[LR153 LR195 LR204 LR205]

SENATOR JOHNSON: Let's go ahead and get started. It's going to be a long day, and I know Senator Schimek has other obligations, as well. So...and I'm not going to go through all of the usual instructions and so on. I think virtually everybody in the room knows those. Let me do remind you of two things: Please turn off your cell phones and that type of thing; and then secondly, would you spell your name as well as say who you are, for the transcriptionists and so on. With that, Senator Schimek, welcome to our humble abode, and would you like to proceed? [LR195]

SENATOR SCHIMEK: Thank you, Senator Johnson and members of the committee. I appreciate your having an interim study hearing on this issue, because I think it's an important issue. As you know, LR195 provides for the study of the state of Nebraska's 24-hour care facilities; specifically, it aims to examine issues regarding treatment and safety of clients, patients, and inmates, as well as working conditions at these facilities, which include the state's regional centers, the Beatrice State Developmental Center, youth rehabilitation and treatment centers, and the veterans' homes. Some of the facilities I have just listed happen to be located in my legislative district. I sometimes hear from constituents who work at these facilities about issues that affect them directly, and in fact, even some of the people who are housed in some of these facilities. I have been told of situations regarding staffing levels, early release, overcrowding, mandatory overtime, and concerns regarding adequate employee pay, that affect the care of clients, patients, and the safety of everyone in these institutions, including those who are employed by them. I am concerned that these situations are placing unneeded stress on our facilities and therefore on the staff and patients themselves. I know that there is frustration felt by some, and I am sympathetic to these constituents who call my legislative office, who are often fearful of retaliation. My staff and I attempt to address their concerns or at least try to help them the best we can, but we often get no feedback on whether the issues they raise truly are solved or if they persist, and I find this frustrating. The vast majority of the state's employees are very dedicated to their jobs

and deserve to work in a safe and fair environment, and those within the 24-hour care facilities--patients, clients, and inmates--should have the same environment. We need to examine systems, policies, and practices to ensure that this is happening. Public safety and patient care are affected by conditions which are regarded as labor/management issues, when in fact they are more than that. Perhaps the Legislature should be more active in asking questions and providing continuous oversight. We all know from recent events at some of these facilities that the issues this interim study raises are serious, and we all know that there have been steps taken to address some of these problems. I believe this hearing gives the Legislature the opportunity to have a public hearing of these issues. I am very pleased that we have representatives of the state's 24-hour care facilities with us today to provide an overview of current systems and practices within these facilities. I look forward to hearing from them and hope that this hearing can shed light on situations and/or systems that have been improved or that can be improved for all of the individuals who are involved. And with that, Mr. Chairman, I really in my opening statement chose to raise questions, and I hope that the committee will be diligent in asking questions, as well. Thank you. [LR195]

SENATOR JOHNSON: Any questions? And first of all, before we get into that, I didn't introduce who we have this morning, and I think we may have one other person joining us. But we've got Senator Tom Hansen, Senator Stuthman, Erin Mack is our committee clerk, and then Jeff Santema is our legal counsel for the committee. So, any questions? I think you've left us speechless, as usual. (Laughter) [LR195]

SENATOR SCHIMEK: Oh, I doubt that. Thank you. [LR195]

SENATOR JOHNSON: So thank you very much, and I know that you do have other things, so when you need to leave, why, that would be just fine. [LR195]

SENATOR SCHIMEK: I appreciate that, but I will be staying for awhile, if I can. [LR195]

SENATOR JOHNSON: Okay. Great. Well, we do have a list of people, and we will go through this. If there are some people that, in addition, want to make comments, obviously you're welcome to do this. And I also have a note here that Sean Samuels needs to testify no later than 11 o'clock, so even though he's down my list, if it comes close we're going to move him ahead, because he has some commitments, as well, apparently. So with that, first on my list is Mr. Bob Houston. Welcome. [LR195]

BOB HOUSTON: (Exhibit 1) Good morning. Thank you. Thank you very much for taking me early. I have a couple other things that were scheduled the same time, so I appreciate it. Good morning, Senator Johnson and members of the Health and Human Services Committee. My name is Bob Houston, it's H-o-u-s-t-o-n, and I'm director of the Nebraska Department of Correctional Services. I appear before you today to provide information in response to LR195 that will illustrate the care the Nebraska Department of Correctional Services takes to address staffing, oversight, and care of inmates in our facilities. The department has and continues to be aware of and address the staffing needs at our facilities. The department has sought and received input on employee retention from employee focus groups facilitated by the University of Nebraska at Omaha. The recommendations from this study have incorporated into a checklist for agency improvement. The department also requested assistance from UNO in conducting exit interviews, receiving feedback this June on issues related to retention. We've used this information, too, to guide us in improving retention efforts. Most rural-based facilities face challenges maintaining a full staff complement. We have been and continue to be aggressive in this effort to recruit new staff, particularly to our one rural facility, the Tecumseh State Correctional Institution. Nebraska's excellent work ethic has buoyed our efforts to decrease our vacancy rate at TSCI, dropping from 71 officer vacancies in January 2007, to 29 vacancies as of this month. Last spring we created the Blue Ribbon Panel, specifically charged to address staff shortages at the TSCI. Other state agency directors in DAS state personnel met every month with TSCI administration and other agency staff to assist in creating additional recruiting and retention resources. This effort has led to a number of new and unique recruiting and

retention methods. Our agency remains diligent in our effort to maintain safe institutions for our staff and inmates. At 140 percent rate of capacity, our agency is required by statute to notify the Governor for consideration an overcrowding emergency. Our prison system held 4,402 inmates as of October 23, 2007, placing us at 138.65 percent of capacity. Our population seemingly leveled off and remained steady at about this same number for the past year. The department continues to implement programs and internal policies to manage our inmate population. For example, the agency has more aggressively and strategically doubled the number of inmates at the community corrections centers. This provides these inmates with opportunities to establish jobs, programming and support in the communities that assists them when they are paroled or discharged. This action also lowers the number of inmates held in our higher security institutions, thereby providing a safer environment for those working and living in these facilities. Another example of how we've addressed the needs of our population and concurrently the good operation of our facilities is what the agency refers to as Plan B, a reorganization and expansion of mental health and substance abuse programming for the inmates under our care and supervision. This effort, too, will aid both the inmates in our custody and care and the staff that provide their care by addressing the significant number of inmates that have substance abuse and mental health needs. I am very pleased you are taking the time to study the challenges that our department and other 24-hour care facilities face. [LR195]

SENATOR JOHNSON: Senator Hansen. [LR195]

SENATOR HANSEN: Thank you, Senator Johnson. Good morning. [LR195]

BOB HOUSTON: Morning. [LR195]

SENATOR HANSEN: I have one question. The 4,402 inmates in the prison system; does that also include the work ethics camp at McCook? [LR195]

BOB HOUSTON: No. In addition to that, we have 73 inmates as of yesterday. [LR195]

SENATOR HANSEN: Seventy...? [LR195]

BOB HOUSTON: Yes. Twelve of those are... [LR195]

SENATOR HANSEN: But your agency does cover the work ethics camp; is that correct? [LR195]

BOB HOUSTON: Yes, exactly. [LR195]

SENATOR HANSEN: What about the turnover there? [LR195]

BOB HOUSTON: The turnover there has really not been significant, I believe. Connie, do you know of anything other? [LR195]

_____: No, it has not been significant. [LR195]

BOB HOUSTON: We've had some turnover, but it's not been significant there. It has a smaller number of staff. There we have 82 staff, I believe; could be 81. [LR195]

SENATOR HANSEN: Okay, thank you. [LR195]

SENATOR JOHNSON: Sir, you talked about, you know, that you'd actually put together a panel to investigate and try and improve the retention and so on. What are the problems that you've encountered as far as being able to develop and maintain a work force? [LR195]

BOB HOUSTON: Well, the population base from which we're drawing is small, and when we look at the distances from where people drive, that's considerable. And we

also recognize that it is a farming community, and so the lifestyle of the people in southeast Nebraska is a bit different from people in the metropolitan area. And so there are some logistical...I mean, if you have a low base of population and you have distances they have to drive, especially with gas prices being what they are, it becomes fairly significant. What has also been a problem has been...is the...we have in the Department of Corrections security posts. We have a minimum number of posts, and those are developed because of housing units, site lines, and so forth. Once we establish those, they have to be staffed, either 8, 16, or 24 hours a day, and so we have to mandatorily overtime people to maintain those posts. That gets very tiring, and sometimes it's kind of like the dog chasing its tail. People leave because they're working those mandatory overtime. But what we're finding also is that if we can hit the point where we're sufficiently staffed and people don't have to work that mandatory overtime, it will make a huge difference in not only how the staff feel about their job but also how they feel about supervisors and the institution, in general. I faced a very similar challenge. I was director of Douglas County Department of Corrections, and we had low staffing, a lot of mandatory overtime. Being in an urban area, we were able to hire staff more quickly, and when we did we hit that point, and now staff were looking for overtime rather than trying to fight against it. It made a huge difference in the morale of that facility. So that's what we're, you know, aggressively going towards at Tecumseh. [LR195]

SENATOR JOHNSON: Yeah. I understand where you're coming from when you say that. Out in Kearney, why, there was a plant out there that got a big order, and basically they...everybody was on overtime for a couple of months. And for the first few weeks, everybody was smiling because of the size of their paychecks, but by the time it was over they were all ready to quit and go somewhere else. So I understand what you're talking about. The...how far...and I would presume that Tecumseh is the main problem that way, because of the population around from which you hire. [LR195]

BOB HOUSTON: Yes. [LR195]

SENATOR JOHNSON: How far is that from Lincoln? [LR195]

BOB HOUSTON: From Lincoln? [LR195]

SENATOR JOHNSON: Yeah. [LR195]

BOB HOUSTON: I'm not sure of the exact mileage, but it's about 48 minutes--45 to 48 minutes, depending upon where you start from in Lincoln. [LR195]

SENATOR JOHNSON: Okay, so close to an hour of travel each day. [LR195]

BOB HOUSTON: It's an hour. From my house in southwest Omaha to Tecumseh is about an hour and four minutes, and so it's...and it's two lane and that makes it a little more difficult. One of the things that...we have a management team looking at alternate shifts, to see whether or not that would assist. And the reason for that is, is that understanding the lifestyle of the people that live in southwest Nebraska, being from a rural community, the fact that gas prices are climbing, to have people travel fewer days. If it was a 10-hour shift, it would be 52 fewer days you would travel. If it's a 12-hour shift, it's 78 fewer days. And so we want to consider those options. [LR195]

SENATOR JOHNSON: Yeah. I know that there's hospitals that have done that with their nurses, with some success. Senator Stuthman. [LR195]

SENATOR STUTHMAN: Thank you, Senator Johnson. Mr. Houston, you brought up the fact of substance abuse and mental health needs. Do you feel that there's a lot of substance abuse, and that is the reason why they're put in the prisons? Is that a major component of it? [LR195]

BOB HOUSTON: Well, the people that we get in on drug offenses are in on more

serious offenses. One of the things that the Community Corrections Council has done a good job of is addressing the needs through the SASS program, the probation is established in day reporting centers. So a lot of those issues are being addressed for drug users. We have people that are either repetitive offenders or are involved in the distribution of drugs. But again, they also have a lot of substance abuse issues they have to face. Currently we have 232 residential substance abuse beds. That number is going to go up to 440 over the course of about the next 18 to 24 months, which means we're going to have 10 percent of our population at any one time in residential substance abuse beds. We have an additional 15, closing in on 20 percent of our population that will be on outpatient substance abuse at any one time. Does this address all of their needs? I think it comes very close. I think we're well resourced, and we have no excuses for why we don't address those issues with the resources we've been granted. So the other thing that we're doing with the mentally ill is that we do get people in that are highly volatile and mentally ill, and they're properly placed inside of our correctional institutions. So along with what we call Plan B...I went before the Appropriations Committee last year. We had clinical psychologists, physicians. We gave up a couple positions in central office to get an additional psychiatrist that we're recruiting for now. And so we are becoming better resourced to deal with those inmates. [LR195]

SENATOR STUTHMAN: Thank you. The fact is very alarming to me of, you know, what you just stated--the increase of the need for the substance abuse. I'm trying to find something that we need to be doing so that we don't have to have that increase in need. You know, we can't continually just expand that. We've got to get to the problem of this thing of, you know, education and keeping them from this substance abuse. That's where I think we need to be spending a lot more of our, you know,... [LR195]

