocacy for Traumatic Brain Injury Act, Nebraska Advocacy Services provides legal and other advocacy services to persons with traumatic brain injury. I am here today to offer my personal testimony in support of LB 1233. As a consultant for the Nebraska Advocacy Services Traumatic Brain Injury Program, I spend a great deal of time speaking with people who are traumatic brain injury survivors. I have listened to the frustrations of a person with a traumatic brain injury who needs a work coach to assist in holding a job he desperately needs but is unable to afford to pay for such service. I feel their pain from a personal perspective because my brother, Paul, had a traumatic brain injury in his mid-40s. He was not married and I became his guardian. For over a year I moved Paul from facility to facility, from Denver to Omaha and back. Paul was allotted pieces of time for each of his recovery steps. The allocation of time was based on insurance regulations. Each rehabilitation step was both painful and exciting. As Paul progressed, we were hopeful that he would be able to recover and live on his own or with either myself here in Nebraska or my brother in Colorado. Paul's recovery was slow, and at the end of the year we were told that Paul had reached the end of his allotted rehabilitation time. With no private funds to facilitate further rehabilitation, Paul was unable to live on his own or with any of his family. Paul's placement in a nursing home was inappropriate but with no other resources available, it was our last resort. Had Paul been given the financial assistance for further rehabilitation or access to technology, we feel his outcome would have been different. I recently had the opportunity to attend a seminar in child abuse presented by Dr. DeMare. Dr. DeMare is a pediatric trauma physician from Omaha. Dr. DeMare stated that the numbers of children who will be diagnosed with traumatic brain injury will dramatically increase over the next several years because more and more doctors at hospitals across the state of Nebraska are ordering full body CT scans in cases of suspected child abuse. Instead of a child being diagnosed as having a developmental disability as they begin

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school, the diagnoses will already have been done and made in early childhood as a traumatic brain injury caused by child abuse. So as the numbers of people who will be diagnosed with traumatic brain injury increases, so will the need for services and resources, many of which will not be provided by Medicaid. Thank you for the opportunity to appear before you today. Do you have any questions for me?

SENATOR BYARS: We appreciate your testimony. Any questions? Thank you for your testimony.

GLENDA FERGUSON: Thank you.

SENATOR BYARS: I think this is our last proponent. Any other proponents? Okay, thank you.

MATT CLOUGH: (Exhibit 14) Thank you very much for the opportunity, Senator Byars, Senator Jensen. My name is Matt Clough. I'm with Quality Living in Omaha, Nebraska. It's Clough; the spelling is C-l-o-u-g-h. I'm here representing Quality Living. We are a proponent of LB 1233 and believe that this is a terrific next step to secure the least restrictive, most appropriate services for individuals with traumatic brain injury in the state of Nebraska. Thank you very much.

SENATOR BYARS: Thank you, Mr. Clough. Appreciate you being here and being patient.

MATT CLOUGH: Thank you.

SENATOR BYARS: Any questions? Thank you. One last time, any other proponents? Anyone in opposition? Anyone testifying neutral? That will conclude the hearing on LB 1233. Would you like to close, Senator Jensen?

SENATOR JENSEN: No, not at this time.

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SENATOR BYARS: Okay. Senator Jensen to open on LB 1178.

SENATOR JENSEN: Thank you, Senator Byars, and thank you

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committee, first of all, for staying with us. For the record, my name is Jim Jensen, representing District 20, here to introduce LB 1178. LB 1178 was introduced at the request of the Nebraska Health and Human Services System because federal funding from the National Centers of Disease Control and Prevention for the Nebraska Brain Injury Registry has been discontinued and there are no state funds available to continue that registry. We seem to be hearing a lot of that lately. The Nebraska Health and Human Services System has access to a hospital discharge data base provided under the contract with the Nebraska Hospital Association. That data base contains a majority of data required under the Nebraska law relating to the registry. LB 1178 proposes to eliminate certain data elements from the registry which are not provided on the current available hospital data base. The bill outright repeals Section 81-658, and eliminates a reporting requirement from all patient post-acute-care facilities including nursing homes and rehabilitation centers. The bill would require reporting only to hospitals and rehabilitation centers located within that hospital. Reports would no longer be required to include race or ethnicity, and, with respect to the cause of injury would only be required if practical to include whether the injury resulted from an accident involving alcohol. Personnel from the Health and Human Services System are here to provide testimony in support of this legislation and to answer any questions from the committee. Thank you. That will conclude my opening.

SENATOR BYARS: Thank you, Senator Jensen. Any questions of Senator Jensen? Thank you very much. We do have a letter that we just received, written testimony for LB 1233 from Luke Craig supporting the legislation. Senator Peterson.