BOB HOUSTON: I appreciate that. [LR195]

SENATOR STUTHMAN: ...money and resources, because if we continually just add on

to hopefully take care of what we have as a problem, we're going to bankrupt ourself. We've got to start from the bottom with families and making sure they never get on this substance abuse. I mean, that's what I would like to take a little time and study that, so. [LR195]

BOB HOUSTON: Well, I agree. Yeah, your first level of social control is much better than the second. [LR195]

SENATOR STUTHMAN: Yes, yes. But thank you for your comments. [LR195]

BOB HOUSTON: You bet, um-hum. [LR195]

SENATOR JOHNSON: One other thing, and certainly that's an extremely important thing that Senator Stuthman has brought up. The other thing, however, I'm a great believer in the value of jobs, as far as not only keeping people out of jail and so on, but just their own personal worth in their own eyes, and so on. How good a job do we do--and I realize that there are certain people in your institutions that we don't need to worry about them having jobs and things like that, but for the, shall we say or use the term "low-level" offender, how do we do in preparing them to go back into society? What kind of success do we have of them having jobs and so on? I know, for instance, Nebraska has one of the lowest jobless rate in the United States, so apparently there is the need for people to fill these jobs. Are we able to, for want of a better word, train people well enough so that they can go into these jobs and so on, that are theoretically waiting for them? [LR195]

BOB HOUSTON: When we place inmates in our community centers, they're tasked with getting a job, and we provide assistance and tips on employers to go to. And if they don't obtain a job within a couple weeks, they can be returned back to a correctional institution. It is very rare that somebody goes back to a correctional institution because they can't find a job. But now is that job a job that they want to stay with? Likely it could

be and likely it couldn't be. So now going back into the institution, our education program, we are now going public with our education. We're going to have certified teachers that will be state employees, and everything we do beyond the...well, in addition to the adult basic ed and the GED and now the high school diplomas they'll be able to earn in our youth facility, is going to be geared towards reentry. Inside the institutions all inmates in general population are assigned to jobs. We have a...we're one of the leaders in the country as far as employing inmates in our industries program. We have about 15 percent of our inmates at any one time working in industry jobs, and those jobs pay better. We also have private industry that employ inmates inside, and some of those employers guarantee the inmates jobs when they get out, in the operations they have in the community. We also have reentry officers. We received a reentry grant from the U.S. Department of Justice, all geared towards our class vacation system and developing the structure to allow inmates to prosper inside the institution and then once placed in the community. So we do a good job; we can always do a better job. But we are now able or are positioned to expand our reentry efforts with reentry officers working more broadly in the Omaha/Lincoln community and then Greater Nebraska. [LR195]

SENATOR JOHNSON: How much use do we make of our community colleges in this system? I understand, you know, the GEDs and those kind of things, and familiar with what they do out at YRTC in Kearney and so on, but how much integration is there with your facilities with the community colleges? It seems to me that would be quite a resource in that. [LR195]

BOB HOUSTON: Yes. We've had...over the years we've had contracts with area colleges. We continue those relationships. Our contract has been through the Metro Community College for the past ten years, and even as we go to self operate, we're now moving the credentials up to certified teachers. We were in conversations this week and have been for the past several weeks with the University of Nebraska-Omaha. We do a lot of work with them. They have professors who have worked with education in

correctional institutions in other states that are now professors at the university, so we'll continue to work with them. We also intend to work with the community college in McCook for the needs out there. So we find not only that we need them, but they have adequate resources--good resources--for us, and even beyond that, very helpful attitudes. And there's really nothing that we can ask for that they don't help us out in some way. [LR195]

SENATOR JOHNSON: Thank you. Any other questions? Seeing none, thank you very much, sir. [LR195]

BOB HOUSTON: Okay. Thank you, um-hum. [LR195]

SENATOR JOHNSON: Chris Peterson is next on my list. Good morning. [LR195]

CHRIS PETERSON: (Exhibit 2) Good morning, Senators. Chairman Johnson, welcome back. Good morning, Senator Johnson and members of the Health and Human Services Committee. My name is Chris Peterson, P-e-t-e-r-s-o-n, and I am the chief executive officer of the Department of Health and Human Services. We've provided you with a packet that's broken into four areas. We start with the BSDC, Beatrice State Developmental Center--that's the first packet, and the form that it's in is how the other packets are. There's the testimony on the top; the second sheet then has all of the budget and fiscal information, FTEs; and then the last has what we wanted to give you an idea of the layout of the facility and the areas of the campus, as well as provide you just some pictures of different buildings on the site. So we'll be using the first packet, which is titled "Chris Peterson," and then it has "Introduction and Beatrice State Developmental Center." First of all I'd like to thank Senator Schimek for the opportunity to visit about our 24-hour facilities and talk about some of the things that we are addressing, the challenges we have, and some of our successes, and some of our further challenges. In addition, I'll be visiting with the senator. If there has been no feedback received, we'll certainly make sure that that does not continue. The

department is responsible for three regional centers, the four state veterans' homes, the two youth rehab and treatment centers, and the Beatrice State Developmental Center. And as an idea of the oversight that we have, whenever we have federal money that goes into any of our facilities, we also have oversight by that federal agency. So CMS, which is Medicaid and Medicare, Veterans' Affairs, Department of Justice, as well as our own state agencies, all provide oversight to us in the form of doing surveys. Before this July when the new department structure of six divisions went into effect, all 24-hour facilities were part of the former Department of Health and Human Services. In the new department, the 24-hour facilities are located in four of the six new divisions, providing much more focus. The directors will be providing an overview of the census, capacity, challenges and responses to those challenges. And as I said, the budget information on each facility is provided in the attachment. Following my testimony on the Beatrice State Developmental Center, Division Directors John Hilgert, Todd Landry, and Scot Adams will provide specific information about the facilities operated within their divisions. We do have a new director of developmental disabilities. His name is John Wyble (phonetic). Just the way...the luck of the draw, he's closing on his house in Arkansas this weekend and so was not able to be here today. I'd like to now provide you with information on the Beatrice State Developmental Center or BSDC. It is an intermediate care facility for the mentally retarded, and it's referred to in that level as an ICF/MR, and I want to thank Senator Johnson for visiting the facility, as well as I believe Senator Gay came out. Senator Wallman and myself hosted a meeting out there and a tour and lunch with the friends and families of BSDC residents, and we have a really nice turnout. The ICF/MR campus capacity is 406; however, it is currently budgeted...the total amount of the appropriations is budgeted at 325. In addition, the capacity for the acute or the hospital care is 31, and 14 for the Bridges Program, which is located on the Hastings Regional Center campus. The total capacity for these three levels of services is 451. The past year has been a time of growth and change for BSDC, triggered by a CMS survey in September of 2006 that found a number of areas of concern. Actually, of the eight conditions that we are required to meet--and under each of those conditions there are hundreds of what they call "tags," we failed seven out of the eight. It was the largest

survey that had come. I believe it was over 480-some pages, and they faxed it to us--it took hours. CMS, though, has accepted our original corrective action plan, and we have received many positive comments about the efforts of the staff to make a positive difference in the lives of the residents. As I told you, we originally failed seven out of the eight, and after the corrective action plan was approved, CMS then came back out for another unannounced survey. At that time we passed six out of the eight, and currently we are now under the final corrective action plan, we hope. And CMS is there today. They showed up, I believe, on Tuesday. They'll be there for five days to seven days. There are five of them from Baltimore, Chicago, and then they have several independent consultants there. They are checking on all the changes that have been put in place to provide safety and improve the quality of the life of the residents. As I said, the facility is budgeted with a total of 896.5 full-time equivalent positions. Currently, 733 positions are filled and 132 are vacant at the BSDC facility. The Bridges Program, which is located at the Hastings Regional Center, has 29.5 FTEs, of which 27.5 are filled, and two are vacant. The total resident census is 340. Of those, 322 are in the ICF/MRs, 6 in acute care in the hospital located on the campus, and 12 in the Bridges Program at Hastings Regional Center. I'd like to provide the following challenges and our responses to these challenges. First I would like to echo Director Houston's comments on the recruitment of staff for our facilities, not just BSDC, but there are others, too. I've joined the...become a part now of the Blue Ribbon panel, and we will be using certainly all of that information, some of which we already do. In addition, we'll be working with training and work groups to study how our staff feel, because recruitment is not only an issue for us, but also retention. We've done a variety of things, including shift differentials, credit for work experience. Director Hilgert, I'm sure, would be glad to talk about how they've changed the shifts at the Grand Island Veterans' Home. In addition, at BSDC we actually bussed staff from Hastings Regional Center to BSDC. And one of the things that we're doing now, we have the Employment First program, and we are actually having work experience done at the 24-hour facilities by bringing Employment First people who are on a contract there to train. I'd like to update you now on the Centers for Medicare and Medicaid, as we call CMS. Since September of 2006

BSDC has undergone major changes in administrative personnel, administrative and managerial structure, and service delivery in response to CMS. Because of that, significant improvements have been made and continue to be made within the organization. And as I said, they arrived October 30 to review the implementation of the most recent CMS plan of correction. In addition, we had a visit from the Department of Justice. They were here for approximately a full week. There were five independent consultants, two attorneys, and an investigator. And they spent again, I believe, five days on the campus, as well as one day at the Bridges Program at Hastings. They pulled files, worked with the staff, and we anticipate that we'll be hearing response back from them probably within two and a half to three months. And as always, when you have a survey, their role is to help us find ways that we can better serve the clients. And so we had a very good meeting with them. They were very appreciative of the friendliness and the helpfulness and the professionalism of the staff. So we wait to hear what their response is. Experts provided an overview of their impressions of our strengths and areas of needed improvement and we will get, as I said, more information on that in two to three and a half months. Third, BSDC has an extremely dedicated core group of employees who consistently go above and beyond to improve the lives of those receiving services. But we also currently have 112 vacant developmental technician--DT--positions, which is a 26 percent shortage. In response, BSDC is relying on voluntary overtime, freezing staff for overtime--that was the mandatory overtime that Director Houston explained, and the use of on-call staff, given the shortage of developmental technicians needed to provided services as well as meet the expectations of CMS. A continuing recruitment campaign assists in recruiting staff. One of the other things I would tell you is that we are trying to recruit in different ways. We have always done active recruiting through the newspaper. We're now using the radios, billboards, newsletters, and some of the employment agencies that you have on the Internet. So I'd be glad to try to answer any of the questions you might have. [LR195]

SENATOR JOHNSON: Senator Stuthman. [LR195]

SENATOR STUTHMAN: Thank you, Senator Johnson. Good morning, Chris. [LR195]

CHRIS PETERSON: Good morning. [LR195]

SENATOR STUTHMAN: So nice to see you here this morning. [LR195]

CHRIS PETERSON: Thank you, Senator. [LR195]

SENATOR STUTHMAN: In the Beatrice home are you, because of all this, are you moving patients out to different homes or group homes, anything like that? [LR195]

CHRIS PETERSON: One of the focus always with the developmental disability population is that they are served in the least restrictive setting, and so that's always an evaluation that is done. We did close one unit. We have actually reduced it, I think, by approximately around 25 through the year. That's through...some have gone to the community. Some have passed away. But yes, they're continually evaluated, and if there is a community placement that they agree to go to, because this is a...BSDC is all voluntary, and they make arrangements with their provider, which we help set up, then yes, we put them into the community. [LR195]

SENATOR STUTHMAN: Now you stated if the individual there--I guess I wouldn't call it an inmate--I've got a constituent... [LR195]

CHRIS PETERSON: Resident. [LR195]

SENATOR STUTHMAN: Resident. Inmate is the wrong word. [LR195]

CHRIS PETERSON: They're all there voluntary, and they're residents. [LR195]

SENATOR STUTHMAN: And this individual is elderly, and he's blind. [LR195]

CHRIS PETERSON: Um-hum. [LR195]

SENATOR STUTHMAN: And they were going to move him to another home, and he was really upset about it, so. [LR195]

CHRIS PETERSON: Move him from BSDC to another home? [LR195]

SENATOR STUTHMAN: Um-hum. [LR195]

CHRIS PETERSON: Hmm. [LR195]

SENATOR STUTHMAN: And I'd have to go back on my notes, but it's been several months since the family contacted me. So...and that's a concern that I had, you know, for an individual like that, that is accustomed to a certain area. [LR195]

CHRIS PETERSON: Absolutely. Let me look into that, Senator. [LR195]

SENATOR STUTHMAN: Yeah, yeah. But, but...yeah, I... [LR195]

CHRIS PETERSON: Yeah, I'd have to...I want to see exactly what they were requiring him to do, because again it's based upon the evaluation, and it's a team approach and it involves the resident, the voluntary guardian, if they have it, family members. And so I'd certainly want to take a look at that one. [LR195]

SENATOR STUTHMAN: Okay. Thank you very much. [LR195]

CHRIS PETERSON: We wouldn't force them out. [LR195]

SENATOR STUTHMAN: Yeah. I'll get you some information. [LR195]

CHRIS PETERSON: Okay, thank you. [LR195]

SENATOR JOHNSON: Senator Hansen. [LR195]

SENATOR HANSEN: Thank you, Senator Johnson. Chris, good morning. [LR195]

CHRIS PETERSON: Morning. [LR195]

SENATOR HANSEN: Is the 26 percent shortage in staff a part of the CMS overall? Are they concerned about that? [LR195]

CHRIS PETERSON: Very much. That was one of the specific things. [LR195]

SENATOR HANSEN: So are you ever going to be able to comply, if you don't become fully staffed? With the turnover...I mean, there's going to be turnover anyway. [LR195]

CHRIS PETERSON: Um-hum. We have that challenged in all of our facilities, Senator. It's something we try to staff to, but if we aren't able to do it with staffing, then we try to do it with training. And there are a variety of ways you can do that, which is to make sure that if you're having temporary staff come on, if you're working through a pool, those people are trained on campus. What the concern CMS has, is because you have a constant turnover of staff, they're not trained adequately. So what we have to make sure of is that our training efforts on the front end meet the requirements that CMS has laid down for us and that they have the knowledge of what they're supposed to be doing, as well as the knowledge of the person that they're working with. So it is a challenge; there's no doubt about it. That's why for us, if we can retain them once we get on...to go through the whole phase of training them and have somebody then walk away, that just sets us back. So we're working on having mentoring done once they go into one of the units, and we've moved now to neighborhood units, so that people feel

they're more part of a family style of living. Once they go onto that unit, then they have the ability to help look at the times that they'll work, when they'll take their time off. They'll have some say in their scheduling along with the others. And so by fostering that feeling that they're part of BSDC, and not just help coming on and moving through, we'll be able to retain them. That's our goal. Right now in BSDC, obviously unemployment is very low. There are competing markets there. So it's just a challenge for us there, but yes, it was very clear from CMS that was a concern. [LR195]

SENATOR HANSEN: I understand from last spring when you talking about that there's an industry that has come into Beatrice and is competing for jobs. How far is it from Lincoln to Beatrice? I mean, we talked about how far it was from... [LR195]

CHRIS PETERSON: Thirty-five minutes. [LR195]

SENATOR HANSEN: Thirty-five minutes, okay. Carpooling? Busses? [LR195]

CHRIS PETERSON: And we recruit. We looked at busses, yes. We look at all of those things. [LR195]

SENATOR HANSEN: Can you pay for mileage to reimbursement part of that? [LR195]

CHRIS PETERSON: That I could not answer without checking with HR and whether we're able to pay for mileage. I just...I don't know the answer for that, and I know Mr. Marvin is here. Maybe he'd be able to answer that later, or I can find out before the end of the hearing. Let's put it that way. Why don't I do that? [LR195]

SENATOR HANSEN: Okay. Well, I appreciate having these facilities in other towns other than Lincoln and Omaha. But I see the challenge that you have, especially when you compete with a new shiny facility down there to produce something. I can't remember what the factory was. [LR195]

CHRIS PETERSON: Lawn mowers. I think it's lawn mowers. [LR195]

SENATOR HANSEN: Lawn mowers? [LR195]

CHRIS PETERSON: Yeah. One of the things that we see in our staffing at BSDC, we have family members, and they've worked there for a long time. And we have other family members that have heard about that, so we are careful in terms of...obviously with, you know, of hiring in light of supervision. But you know, people know each other in a small town, and so if they hear good news about a facility, then they're going to go there and work, and so we rely on that a lot. [LR195]

SENATOR HANSEN: Thank you. [LR195]

CHRIS PETERSON: Um-hum, thank you. Any other questions? [LR195]

SENATOR JOHNSON: No. I guess I'd just like to make one comment, is when I did go through the facility down there and so on, I must say that I was impressed by what you are accomplishing. There's lots of hurdles to overcome when you go from the institutional, big building concept to more of a group home type of thing, and I understand all of the problems in doing that. And so I think you're to be complimented. And one other thing. I'm familiar with Mosaic or Bethage Mission out in Axtell, which has similar clientele and so on, and there I know they have the same problem in many respects, in that whereas there certainly is this group of dedicated people that work at both of these facilities, they derive great satisfaction from taking care of these people, they still have to pay their bills. And so there is this almost a schizophrenic attitude about their jobs, in that they thoroughly enjoy and take this satisfaction, but the pay is such that I know in the Axtell/Kearney area, the competition for these people is such that...they don't have the lawn mower factory there, but they've got lots of other places to work, and so what they're able to pay is getting to the point where it's hard to attract

or retain people. And I see the same thing at Beatrice, and so I think, you know, that's one of the things we're going to have to consider. Is there any chance of raising the pay for these people? [LR195]

CHRIS PETERSON: And you may be aware, Senator Johnson, that these were the people that were affected by the CIR ruling. The developmental techs will be the ones that were moved into the new comparability range, so we're certainly hoping that that has an impact. Definitely we're talking about that. And again, as I said, it's a small community and word of mouth. So if we can be a good place for people to work, I think then that probably is one of our best advertising pieces we have, is that yes, I work there; it's a good place, you know, and we do good things for people, so. [LR195]

SENATOR JOHNSON: Yeah. Well, I remember a few years ago when Smuckers got the national award for the best company to work for. [LR195]

CHRIS PETERSON: Yes. [LR195]

SENATOR JOHNSON: And all of the comments were about what a great place it was to work and that pay was down the line a ways,... [LR195]

CHRIS PETERSON: Um-hum. [LR195]

SENATOR JOHNSON: ...and so I think there's that aspect of it, as well. [LR195]

CHRIS PETERSON: We need to make sure our workers feel that they are part of the community and that they know how important their job is, and that's the word we want to get out. Thank you. [LR195]

SENATOR JOHNSON: Thank you. We've had Senator Gwen Howard join us. Welcome, Gwen. [LR195]

SENATOR HOWARD: Thank you. [LR195]

CHRIS PETERSON: Hi, Senator. [LR195]

SENATOR JOHNSON: If you have any questions or comments, obviously feel free to join in. Chris, thank you very much. [LR195]

CHRIS PETERSON: Thank you. [LR195]

SENATOR JOHNSON: Next is John. Welcome. [LR195]

JOHN HILGERT: Good morning. Thank you. Good morning, Chairman Johnson, members of the Health and Human Services Committee. My name is John Hilgert, J-o-h-n, H-i-l-g-e-r-t. I am testifying as the director of the Division of Veterans' Homes. I am pleased to be with you here today to review the state's 24/7 care facilities. I'd like to begin by thanking you for LB296 which allowed for the creation of this division. Since the creation of the division we have set to work in creating a system that is already showing improvement. In fact we had the opportunity to celebrate as a system the accomplishment of the Eastern Nebraska Veterans Home staff in opening their facility this past July 14 and soon after being certified deficiency free by the United States Department of Veterans Affairs. The census has been steady and climbing over the past six months, while at the same time we have been defining, setting and training for new and higher standards of care. We have hired new administrators in all four homes and added the position of a systems clinician to the division. We have studied issues such as pharmacy, staffing, resources with an eye towards the ever-changing needs of Nebraska's veterans. With the Governor's leadership as well as your commitment to our veterans, these are exciting times for the Veterans' Home Division of DHHS. Thank you again. In the Grand Island Veterans' Home the full-time equivalent employees at the Grand Island Veterans' Home is 387.98; 329.82 are filled and 58.16 are vacant. These

employees provide skilled nursing and assisted living to veterans and certain nonveterans who are authorized by law to receive services, such as Gold Star parents or spouses of veterans. The capacity at the Grand Island Veterans' Home is 266. The census, or the number of veterans being served, is 239, with an additional 3 scheduled admissions this next week. I would like to provide information about some of the challenges in the Grand Island Veterans' Home and along with how we're responding. First, staffing and mandatory overtime and the wage scale for this area provide challenges. In response, we're proactively working with staff to facilitate temporary 12-hour shifts rather than 8-hour shifts, providing an opportunity for employees to better meet both work and family responsibilities. Mandatory overtime has drastically been reduced with these new schedules. But we're currently holding job fairs and same-day employee screening, interviews and reference checks to speed the process of filling these open positions. Obviously the wage scale is mandated by the negotiations. Second, the size of our facility in Grand Island and the logistics of the units provide challenges. In response, because of the enormous size and layout of our facility, we basically operate seven nursing and assisted living areas. Each unit is comparable to a skilled nursing facility in the vicinity. Third, the age of the infrastructure of our facility in Grand Island provides challenges. In response, we continually evaluating the necessity of renovating the existing areas. The Western Nebraska Veterans' Home in Scotts Bluff: The number of FTEs is 101.1; 98.6 are filled, and 3.5 are vacant. Other agency-placed employees are five. The capacity is 115; 65 assisted living, only 50 nursing. In Western Nebraska Veterans' Home the census is 81 members. Some of the challenges and how we're responding to them in the Western Nebraska Veterans' Home in Scotts Bluff: First, increasing the census of the facility is a challenge, as there are many individuals wishing to stay in their homes as long as possible. The community has met their needs well by providing services, making this possible. We're currently at full capacity in nursing, with open rooms in assisted living. The response to this challenge could be an addition to our nursing unit and a remodel of the assisted living. Second, staff turnover is a challenge for the facility. In response, a retention program will be implemented throughout the facility, changing the culture of the workplace to be more desirable to a

wide range of people. Eastern Nebraska veterans' Home: The current number of filled FTEs at the Eastern Nebraska Veterans' Home is 156; 116.4 are filled; 39.6 are vacant. The capacity is as follows: There are a total of 120 beds at the Eastern Nebraska Veterans' Home. The Eastern Nebraska Veterans' Home comprises four distinct neighborhoods or living areas. There's a 30-bed assisted living neighborhood, a 30-bed secured memory support neighborhood, and two 30-bed neighborhoods for general skilled care. Our capacity has been set at approximately 113 beds to allow for changes in conditions which veterans in the home experience, necessitating their movement on occasions between levels of care. The census or numbers served for the Eastern Nebraska Veterans' Home is 79. We are admitting weekly to reach our capacity goal of 113. I'd like to share some of the challenges at the Eastern Nebraska Veterans' Home and our responses. We face staffing challenges. Specifically, staffing in general and nursing care staff in particular are the biggest concerns for the leadership at the Eastern Nebraska Veterans' Home. Currently, Eastern Nebraska Veterans' Home has 42.4 staff vacancies. There are two nursing supervisor vacancies and 3.7 registered nurse vacancies, 7 LPN vacancies, 16.3 medication aide/certified nursing assistant vacancies, as well as 5.5 custodial care vacancies, including 2 custodial staff dedicated to the dietary department, and 3.6 dietary staff vacancies. The biggest impediments to attracting and keeping qualified workers seem to be salary and the concept of mandatory overtime. In response to this challenge, the Department of Health and Human Services' human resources section is providing outstanding support and creative ideas to help with staffing concerns. A large number of personnel are applying for the med aide/certified nursing assistant positions. However, only a small number from this pool of candidates is able to pass our very stringent screening process. Since we are taking care of vulnerable adults, changing these requirements is not practical nor feasible. As far as licensed professional staff is concerned, the pool of applicants is much smaller, and many of the advertised positions are not getting any candidates. To help this situation, two job fairs to be held right at the Eastern Nebraska Veterans' Home are planned for November. Meanwhile, Eastern Nebraska Veteran's Home must rely on temporary staffing agencies to fill these gaps. Norfolk Veterans' Home: The current

number of FTEs at the Norfolk Veterans' Home is 192; 187 are filled and only 5 are vacant. In addressing capacity, there is a total of 159 licensed beds at the Norfolk Veterans' Home. Norfolk Veterans' Home is comprised of six separate pods or distinct care units with differing levels of care. There's a 20-bed domiciliary unit, a 10-bed secured memory support (Alzheimer's) unit, and four pods with levels of care from intermediate to skilled. Our capacity has been set at approximately 143 staffed beds, to allow for changes in conditions which veterans living in the home experience which necessitates the move between levels of care. The current census is 143. Norfolk Veterans' Home, they also face staffing challenges in this home. Specifically staffing in general and nursing care staffing in particular is of greatest concern. Currently, Norfolk Veterans' Home has 11.5 staff vacancies; there are .5 FTE registered nurse vacancies, 4 LPN vacancies, 3 FTE certified nursing assistant/med aide vacancies, as well as 1.5 food service assistant, 1 administrative secretary vacancy. The biggest impediments to attracting and keeping qualified workers seem to be salary and the necessity of mandatory overtime. To date the Norfolk Veterans' Home has been able, through requiring mandatory overtime, to defer using contract nursing staff, a highly expensive alternative to adequate caregiver staffing. In response to this challenge, the Department of Health and Human Services' resources section is providing outstanding support and creative ideas to help with staffing concerns. Again, the application of stringent hiring criteria is necessary in order to assure the highest level of quality care. Multiple applicants often result in identifying only a few select capable of delivering the consistently high levels of care required for our highly vulnerable and increasingly acute veteran population. For license nursing staff, we have used creative scheduling to provide meaningful opportunities for professional careers and have greatly been aided by this in the state's benefit structure. And I will certainly attempt to answer any questions you might have, and I will note that I have changed my testimony in three places, because our census keeps on going up, and I wanted to give you the latest figures. [LR195]