CHRISTINE PETERSON: (Exhibit 1) Thank you, Senator Byars. Good afternoon, Senator Jensen, Senator Byars, and members of the Health and Human Services Committee. I'm Chris Peterson, P-e-t-e-r-s-o-n, Policy Secretary for the Health and Human Services System. I would like to thank Senator Jensen for introducing this bill on behalf of the Health and Human Services System, and I am here to testify in support of LB 1178. LB 1178 is needed to allow the Nebraska Traumatic Brain Injury Registry to continue to operate by changing the data that is required to be collected. LB 1178

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is also needed to prevent HHSS from being in violation of current data collection requirements. The Nebraska Brain Injury Registry has collected traumatic brain injury data via reporting from diagnosis and treatment facilities since 1994. From 1998 to July of 2005, the registry, including on-site data collection, was financed by a grant of approximately \$100,000 from the National Centers for Disease Control and Prevention. In 2005, at the beginning of a new five-year grant cycle, the CDC reduced the number of state registries funded from 6 to 4 because limited federal funds were available. While the Nebraska Health and Human Services System applied for continued brain injury data funding from the CDC and the CDC grant reviewers recommended funding, funds ran out and unfortunately Nebraska was one of the two states eliminated from the program. There are no available state funds to continue the position of Brain Injury Registry Coordinator. As Senator Jensen said, the Nebraska Health and Human Services System can collect almost but not quite all of the brain injury data required by current state law through a hospital discharge data base provided under contract with the Nebraska Hospital Association. One hundred percent of acute care hospitals, those where brain injury is likely to be diagnosed and treated, report to the Nebraska Hospital Association. This bill would allow facilities to report through that association. In addition, the hospitals, physicians, and psychologists will continue to report to the department all brain or head injuries, thereby picking up the rest. If you look at the colored graph that was handed out, it shows you two different ways of how we recognize the amount of data that comes in. If you look at the green slide, that is actually what the Traumatic Brain Injury Registry covers. If you look at the two that are marked HDD, hospital discharge data, and there are two elements of that, you can see that that information will provide more than the actual requirements of the Traumatic Brain Injury Registry at this time and have significantly captured more over the past several years. The coordinator that was hired, the money provided for that coordinator to actually do on-site visits where they did patient chart abstractions and audited all of the cases and reported to the CDC, travelled to the conferences and did training for the CDC. We will continue to do the extraction and analysis of the traumatic brain injury data. This bill will allow the Department of Health

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and Human Services to continue the collection of brain injury information at a minimal additional cost to the state. The information will become a part of the Injury to Nebraska Report, and I handed that to you, and we will include in there as part of our annual report, the traumatic brain injury piece. And we've been working on that since last year. We would like to submit the following amendment, which will provide a time requirement for reporting. This was inadvertently left out. We discussed it with Senator Jensen's office. What it is, it does put a time frame into the reporting that the hospital physician and psychologist are required to do. It says to do that within one year. The hospital discharge data is sent to us within one year, and so that would fall into the guidelines of this. Thank you for the opportunity to testify before you today. I would be happy to answer any questions that you may have.

SENATOR BYARS: Thank you, Senator Peterson. One thing I noticed at the beginning of the handout, the Injury in Nebraska booklet, you very appropriately made note that injuries are preventable; they don't occur at random. But as I glance, peruse very quickly, your publication, when it comes to motor vehicle deaths there's not one word in here about the use of seat belts as far as prevention. And I wonder if we're looking at these instances, shouldn't we as a public policy making...and shouldn't the executive branch be looking at making aware of how you can prevent these injuries and these deaths?

CHRISTINE PETERSON: I will certainly make sure that's included, Senator.

SENATOR BYARS: I appreciate that very much. Any questions or comments? You notice, Senator Jensen, I didn't say a word about motorcycle helmets? (Laughter) Senator Johnson.

SENATOR JOHNSON: Well I would just like to second what they talked about with the seat belts. As I recall, this last year, 226 of 275 deaths were caused by not wearing or the person wasn't wearing a seat belt. So that's 75 percent of the people. And I think it's in excess of 75 percent of the people wear seat belts, so that means 25 percent of the people are having 75 percent of the deaths.

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CHRISTINE PETERSON: It'll be in there.

SENATOR BYARS: Thank you very much, Senator Johnson. Any other comments or questions on the part of the committee? Thank you. That was an excellent presentation.

CHRISTINE PETERSON: Thank you.

SENATOR BYARS: Any other proponents of LB 1178? Anyone in opposition to LB 1178? Anyone to testify neutral on LB 1178? If not, that will close the hearing on LB 1178. Would you like to close, Senator Jensen?

SENATOR JENSEN: No, thank you.