SENATOR JOHNSON: Senator Hansen. [LR195]

SENATOR HANSEN: Thank you, Senator Johnson. Good morning. [LR195]

JOHN HILGERT: Good morning. [LR195]

SENATOR HANSEN: On our...we had a tour a few weeks ago of the HHS facilities. We toured the Western Nebraska Veterans' Home, and they, according to your census numbers here, they have...well, they have 80 members and have a population...have a capacity of 115, and no Alzheimer's unit. They are just in the general population, as I recall. The big thing that they have out there is that veterans come to the veterans' home, which is...that's why it was built. But they have the 75.5 rule, where veterans' wives cannot be in that facility, over a population of 25 members--25 percent of the members... [LR195]

JOHN HILGERT: Yes, sir. [LR195]

SENATOR HANSEN: ...can only be veterans' wives. Western Nebraska is not real heavily populated. What has to happen to change that rule? Is that a federal rule? [LR195]

JOHN HILGERT: Yes it is, Senator. And you are correct in referring that we only can have 25 percent, and they consider them nonveterans. So the veterans that they allow in the homes of the USVA are wartime veterans. We can have 25 percent nonveterans, which are spouses, the Gold Star mothers, et cetera, and widows. And that is a federal rule that we can't...we don't have any...and how to go about changing that, I would defer that to your contacts and relationship with our congressional delegation. We certainly don't have a position currently at this time. Should you wish to pursue that, we could certainly consult with the Governor's Policy Research Office to have a position on that. [LR195]

SENATOR HANSEN: It looks like a facility that needs more members because they're fully staffed, but they don't have enough clientele. [LR195]

JOHN HILGERT: Yeah, and I reference that. One of the...we have a waiting list. In fact, on the wonderful web site that HHS, has a veterans' homes statistics and a waiting list that we update every week, to let our CVSOs, our veterans' service organizations, as well as any interested parties, to keep track and look at our waiting list. In Western Nebraska we do have a waiting list for skilled care but not for assisted living. So what our new administrator, Lonnie Starke, and we have talked about is exploring how could be convert some of those assisted living beds, which are not utilized, into nursing beds. And what that would take, we're just in the discussion phase of that, but that would be one approach. It is frustrating to have empty beds in a facility while there's a waiting list, but it's not for the appropriate care. So...and we're looking at that. [LR195]

SENATOR HANSEN: Okay. One other follow-up question. [LR195]

JOHN HILGERT: Yes, sir. [LR195]

SENATOR HANSEN: I...at the same time we were up there, we had a problem in North Platte at a private nursing home, with background checks. And as we were introduced to the staff there, the HR person, I asked him what he does for background checks, and he said he did them himself. Is that typical of veterans' homes and not nursing homes? [LR195]

JOHN HILGERT: I really couldn't comment on what is typical or not in the private sector, Senator. I have very little experience. Only of late with my mother in assisted living do I have some experience there. The background checks are performed by the HR, which is a tenet activity of our system. They're not members of our division; they're support services, and I understand that they can do those quite rapidly. We also, just for your edification, Senator, we also do background checks as far as all of our members coming

in, as well. So we do search a rather...have some...and it's fairly quick turnaround, I would say as well. I have never heard that as a problem or an impediment to filling our staffing positions, is the background check. I have not heard that to be case, and frankly, I've had a lot of discussions about HR and staffing in the last six months, and that hasn't come up, Senator. [LR195]

SENATOR HANSEN: Well, in the private sector, at that time it was taking up to 30 days for a background check. And when I heard that gentleman say that he can do them in 15 to 30 minutes, I was... [LR195]

JOHN HILGERT: That's what I'm saying. I can't comment on the private sector, but we just have a good working relationship. And the folks in human resources have a lot of skill; they've been doing this for quite a long time. They've been able to share their skills with the Nebraska Department of Veterans' Affairs in having the Nebraska Department of Veterans' Affairs...enabling them to do very rapid background checks as well on some of the members. [LR195]

SENATOR HANSEN: Well, I was very impressed with the tour of the veterans' home that we did go to. [LR195]

JOHN HILGERT: Well, thank you very much, Senator. I'll pass that along to Lonnie and his staff. [LR195]

SENATOR JOHNSON: Well, I was going to make some of the same comments that the senator did, in that I really was quite impressed with the facilities and how they are run and the staff who were working there. They seemed to be genuinely enthused about the good work that they were doing, and it's looks to me like it's pretty good. [LR195]

JOHN HILGERT: We're energized, Senator, you know. [LR195]

SENATOR JOHNSON: Well, it looks that way. [LR195]

JOHN HILGERT: And I can't say enough about Eastern Nebraska Veterans' Home, with all the issues they've had. A lot of those...most of the same staff were in. But we've had wonderful staff buy-in. We've looked at how we do things differently, and I think the division is fairly energized and see the direction we're going in. [LR195]

SENATOR JOHNSON: A couple of things: One is, I was also going to talk about the 25/75 rule and so on. And I guess I wonder, you know, we've got a couple of, I think, pretty good friends of veterans in Congress. And I'm thinking of Senator Hagel and Senator McCain in particular, and I guess what kind of popped into my head is that in other branches of government and particularly with Medicaid and these type of things, we have waivers of rules. And I guess it, you know, kind of entered my head a little bit. Is there an opportunity where when we get into situations where...like what we have particularly out in Scotts Bluff, to have a waiting list and then empty beds just doesn't make sense. And...so that when you get into a situation like that, is it possible that you could "apply for a waiver." In other words, could we work with the national veterans' agencies to come up with that type of procedure that we could go through. [LR195]

JOHN HILGERT: Well, let me first talk about a waiver itself. We should be proud in Nebraska, because we have more veteran home beds per capita than any other state in the union, and we're only allowed to do so by a waiver from the Secretary of Veterans' Affairs in Washington, D.C. We had to get a waiver in order to build the Eastern Nebraska Veterans' Home, signed by Secretary Prencipe (phonetic) himself. He was a very approachable secretary. And he signed that waiver to allow us to proceed with the replacement of the Thomas Fitzgerald Home. So that's certainly not out of the realm of possibility. I will say that that has not been pursued. There's two other factors beyond simply applying--not simple--but beyond applying for a waiver that I'd like to make the committee aware of. One is that our funding for the Division of Veterans' Home stands on a triad of General Funds, cash funds generally from the member, and insurance, et

cetera. Third would be federal funds. The federal funds are provided on a per diem basis for the veterans that are eligible--that 75 percent. If we would open it up beyond...or get a waiver of beyond the 25 percent, there may, in fact, and I would almost...you could safely assume that there would be some budgetary impact on that, regarding the resources coming into the system. The second point I'd like to bring up would be that obviously... [LR195]

SENATOR JOHNSON: John, if I could comment on that for just one second. [LR195]

JOHN HILGERT: Yes, sir. [LR195]

SENATOR JOHNSON: One of the things that comes to mind, however, is that that second person in the room who would--wife, husband; it could be either--would have to be healthier than the person who is there, so he or she would require less care. And so there wouldn't be the doubling of cost in that room. [LR195]

JOHN HILGERT: No, no. And what I'm saying is that we get a per diem for a wartime veteran. We would not be getting the per diem for a non-wartime veteran, be it the spouse, widow, survivor. So we wouldn't be able...if you're not going to get the federal money coming in, we would have to increase our cash or our general. [LR195]

SENATOR JOHNSON: I agree, but perhaps that... [LR195]

JOHN HILGERT: Yeah. [LR195]

SENATOR JOHNSON: ...wife or husband could pay for that. [LR195]

JOHN HILGERT: That's something...that would be something to look at. And the second thing in reaction to that, the resource issue, on the home side going out, would be the provision of the care of skilled nursing. It's a higher acuity than assisted living, and

therefore it takes more resources and staffing. Again, I'm not trying to suppress the idea; I'm just trying to let you know that there would be some considerations before we would apply for that waiver. But that is something that certainly we could examine. It's interesting. You have in nursing homes in general, I think, you have a mix of acuity. You say, you know, can you take this person with this level of acuity. Well, maybe you could take this person with this level of acuity, but if you had everyone in skilled nursing with a high level of acuity, you couldn't. So there's some science to it, on how we allocate resources, the staff care time. Some members care for...need more care than others. And my own mother's example: She's a sliding scale diabetic. She's in assisted living, but she needs a higher level of assisted living care than someone who's not a sliding scale diabetic suffering from hypertension and a cancer survivor like my mother. So there is some science along with this, and the reactions that we have to serving our veterans need to be done thoughtfully, with the best clinical approach in mind. We certainly want to make sure that if we make that commitment to ask an Nebraskan to make this facility their home, we need to make sure that we're committed to providing the highest standard level of care that we can. But thank you. [LR195]

SENATOR JOHNSON: We better go to our ladies first here. Senator Howard. [LR195]

SENATOR HANSEN: He's had a turn. He's had a turn. Thank you. Thank you, Senator Johnson. Senator Johnson and Senator Hansen make such good points. The facility really is to assist the veteran and their families, and everyone knows that with family support, people certainly live longer. And for someone that's been with a spouse for a number of years, I would think that would be a very severe emotional hardship to be separated from that person, and I certainly would stand with Senator Johnson in requesting or certainly saying that it's worthy to look at the option of a waiver. These homes really are to help people to live out their lives, and I would think we should have the commitment to do whatever that would require. [LR195]

JOHN HILGERT: Right. And by the way, one of the reason we do have that restriction

by the federal government is because the federal government obviously did help pay for not only the acquisition, construction, and renovation of these facilities. So that's why we're kind of...that's why we have to follow...but... [LR195]

SENATOR HOWARD: Well, we're all grateful to the federal government, but... [LR195]

JOHN HILGERT: But I understand the waiver. And I hear you loud and clear, Senator. [LR195]

SENATOR HOWARD: But I think we have an obligation to let the federal government know what our particular need is. I mean, sometimes communication works two ways. [LR195]

JOHN HILGERT: And yes, we've been communicating quite a lot, of late, and Nebraska is heard from, I can assure you. There are a lot of issues that we are dealing with, with the federal government--our acuity with our geriatric psychiatric patients and so forth, and how to make sure that there's a seamless transition, how do we get the adequate support from our federal partners. We have had many discussions, and I will look into this and report back to the committee. [LR195]

SENATOR HOWARD: I also had...I'm sorry. [LR195]

SENATOR JOHNSON: Well, go ahead. Let me say just one thing, just to follow up on what you are saying, is you know...the irony to me is that the administration that is present now makes a very big point of family values and so on, and yet from a practical application, we break up families. That's what bothers me. Excuse me, Gwen. Thank you. [LR195]

SENATOR HOWARD: No, that's such a good point, such a good point. I also had an additional question on that. My grandfather was in the Grand Island Veterans' Home for

many years. You may know that because I often attend the events at the Grand Island home in Omaha and remember him. And he received good care. But I'm very concerned about the issue of the mandatory overtime and how that affects the employees and their families. How long do you anticipate that will be required? [LR195]

JOHN HILGERT: We're trying to do everything we can. I can't tell you, on a specific care level and a specific community--that's what they call...they call them neighborhoods in Bellevue and in the Eastern Nebraska Veterans' Home; they call them communities in Grand Island. I can't ever guarantee that we'll never be doing that. What I can say was that we instituted the temporary 12-hour shifts on October 1, and we've cut the mandatory overtime over 75 percent, the two weeks prior to that, from the two weeks after that. So we've seen a 75 percent reduction on Ginada Hostetler's efforts and the efforts of our human resources advisors, so we are making progress on that. We need to be very aggressive, and echoing Director Peterson's comments, recruitment is one thing, but retention is another thing. We need to make our Nebraska facilities the place of choice to work, and you do that by environment. We're trying to minimize that. I've talked to some of the CNAs. They've called me after hours. I've called them back at home, and I certainly understand the hesitancy--the stress it puts on the family. I talked to one CNA not making a soccer game for her daughter. [LR195]

SENATOR HOWARD: (Inaudible) right there. [LR195]

JOHN HILGERT: And then if you have a certain key family event, you know, maybe having to call in because you don't want to risk being held over. So it builds upon itself. So it's something we're aggressively trying and I think making some very real progress on trying to stop that process that feeds upon itself. [LR195]

SENATOR HOWARD: Well, and with the problems that you're facing, I don't see how you can put more pressure on the employees. [LR195]

JOHN HILGERT: No. [LR195]

SENATOR HOWARD: That discourages that very thing you want, which is the longevity of the employee. And it's also harmful to the members, because people develop relationships. And when you have a constant turnover of caretakers, I can only think that would be hard on the members. [LR195]

JOHN HILGERT: That's why...I'm sorry. Forgive me. I didn't mean to interrupt, but you're right. Continuity of care is extremely important. Agency staff is a response to a situation. It's not a way to manage a facility and provide the continuity of care that our veterans deserve, and I recognize that and we have taken pretty aggressive steps. And we are trying to do everything we can. We still have, you know, the issue of compensation and then competition in the area, and that is something we're going to try to do our best to try to counteract, but there are stressors involved in hiring, as you've heard from certainly Director Houston and Director Peterson, as well. And certainly my four facilities that I'm responsible for are not exceptions. They share in the same commonalities that you've heard elsewhere. [LR195]

SENATOR HOWARD: Thank you. [LR195]

JOHN HILGERT: Thank you, Senator. [LR195]

SENATOR JOHNSON: One other last thing that might help us down the line just a little bit is, the university med center is in the process, I guess, might be the best word, of establishing a nursing school in Norfolk. [LR195]

JOHN HILGERT: Oh. [LR195]

SENATOR JOHNSON: And if that indeed comes about, that should help relieve the nursing shortage stress, at least to some extent. So there's a little light in the tunnel

there. [LR195]

JOHN HILGERT: Yeah, and you make a good point. And again, some of the...I mean, this is premature, but I'll share it with you. We've talked to our community college system. If you've been to the...you've been...Senator, we helped tour the Eastern Nebraska Veterans' Home. [LR195]

SENATOR HOWARD: Absolutely. [LR195]

JOHN HILGERT: It's a fantastic...find a better place to do a practicum than there. I mean, to...and get the opportunity for a CNA or a med aide to experience a state veterans' home and perhaps then encouraging the second step, to encourage employment and joining our team, and joining where we're going with our service. So we're trying to look at just about everything, to try to address that. [LR195]

SENATOR JOHNSON: And it works both ways, because then you can pick out the best of the ones that come through. Any other questions? Thank you very much, sir. [LR195]

JOHN HILGERT: Senator. Thank you all. [LR195]

SENATOR JOHNSON: All right. On my list...where are we doing timewise? I guess we're still all right. Todd Landry, welcome. Good morning. [LR195]

TODD LANDRY: Good morning. Well, good morning, Senator Johnson, members of the committee. My name is Todd Landry, that's L-a-n-d-r-y, director of the Division of Children and Family Services. Among the responsibilities of this division is management of Nebraska's two youth rehabilitation and treatment centers, otherwise known as the YRTCs. These are detention facilities to which juvenile offenders are sentenced by court orders to the custody of the department. The Kearney facility serves young men; the Geneva facility serves young women. I will start by providing information about the

YRTC at Kearney. The YRTC Kearney has 148.6 full-time equivalent positions; the rated capacity at the Kearney facility itself is 172. As of November 1, the YRTC Kearney's official census was 225. This includes 182 youth on campus at the Kearney facility, 2 youth in Buffalo County Detention Center, 40 youth at Hastings Juvenile Chemical Dependency Program at HRC, and 1 on-court status. When you look at the five major categories of expenditures, between the PSL salaries and benefits, it accounts for 83 percent of our budget, operating expenditures of $1.5 million are 17 percent of the expenditures. We do not have any capital outlay expenditures, resulting in a total expenditure budget of $8.8 million. As of September 30, 25.21 percent of the year is completed. We've spent 28.28 percent of the budget at YRTC Kearney. That results in a 3.07 percent overage. The overage at this point in the year is primarily due to one-time costs for summer school teachers and scheduled fall training conferences for staff. In addition, the ongoing increase recently in youth committed to the facility has increased clothing and supplies cost for the youth. There has also been an increase in pharmaceutical costs. DAS State Building Division has continuously renovated or replaced the utility infrastructure of the Kearney campus, including a boiler system replacement, electrical distribution system replacement, the water distribution system, and total roof replacements. At the present time, new backup gas-fired generators are being installed to support the living units and primary service areas in case of power outages. Also, a fire suppression system, which Kearney has never had, is in the final planning stage prior to installation in all the youth living units and other key daily use living areas. I'd like to talk briefly about the YRTC Kearney challenges and our responses to those challenges. First of all, Kearney continues to serve an increasing number of juvenile delinquents with severe mental health disorders that have not been able to be addressed in prior residential and community programs, due to the youths' noncompliance and behavioral acting out. In response to this, Kearney staff have continuously upgraded individual treatment programming to focus on the needs through varied strategies designed for specific outcomes. Kearney psychiatrist meets bi-monthly with these high-needs youth and provides guidance and direction for staff to meet their mental health needs. One part of this effort has led to increased pharmaceutical

services, which drives our pharmacy costs up. Currently, pharmacy expenditures are at 56 percent, with only approximately 30 percent of the fiscal year completed. The second major challenge is, is the facility has received over 80 more court-ordered placements this calendar year than last year at this time. In response to that, Kearney staff have continuously worked with agency caseworkers and Magellan to ensure appropriate placements for all of these youth. And the third of the major challenges is staffing. Currently, 18 of our 31 Youth Security Specialists II positions, which are direct care staff at Kearney, are held by staff with less than 12 months in the position. We are also currently recruiting for vacant YSS II positions. In response on the recruitment side, we are advertising in area newspapers within a 50-mile radius around Kearney, attending career fairs at local colleges, and encouraging our current staff to recruit their colleagues. As well as the training and the usual human response recruitment efforts, retention of staff has improved, with assigned position mentors and performance reviews at 60-, 120-, and 180-day points. Increased and quicker direct involvement and training with experienced direct care staff has also increased, with the goal to stabilize this facet of our work force. I'd like to now provide a little information about the YRTC at Geneva. There are 101.85 full-time equivalent positions at Geneva. Rated capacity of the Geneva facility is 82, the yearly/daily count is 74, or the current daily is 74, as of October 26. Similar to Kearney, when you look at our expenditure budget by categories we have about 77 percent of our total budget is in salaries and benefits, operating expenditures are about 23 percent, total expenditures of $6 million. As of September 30, 25.21 percent of the year, again, is complete. We've spent 27.5 of our budget, resulting in a 2.37 percent overage. At this time of the year, and again, similar to Kearney, the overage is primarily due to one-time costs in summer school teachers, the special summer IMPROV leadership and communication program, scheduled conferences, as well as some furniture items for the year. As I mentioned, these are all one-time costs. Geneva also received $42,000 from Title I for school personal services and benefits, and the LB/Tobacco amount is $89,000 and is used for two social service staff PSL salaries and benefits. Two major changes are currently planned for the facility: First, the school administration building, which was built in 1956, plans are underway for major

renovations in the school area of that building, beginning in April, 2008. These renovations funded by the 309 fund include a new heating and air-conditioning system, a new roof, and new light fixtures. The renovation will require temporary relocation of services to another area of the campus and the continuation of those educational services while the work is taking place will, of course, require coordination and planning. Second, Dunbar Cottage, which was built in 1929, was closed as a living unit for the girls in February of this year. Plans are currently underway to equip the building for emergency situations, and the YRTC Geneva will be involved in a pandemic flu exercise in November, as part of the building's conversion. Let me present the YRTC Geneva major challenge and our response to that challenge. The major challenge for Geneva is we continue to see an increase in the number of court-ordered placements of young women with significant mental health issues. With this increase comes corresponding challenges of providing adequate supervision for these girls, as well as enhanced counseling services and consultation by psychiatrists. The budget, of course, is also impacted, in that additional staff are also often called in to provide additional supervision for things such as constant visual supervision following a suicide gesture, one-on-one attention, or following a significant incident. We're also facing rising medical costs, mainly due to drug costs; more specifically, psychiatric drugs. And to date we have reduced other purchasing to accommodate this expense in our budget outlay. Also in response to this challenge, YRTC Geneva has dealt with the issue by utilizing current resources, reviewing our existing programming, and relying on outside consultants to evaluate our programming. With that, I thank you and be happy to attempt to address any questions that you may have. [LR195]

SENATOR JOHNSON: Any questions? Senator Hansen. [LR195]

SENATOR HANSEN: Thank you. Good morning, Todd. [LR195]

TODD LANDRY: Morning. [LR195]

SENATOR HANSEN: When Dunbar was closed at Geneva--and I didn't...I guess after our tour I didn't realize that it was closed just last February--did that have anything to do with the total count of clients there? I mean, did you have to send elsewhere when you did close Dunbar? [LR195]

TODD LANDRY: No, we did not. It was really a space utilization plan for the entire campus, making sure that we were utilizing all of our space more appropriately. We didn't have to move any girls to different locations or different placement settings. We simply moved them out of that building and into other vacancies within the campus. [LR195]

SENATOR HANSEN: Does the renovation of Dunbar for pandemic exercises...can that be put off for awhile? [LR195]

TODD LANDRY: Oh, it certainly could be. Right now we are on plan and working with our sister division in the Division of Public Health to utilize that building for emergency situations such as a pandemic flu exercise. It is costing us relatively an insignificant amount of money as far as renovation. It's more just participating in the exercises, making our staff available for those activities, things of that nature. [LR195]

SENATOR HANSEN: Okay. Thank you. [LR195]

SENATOR JOHNSON: Senator Howard. [LR195]

SENATOR HOWARD: Thank you, Senator Johnson. Todd, I just want to thank you for taking this responsibility. You've taken on a big job, and you and I have had some conversations and spent some time talking about this, and I wish you well with all that you've...not only these facilities, but also the case management staff and people that are very hopeful that there's going to be some positive changes with your leadership here. [LR195]

TODD LANDRY: Well, thank you, Senator. I'll do my best. [LR195]

SENATOR JOHNSON: Yes, Senator Stuthman. [LR195]

SENATOR STUTHMAN: Thank you, Senator Johnson. Todd, I also want to thank you. The thing that concerns me is these court-ordered placements. There's an additional 80 that you have in your remarks here. Why is this happening? Are there no parents at home for the kids to be reporting to, or why are they sending them to...as a court-ordered placement? You know, I sympathize with these youths. They need leadership, they need training. And sending them to facilities like this, in my opinion, is not the right place to go for these kids. But it's the last thing for them to go to. But I'm concerned, you know, that we're sending a lot of kids there, just for the fact that, you know, that there aren't parents at home or some place for them to go. Is this what you're seeing? Or why do you feel that there's a lot more court-appointed placements? [LR195]

TODD LANDRY: I thinks there's a, from my perspective, there's a variety of reasons that we're seeing this increase versus last year. Certainly, across the country I believe we're seeing a relative increase in the level of violence that's occurring in some of our communities, particularly among some of our youth in the communities. Not that long ago I believe it was on CNN that did a major story and looked into the situation in a much larger city, in Philadelphia, versus our cities here in Nebraska. Nonetheless, I think there was a statement made in that by one of their experts that I think could lead to a partial answer to your question. When they...this expert indicated that 15 years ago, a relatively minor disagreement or squabble among youth, or in some cases adults, may have led to a physical interaction and a physical altercation--you know, going to fists to cuffs, so to speak, et cetera. And now it seems to be more escalated, in that many times now we're seeing the response to that being much more violent, with other weapons, whether it be guns, knives, or whatever the case may be. Certainly there have been repeated, in some additional stories and in the media, about some escalation of

violence that's going on in certain communities within Nebraska. That certainly does not exempt the youth and the juveniles. They certainly are a part of that issue, as well. One of the responses that I hope that we're going to be able to move towards--and it doesn't happen overnight--but one of the things I hope that we can be able to move towards is in working in collaboration with the court system to implement an improved response in dealing with the level of need of the youth, and trying to make sure that we're putting in place the appropriate intervention for that youth and using some assessment tools in order to make sure we're doing it correctly. And I think that's one potential advantage, particularly as it relates to YRTC Kearney, in that we want to make sure that the youth who are there truly need to be there, as opposed to being able to be treated and keeping the community safe, within their own communities. And so I think, one, we need to do a better job of escalating or de-escalating sanctions as well as rewards, if I can use that term for these youth. I think the second thing that we want to do is certainly try to involve family members earlier in the process wherever possible, to try to deal with the issues when they're a small problem, as opposed to the larger problem. And so those are a couple of areas where I think we have to make some improvements. That does requirement cooperation and collaboration with the courts, which we'll be working towards increasing. So those are a couple of the ideas that are happening. You know, clearly they're not the only solutions. I do believe there's always, or for the foreseeable future, going to be the need for facilities like Kearney and Geneva. What we need to do is make sure we're taking advantage of the full range of services that we can provide, to make sure youth are receiving the services when needed, and for only as long as needed. [LR195]

SENATOR STUTHMAN: Thank you. [LR195]

SENATOR JOHNSON: Senator Howard. [LR195]

SENATOR HOWARD: You know, I feel compelled to respond to that, also. I think the courts and the department work to address the issue of least restrictive. That's a phrase

that when I worked for the department we always kept in mind, and when a child does go to a facility such as this, it's because least restrictive has been exhausted. And one of the great difficulties of treatment closer to home is lack of resources, and so until the resources are in place to support the youth's need, the consequences are placements (inaudible) Geneva or Kearney, so. [LR195]

SENATOR JOHNSON: Thank you very much. Let me ask a question of our group assembled here. We're halfway through the morning and looks like we're in pretty good shape. But how many people do we have that would like to speak this morning? One, two, three, four, five, six. Okay. Well, we're going to talk a little less on this side of the table then and try and move along. But we've had good questions and everything this morning. At any rate, let's proceed. Scot Adams, I believe, is next. Good morning. [LR195]

SCOT ADAMS: Good morning. I hope you're all doing well, and thank you for your time with us today and for your service. Senator Johnson and members of the Health and Human Services Committee, I'm honored and pleased to be here. Thank you for this opportunity. My name is Scot Adams, A-d-a-m-s, though it's probably the S-c-o-t that's the trickier part. I'm Director of the Division of Behavioral Health for the Department of Health and Human Services. A major achievement for the Division of Behavioral Health has been the creation of the Children's Behavioral Health Section within the division. Vicki Maca is the administrator there and will work hard to ensure that our system of care focuses in on children and families and the challenges they face with mental health and substance abuse problems. Today is her second day. Since July 4, approximately $41.5 million in one-time, new, or redirected funding has been generated, focusing on moving services from our institutions to the community. In additional, mental health board commitments to regional centers are steadily dropping, going from 871 in fiscal year '02 to 273 in fiscal year '07 just ended. I'd like now to turn my attention to provide specific information relative to Nebraska's regional center hospitals. With regard to the Hastings Regional Center, or HRC, there are 151 budgeted full-time equivalent

positions at the Hastings Regional Center. About 136 of these positions are filled, about 15 are vacant. Recently we have decided to reduce FTEs by ten. The HRC census as of October 22 is 42 beds, with a capacity of 48. There are 40 youth in the substance abuse program or the chemical dependency program, and 2 youth in the mental health program. In addition, HRC serves 12 adults in the Bridges Program that you heard CEO Chris Peterson speak about earlier. Bridges is operated by the Beatrice State Developmental Center but housed on the HRC campus. I'd like to provide some of the HRC challenges and our responses to these. First, with the implementation of LB1083, Behavioral Health Reform Act, in July of 2004, adult services at Hastings Regional Center moved to the community. Over 160 FTE positions have been eliminated since October of 2004. As the demand for state-operated residential and inpatient services continues to decline, it becomes increasingly difficult to maintain staff, which jeopardizes our ability to maintain current adolescent services at HRC. We continually recruit to fill this need. Second, LB542 created a task force to review state-sponsored mental health programs for adolescents. The task force was charged with reviewing the comprehensive behavioral health delivery system for adolescents, which included the provision of chemical dependency and mental health services at HRC. Depending on the recommendations of the LB542 task force, the services at HRC may have to be further adjusted, which may result in the elimination of some programs at HRC as it is further downsized. We are working with the LB542 task force. With regard to the Lincoln Regional Center, the total number of budgeted FTE positions is 517; 467 of those are filled today. The LRC capacity is 252 beds; census, as of October 22, is 231. I'd like to discuss some of the LRC challenges and our responses to them. Since the passage of LB1083, clients with less severe illnesses have been able to be served in the community. Patients with more acute needs and behaviors are admitted to LRC, which presents increased challenges related to safety, security, and capacity. In response, we are working with the Department of Corrections to review our security procedures. We have also put together a team to improve safety in all of our regional centers. The violent nature of the crimes committed by the not responsible by reason of insanity patients, the NRRIs, prior to the admission to LRC makes it difficult to discharge them to

community providers at times. The regional centers must demonstrate that NRRI patients can succeed in less restrictive settings before community providers are willing to accept them into services. In response, we continue to work with the court system to provide treatment opportunities to show these patients can live safely in the community and to work through the legal entanglements of such difficult, complex cases. With regard to the Norfolk Regional Center, the number of budgeted FTE positions at Norfolk is 206, of which 186 are filled today. The NRC census, as of October 22, is 92. This consists of 45 behavioral health patients and 47 sex offender patients. Total capacity of the licensed spaces is 120. Some of the challenges with regard to the Norfolk Regional Center include the provision of services to both sex offender and to mental health patients in one building can be difficult. The more vulnerable mental health patients must be kept separate from the sex offender population. In response, we've increased security measures, such as the use of cameras, and also decreased access to different floors by patients. All of the regional centers share a number of similar challenges. One, there is a need for integration of the separate regional center hospitals themselves into a more unified, integrated system. One part of our response has been that William Gibson has been appointed as CEO of all three of the regional center hospitals to help standardize operating procedures between and among all of the campuses and programs. Also, the safety of clients and staff are of high concern as the patient acuity levels remain high. In response. we're increasing security and safety through work groups, defining the populations we serve, and also in the development of specific task forces to look into the issue of safety at the regional centers. Thank you. I'd be happy to respond to questions. [LR195]

SENATOR JOHNSON: I'm going to make just one short comment here. This last week I was at a central states regional meeting. And one of the things that has obviously posed a problem to the state of Nebraska is our sex offender population, seems to have grown for whatever reason and so on. I brought this up at this regional meeting and did I ever get a response from the other attendees, that they have the same problems and some of them are quite large in scale. Minnesota was actually building a multi-multi-million

dollar facility for the sex offenders. This is a universal and big problem throughout the central United States and I presume the whole country. But we're not alone. [LR195]

SCOT ADAMS: Yes, sir. That's correct. We were in Kansas yesterday looking at a state hospital in Kansas where they treat their sex offenders. And the projection within the next several years is that they will receive an additional 550 to 850 sex offenders at the Kansas facility. It's a startling number. [LR195]

SENATOR JOHNSON: Yeah, starting number, and the cost per person is very, very high as well. So it's going to be a big challenge and, right now, not one that we have very good answers for. All right. Any other questions? Thank you very much. [LR195]

SCOT ADAMS: Thank you very much. [LR195]

SENATOR JOHNSON: On my list we're in pretty good shape. I did write in the name of Bill Gibson and I thought I saw Bill in the audience. Is he here and does he care to say anything? Bill, any...want to take part at this or not? All right, fine. Thank you very much. All right. It's before 11:00 and it says Sean Samuels would like to speak before 11:00 and we've gotten that job done, at least. Good morning. [LR195]

SEAN SAMUELS: Good morning, sir. I appreciate you fitting me in early. [LR195]

SENATOR JOHNSON: You bet. [LR195]

SEAN SAMUELS: (Exhibit 3) I'm Dr. Sean Samuels, S-e-a-n S-a-m-u-e-l-s. I'm a clinical psychologist here in Lincoln and a board member of Nebraska Psychological Association. I'm here today providing testimony on behalf of the Nebraska Psychological Association, also known as NPA, the state professional association for psychologists. NPA welcomes the Legislature's scrutiny of Nebraska's 24-hour care facilities. In our testimony, we offer some specific recommendations to address the many problems that

are being raised in this hearing. Time does not permit a full explanation of our reasoning behind these recommendations, but they are based on our continuing analyses of progress in mental health reform and conditions in our 24-hour facilities. As always, NPA looks forward to continuing discussions and collaboration with this committee and department leadership to help guide us toward the best possible human service system. The issues of concern in LR195 overlap considerably with the more general issues of mental health reform addressed in LR205. Our recommendations are pertinent to both interim studies and we therefore submit this testimony for both hearings today. We recognize that implementation of our recommendations will require some careful study and coordinated legislative and executive branch actions. We have been brought to this point by our progress so far in reforming the human service system, and especially regional center-based services. Further progress will require a new level of attention to particulars, the devils in the details, and changes in both statute and policy. However, the solutions are practical and within our reach if we work together. Our recommendations include the following, and we will provide to the committee additional background information to reinforce these issues. Recommendation number one: In collaboration with the department, NDHHS, we recommend that this committee undertake a comprehensive reevaluation of the organizational, administrative, and regulatory processes that govern and constrain operation of mental health services directly provided by the state and enact statutory changes if necessary to optimize those processes. In particular, most regional center-based services should be freed from obsolete Medicaid and Medicare regulations that require costly acute hospital-like staffing and practices. The specialized services for the populations that the state serves in the regional centers are very different from acute hospital services. There is no net cost advantage in making these services eligible for Medicaid or Medicare subsidies. Oversight by state Medicaid and Medicare regulators has not prevented abusive conditions or encouraged development of modern rehabilitation and recovery-oriented services. Adherence to alternative accreditation standards would allow more cost-effective services and would better encourage quality and appropriateness of the groups being served. Other statutory and regulatory adjustments also merit attention,

such as allow civil commitment and restoration of competency in community settings when appropriate, removing the artificial separation of forensic from other regional center functions, and ensuring that people with developmental disabilities don't get stuck in the mental health system. Recommendation number two: In collaboration with the department, we recommend that this committee should analyze the specific characteristics of the groups that must continue to be directly served and the service needs of those groups, and develop service programs that most cost-effectively meet those needs. Statutory barriers to implementing changes should be removed. Although the regional centers will continue to provide the physical setting for some services, others will be best provided as satellite programs, operated by the state but in community settings. There are already two such programs associated with the Lincoln Regional Center servicing adolescent sex offenders and adults with severe mental illness, respectively. More extensive use of satellite programs and other specialized services within the regional centers will optimize the cost-effectiveness. It is unclear what legislative actions may be required to remove barriers to developing these services before the groups and services are fully identified. If legislative remedies are necessary, they will probably overlap substantially with changes in Medicaid and Medicare adherence addressed in recommendation number one. Recommendation number three: The Legislature should reevaluate the impact of LB1199 and establish new administrative and funding channels pertinent to criminal sex offenders so that regional center beds and other resources needed for people with mental illness are not diverted for continued incarceration of criminal sex offenders. In addition to existing services and funding channels in the mental health system, new legislation should provide for expanded treatment in the correctional system with release from the correctional system contingent on progress in treatment and for transitional programs to allow continuing treatment and supervision in community settings operated by the Department of Corrections. It is important to accurately distinguish those criminal sex offenders from sex offenders who have a co-occurring major mental disorder who may be better served in a mental health setting. As I said earlier, these recommendations have been boiled down from a great deal of information from many members across the

state in both public and private clinical practice. We will provide to the committee additional background. Thank you for your time today and I am available for any questions you may have. [LR195]

SENATOR JOHNSON: Sean, thank you. I didn't realize I provided you such a good lead-in for what your subject was. Any questions of the committee? Well, I think that the questions are there. We just don't know how to frame them, frankly, at this point in time. [LR195]

SEAN SAMUELS: Fair enough. [LR195]

SENATOR JOHNSON: Because as we mentioned, it is a bigger problem than what any of us anticipated just two to three years ago. So we're going to have to spend a little time trying to come to a sound resolution with this. I don't think there's any question. Any questions? I think you've left us speechless. [LR195]

SEAN SAMUELS: Thank you very much. [LR195]

SENATOR JOHNSON: Thank you very much. Next on my list I have a representative from NAPE. Are you here? [LR195]

_____: We have several here. [LR195]

SENATOR JOHNSON: Okay, great. Why don't you kind of...if you would all kind of come to the front, why, it would just be great. And sir, would you just kind of run the show here as far as the order in which we go, and we can be the most efficient by doing that. [LR195]

PAUL VERSAW: Good morning. My name is Paul Versaw, V-e-r-s-a-w. I have the fortune this morning to come to you as a direct care person from the regional center. I

was sitting there thinking about what it was like my first week three years ago on the S5 ward and the forensic building. And I wanted to share something with you, if you don't mind. I had never had any experience with mental health, didn't know what they did, so I went through my two weeks of training and my first week. And I'm sitting on the ward and a patient who had a grudge against a nurse managed to smear a handful of human feces in her face and run laughing hysterically across the ward. We did the normal thing. Of course, we had to restrain him, put the cuffs on. He was covered with the stuff and so were we. A couple of my coworkers were slammed against a screen in a window and of course lost a few pieces of skin. Those things happen when you have to put six people on one guy to take him down. Unfortunately, that's the reality of where I work. You come to work with me on the 11 to 7 shift, you'll notice that I and my coworkers tend to wear long sleeves. It keeps the skin on our arms. Now having said that by way of introduction, I live in Lincoln. I'm a security specialist. I'm here to talk about staffing issues and management practices in the state's 24-hour facilities. Before I came to you this morning, I spent a lot of time thinking about this, talking to my coworkers. Simple question: what do you want me to tell these folks I'm going to speak to? Last night, I have sent them all an e-mail that said, you know, I appreciate what you've told me, you've spoken with me, you've sent me e-mails, I'm going to do my best. So I'm here to do my best. You know, we've endured a series of administrations that have really failed in the areas of public safety, patient care, and my big thing, workplace safety. We come to you exasperated, but at hope. We hope that you will enact the necessary changes to establish some management best care practices in order to: ensure quality patient care, we all want that; and a safe workplace, I want that and so does my family; and also to protect public safety. The reason some of these folks, unfortunately, patients have to be locked up and restrained and so on and taken care of in this fashion, the reason I'm there is a court or a mental health board has decided that they're either a danger to themselves and their family, as already proven by their actions, or they're a danger in general. These are not just homeless people that have been rounded up and locked up. These are people that have committed murder, rape, various assaults. Many of them that I see are repeat admissions. You can almost predict a cycle sometimes. I'm going

to highlight some recent events that are reflective of current management practices. You know, these issues really underly problems at all of our state facilities. And as we've already learned this morning, they've even come to the attention of national regulatory bodies. You know, we've told the last three CEOs, some journalists, and a number of elected officials all the same thing. You need more staff on the wards, and you need to leave violent people who are criminals in prison. We all agree that that's the best thing. For some reason, that doesn't seem to happen. Anyone who's worked where I work long enough--and my coworker Jim Petersen is in the back of the room, has 20-plus years to his credit--we can tell you that administrations come and go, CEOs come and go. They hold meetings, they make promises, they change the name and the structure of the programs, and then shuffle the same deck of managers and directors. But there's one thing that hasn't changed. You know what that is? We still run with the fewest direct care staff possible. You know, I work with some of the nicest and most dedicated people you could find anywhere. Honestly, it's a privilege to be with them. But there just aren't enough of us to do the job, and the grind takes its toll. I've been bit and I've been hit. I've been in the emergency room of a hospital to get tested to see if I caught any disease from being bit. I've got coworkers that are waiting for surgery; one is waiting for surgery on a neck, another one is just recovering from a broken ankle. I've got friends who no longer work for the state because they're now disabled by working for the state. You know, I can't even buy disability insurance that will cover something that happens at work. It'll cover everything except what happens at work. I've got one friend that's a coworker that's off waiting to have his back operated on and he's basically being taken advantage of by the work comp people. They're delaying surgery. He could have been back at work already if they'd have taken care of things. We need him on the ward. He's got experience. We need his wisdom and we need his leadership. And he's home, he can't walk hardly. You know, in September, just to give you a for instance, there were 122 times when staff had to physically restrain or intervene with patients at the regional center. At least one of them, the staff, was severely injured. A number of others were moderately injured. Sometimes it's two or three at a time have to go home. I've been at home and been called in, say we've had a problem, we need you, we've

had to send people home, can you come and help cover. You know, the problem really partly is that we're admitting some patients who, if there was such a thing, should really go to a transitional correctional setting first because they're cons. They've been in prison a long time. They're so violent, they've been in isolation, been locked in a cell in segregation wards. That's all they understand. Put them in a hospital, give them rights, mix them up with other patients, what are they going to do? I sat with one man who was in full beds and he had hit another patient, was the reason he was in full beds. And the patient he hit walked by the open door and he said, and this is a con parlance, anybody that's worked in a prison, I punked you, punk. The man walking by the door, also a con, had to respond. He ran right through the door and jumped on the guy in full beds, and I was right behind him, and pinned him to the mattress. The man in full beds sat up to get away from the clawing and the scratching and hitting. We got a couple of cons there going at it. They're given too much freedom, they're abusing other patients. They should be somewhere else. You know, let me give you a little recent history. In the summer of 2006, for instance, we released a Class 3 sex offender to the community. He had managed to avoid sex offender treatment by simply being unresponsive to psychiatric treatment, and he was demonstrating extreme violence. He came after me three or four times. He could be happy and five minutes later he's ready to kill somebody and screaming at the top of his lungs. Wasn't very therapeutic for the other 17 or 18 patients up there. Wasn't much fun for staff. Wasn't much fun for the psychiatrist or the nurses. Twice he barricaded himself in rooms, broke everything he could get. We called the State Patrol to get him out of those barricaded rooms. The last time they brought a beanbag shotgun and extra officers. He crawled out in broken glass in the face of that shotgun. They cuffed him and took him upstairs. A few months later we discharged him and put him on a bus to another state, without ever undergoing treatment as a sex offender because he beat the system. Just after Thanksgiving in 2006 there was a riot. Patients got together at the behest...two guys really organized the whole thing, and they attacked the staff. And they called more staff and that wasn't enough and they had to call the State Patrol. As soon as the State Patrol walked in, the guys would go to their rooms. The personnel who were there that day said it was the worst thing they had seen

in all their years at the institution. You know, one thing ought to be considered. The forensics building where I work, or security as it's being renamed, might be effectively better run by the Department of Corrections. They have different rules. Okay, different ways of taking care of things. It's not my purpose here to make a case for the change, but maybe we ought to think about it, okay? The other thing we really ought to do, folks, is make it a felony for a patient to physically assault staff. One of my coworkers got hurt and all they could charge the patient with was a misdemeanor. He got two months and time served. July 2007, of course, we all know there was a psychiatrist assaulted on that ward. The victim of that assault later died. The administration responded rather prematurely, I thought. Oh, this wasn't foreseeable and it could not have been prevented. Well, come on. In court the guy said what he was going to do. He threatened all of us. It's written down, it's in the written record. But we couldn't intervene, we couldn't prevent it because the policy and practice at that time, until he does something he's got rights. Now since then, I can tell you that the practice has changed, not the policy. Threats are taken seriously. There's no telling if that kind of resolve is going to endure. We know how human nature works, don't we? You know, some violence really is due to chronic understaffing, which was the thing I led with. If a ward need seven or eight people to run effectively, management is going to try to run it with five or six. Well, then that's going to sometimes prevent us from having off-ward activities, which adds to the boredom of the patients, fostering more conflict. You know, over a number of years there's been one constant. There's been a general unrelenting attempt to continually lower the staffing levels. Part of the problem is some of the managers are heavyhanded, for whatever reason. Building ten was under a staffing emergency from approximately May to August this summer. During part of the time there was also a hiring freeze in place. Makes no sense to me. Responding to a recent grievance, the supervisor said, well, yeah, you shouldn't have been mandatory but you were the only one who could do it. The person had already worked his three overtimes as per the contract. In another building, building three, a young man who's a very talented tech who's a hardworking guy but exhausted, refused to work yet another overtime because he was exhausted, he needed to sleep. His supervisor threatened to cite him for patient neglect if he didn't

work another overtime. He said, I'm done with you people, and he quit. Well, then they called back and said, oh come on back, we're not going to punish you, that was just a threat. Also this summer, one of my coworkers brought a doctor's note advising his supervisor he had pulled a shoulder at home and his doctor released him to work with the provision that he limit the use of the arm. The supervisor says, no, you either stay home or you come here and work as much overtime as I need you to work. No exceptions. In building ten recently, a supervisor told a staff member who had already worked three overtimes, if he didn't work another one, I'm going to charge you with abandoning patients. And then the one that really got me hot this summer down in Beatrice, there's an employee that has a heart condition. His doctor told him you can only work eight hours at a time. So what's this good-hearted, long-term employee do? He works both of his days off every week to help cover the shortage. And they tried to fire the guy because he couldn't work 16-hour shifts. We're tired. I worked 11 to 7, got up at 7:00 this morning, and I'm here to talk to you folks. Systemwide there are a lot of tired folks on every shift. In a recent e-mail to one of my coworkers, the director of nursing expressed concern about the number of overtime being worked, number of hours overtime being worked by that person, and the increasing use of that person's sick time. The director said, you need to cut back on overtime for health reasons. Great idea. The reality is, however, if we don't work, if we do try to cut back, we're simply going to get mandatoried. Same problem that's going on in Grand Island at the vet's home. Fewer people to work the mandatory overtime because the rest of them are working 12-hour shifts. Now in closing, I'd like to emphasize that the solution here is in providing additional resources to the department. I don't see any other way out of it. And then we've got to follow up and make sure that those resources are used to hire and retain direct care staff. I think we just got to have more warm bodies on the ward, folks. The other thing is, I hope that you're going to think about establishing some management best care practices. I don't think our employees need to be intimidated and abused like they're being abused. We do want to ensure quality patient care, we do want a safe workplace, and we do want to protect public safety. We can't do that if we can't keep our employees. Thank you. [LR195]

SENATOR JOHNSON: Thank you. Don't leave just yet. You're a very effective speaker and might say a very sobering speaker, as well. Senator Howard. [LR195]

SENATOR HOWARD: Thank you, Chairman Johnson. I really want to thank you for coming in today. I know you have to come in on your own time. Management comes in on the department's time and the employees come in on their own time, sometimes vacation time. But I think what you've said, everyone needs to hear, everyone needs the reality of how does it really work. And I thank you. [LR195]

PAUL VERSAW: Sure. [LR195]

SENATOR JOHNSON: Senator Stuthman. [LR195]

SENATOR STUTHMAN: Thank you, Senator Johnson. Paul, I want to also thank you for your comments. You know, there's a few things that I picked out about the fact of, I think, people are getting released to you, you know, that shouldn't be released to you from prisons, from correctional places. And I just, I just think, you know, when there's abuse on the staff, you know, that should be penalized a lot greater than just barely a slap on the hand. Because that doesn't do it for that type of people. And I thank you for your comments. [LR195]

SENATOR JOHNSON: Senator Hansen. [LR195]

SENATOR HANSEN: Thank you, Senator Johnson. Thank you, Paul, for coming in today. You gave us quite a list of things to think about and talk about. One I want to ask you about is a Class 3 sex offender was released to another state. Was he released...was that person released to another facility to be treated or just released to the general community? [LR195]

PAUL VERSAW: My understanding is he was put on a bus and sent to another state. And there was not another facility there that was really expecting him. May I point out that we've done that with other patients but not necessarily Class 3 sex offenders. I know of at least two or three other instances. [LR195]

SENATOR HANSEN: The department...you also said the Department of Justice runs their facilities different than you can, but you also said that you change practices rather than policies. I assume the policies are harder to change than the practices. But do you...why do you change the practice rather than the policy? I guess I'd better ask you a question. [LR195]

PAUL VERSAW: Well, practice obviously changes a lot quicker. For instance, after we lost the psychiatrist, the guy that assaulted him was basically on full beds for about three days or locked in his room or both. Now prior to that, that would have been unthinkable. Nowadays, any patient that makes a threat is put on a status. I came to work one night on my shift. We usually have about 17, 18 patients on the ward. I look down the hall and there were 10 of us to cover 18 patients. There had been so many people acting up and put on statuses that they either had to be locked in the room or put one-to-one or both. And when we do that, then you got to have a staff member outside there looking in every ten minutes. Are they still breathing? So the vigilance has been stepped up. The vigilance really wasn't there before. The threats were there, the patients were violent, but the criteria was, well, you know, is it a credible threat. Do you really think they can follow through on this? And now a threat is a threat. [LR195]

SENATOR JOHNSON: Senator Howard. [LR195]

SENATOR HOWARD: Just one comment. I knew Dr. Martin and he was a good, good person, good psychiatrist, and that should have never happened. [LR195]

PAUL VERSAW: We all have feelings like that. Unfortunately, about two weeks before

that happened, we all realized things were coming to a head, at least the direct care staff. One of my coworkers went to the supervisor and said, when are you going to do the right thing here, somebody is going to get killed. Somebody did. In this day and age, folks, I don't see how you can run an institution or a business and not have a warm, direct partnership with your workforce. I really think that the solution to a lot of these things is the direct care staff. But you've got to engage them. You've got to be positive with it. You got to do more than just have meetings. You've really got to listen. It's not a workforce to be managed and manipulated and scheduled. I really think the answers are with the people that have been there 10, 20 years. [LR195]

SENATOR HOWARD: Workforce respect. [LR195]

SENATOR JOHNSON: Thank you very much. Next, please. [LR195]

WILLIAM BRATT: Thank you, Senator Johnson, senators of the committee. My name is William Bratt, B-r-a-t-t. I am a developmental technician at the Beatrice State Developmental Center. Developmental technician is in charge of the daily care of the individuals that we serve, also in teaching and helping them become all that they can be. I echo a lot of the challenges that my colleague has spoke about. Our facility isn't nearly as violent as the Lincoln Regional Center. We do have similar problems with higher behavior individuals. I myself have been bitten. I'm had the muscle groups on both forearms torn on two separate occasions. I currently have three torn discs in my back from having to lift and strain with individuals. Primarily I'm here to discuss the mandatory overtime problems, staffing shortages, and lack of administrative progress to resolve these issues. I'll try to be as brief as I can. I know time is at a premium for all of you. Right now mandatory overtime would be a situation where not enough staff arrives for the shift following your own and you are request, or told, that you will remain for an additional eight hours or as much of that shift as you are needed. A good example of the numbers of overtime that we're seeing, from the pay period of October 15 to October 28, there were between 420 and 514 overtime shifts worked. Of this, 189

people worked one or more overtime shift. That's an average of roughly 2.2 to 3 overtimes in the period. I'm sorry my numbers aren't more concrete than that. At my level, I'm not privy to a lot of the information that comes out of our facility. I feel that mandatory overtime perpetuates its own use in four ways. One, staff is overworked and then are too tired to show up for their next scheduled shift. They call in sick, perpetuating the need for a previous shift being held over. This is a practice that is ongoing, apparently, as staff just becomes so burnt out that they just can't face another day of the problems. And overworked staff, as we all know, does not perform at the level required to properly serve the individuals that we take care of. And that is the key issue; taking care of the individuals that we're in charge of. We make decisions based on giving medication to the individuals. If we're tired and bleary-eyed from working two shifts and a short night's sleep and back to work, there are medications that we can pose severe damage to our individuals if we make a mistake. Also, staff apathy in a case like that, they tend not to care as much about what the individual is feeling and thinking. And that's something that we just cannot have. Ultimately that would then lead to suspension of staff, which unfortunately is something that happens quite often in our facility. We have very minor infractions that, due to policy and procedure in the facility, currently staff is immediately suspended. And with the lack of investigators that we have to take care of these suspensions and get the timely response to solving the problem, we see individuals or staff out of work from three to six weeks. I myself had been suspended for a minor infraction six and a half weeks that I was out of work. [LR195]

SENATOR JOHNSON: Do you get paid during that period of time? [LR195]

WILLIAM BRATT: At that time you did. I don't know what the current policy is, unfortunately. I know that on-call staff, which are staff that are contracted to come in as their schedules permit, they are suspended without pay. [LR195]

SENATOR JOHNSON: Excuse me for interrupting you. [LR195]

WILLIAM BRATT: Oh, no, thank you very much, that's an excellent question. Ultimately the suspensions then and the lack of resolution to those suspensions becomes an even greater amount. I had hoped to have numbers mirroring staff suspension per shift versus overtime worked per shift, but unfortunately again, that's not information that I was privy to. I'd like to cite some hardships that people see on a personal level from being held over. Certainly not being able to plan any semblance of a personal life or events with your family outside the workplace. We never know when we're going to be held over. Many staff are working overtime shifts voluntarily. I myself spent a year working one of my days off overtime full shift so that I would not be held over to a second shift. Because frankly 16 hours in our facility is a bit much. We have very short lead time in finding out if we're going to be held over for another shift or mandatoried. Generally half an hour is the most that we're told that we'll be held over. Once again, we can't make plans outside the work hours. Personally, I've had to cancel several personal engagements. I've wasted theater tickets, cancelled parties that I had 30-plus guests coming to my home, and a half an hour before the guests would be arriving, sorry, party is called off. And most notably I missed two of my anniversary celebrations, which anyone that's married knows how well that's going to go over with your spouse. So I don't have many other particular cases from staff. Most of the staff that I spoke to were afraid to even speak out for fear of reprisal from the administration. It is a very real threat in our facility. I know it's not accepted but it does take place in one form or another. One particular staff told me that--she's a first shift employee, I cannot give you her name however--she was held through second shift, this would be a 16-hour shift then. After her 16 hours of work, she was held into a third shift, which is against our contract policy. But she ended up being held an additional three and a half hours into her third shift of work. This is 6:30 a.m. to 2:30 a.m. that this woman worked. She then went home, went to bed, got up, and returned at 6:30 a.m. that same day for her next shift. The same staff was held over during a time that she was to attend a... [LR195]

SENATOR JOHNSON: Just one little thing, sir. [LR195]

WILLIAM BRATT: Oh, I'm sorry. [LR195]

SENATOR JOHNSON: And I don't want to interrupt your chain of thought, but the people recording this hate when people dance their cards on the table. (Laugh) [LR195]

WILLIAM BRATT: Tap the cards. I am so sorry, I am so sorry. (Laughter) [LR195]

SENATOR JOHNSON: I just about forgot that, because I've been caught guilty of the same thing. [LR195]

WILLIAM BRATT: Bit of a nervous habit of mine. All right, I apologize. Anyway, she was to attend a christening service for a young child that she was godmother for. She had conveyed that to management. Unfortunately, a staffing situation arose. She was held over, told she would have to be held for a short period of time until someone would arrive. They would call her. This event was at 8:00. But 8:30, she called asking if any help was on the way. They said, yes, we have contacted somebody, they will be there within two to three hours to help you. And unfortunately then she missed the christening and the ceremonies afterwards. So we just keep coming back to, you know, the suspensions, the staff turnover. It's very difficult to keep people there. Staff in my position, they're very unwilling to speak to anyone to have them come and work with us because we're afraid of being held over. Obviously our problems are nowhere near as significant as Lincoln Regional Center in terms of the violence of the individuals. But it's awful hard to have a job that you're not able to plan outside the workforce. You do your time as overtime. Yes, we're paid for it and that's nice. But what we also see is a total lack of respect from the administration in doing so. Perfect situation, staff was complaining about the mandatory overtime. This was in a period that we were forced to work 6-day weeks because we had a mandatory 16 hours per pay period. At that time, a staff in my position complained to their management and the management stated that, what are they complaining about, they should be happy that they have a job. This particular management is in a very high position at our facility at this time. So...and the

other problems that we're seeing is human resources. There was a period of time in addressing these overtime problems and staffing shortages that human resources was hiring on-call staff to try to plug the holes. As I understand, it's over 100 on-call staff were signed on to be SDC. Don't have the exact number. But when we see the increase in overtime, mandatory overtime again, we asked our timekeepers where are all these on-call staff that were to save the day. Oh, they all went back to college. So unfortunately we're back in the same position that we were before. I'd like to thank you all for the opportunity to speak. I'm sure that something can be done to alleviate this problem and be happy to answer any questions that you might have. [LR195]

SENATOR JOHNSON: Senator Hansen. [LR195]

SENATOR HANSEN: Thank you. Thank you for coming today. [LR195]

WILLIAM BRATT: Thank you, Senator. [LR195]

SENATOR HANSEN: You mentioned the investigations of staff after a violation. Who are the investigators? [LR195]

WILLIAM BRATT: The last that I was aware, we have three investigative positions. They are staffed on BSDC that will go out and gather all the information regarding what the infraction was and they comprise a report. And then that's met with the managers, the upper administration. And then a hearing is convened so that the staff can speak on their own behalf. But the investigators are BSDC or state employees. [LR195]

SENATOR HANSEN: What about the idea of the investigations going ongoing while the person continues to work. Would that be a...what would you think of that idea? [LR195]

WILLIAM BRATT: I think that would...I'm sorry to interrupt you. I think that would be a brilliant idea that keeps the staff working, especially if staff are being paid while they're

on suspension. We need to get some use out of them. However, I believe that is totally against BSDC policy now because we need to separate the staff from the individuals if it's an alleged abuse or neglect case. [LR195]

SENATOR HANSEN: One other question. What about 12-hour shifts that you know you're going to be there for 12 hours rather than an 8 and maybe another 8, 12-hour shifts rather than going through the 3 shift? [LR195]

WILLIAM BRATT: Yeah, that's definitely a possibility. I know there are wards or areas of our facility that are experimenting with that now. I personally have not worked a shift like that to see how it would work or spoken with any of the members that are on that shift. [LR195]

SENATOR HANSEN: Thank you. [LR195]

WILLIAM BRATT: Thank you. [LR195]

SENATOR JOHNSON: Any other questions? Sir, thank you very much. [LR195]

WILLIAM BRATT: Thank you. Thank you very much. [LR195]

SENATOR JOHNSON: Next please? Just for my own head count and how much time we have, how many other people besides this gentleman? One, two, three. Okay, fine. Thank you. Sir, go ahead. Welcome. [LR195]

JIM PETERSEN: Thank you. My name is Jim Petersen, P-e-t-e-r-s-e-n. I'm a 26-year employee of the Lincoln Regional Center and the security in it. Well, as one of my coworkers mentioned, we're going to be called the security unit. We formerly were and then we switched to being the forensics unit. Now we're going to call it the security unit again. In listening to the testimony that's been made by other people here this

afternoon, this morning, I've heard many things said that occasion me to want to remark on that, and I'm adding that to what I was prepared to say already. And I know I've got some limited time here but there's a lot of stuff to cover here and it's all very important. I guess one thing I want to emphasize is the longevity of this issue of mandatory overtime, that this is not anything that has developed as of late. Fifteen years ago there was an employee that worked on the 3 to 11 shift that we really enjoyed working there. He's just the kind of guy we wanted to work there. But he was the low man on the totem pole and he had been mandatoried so many times that he was literally at the point of saying, I'm quitting, I'm out of here. I mean, right then and there at that moment. I volunteered to work the overtime just so he wouldn't quit, and I did that three times in a row so he wouldn't quit, and he didn't. He stuck around for another 15 years but he did quit here just this last year finally. The point of this is not to give any kind of pat on the back to myself for jumping on the grenade for him but to emphasize the fact that without somebody having done that, he would have quit. And just recently on Labor Day of this year, I had to do the same thing again because there was another employee who was caught at the front door of the facility at 11:00 at night and was told that she was going to be mandatoried at work. And she noted to them that she had a doctor's order not to work overtime for medical reasons and they were going to disregard that and mandatory her anyway. And she was at the point where I think the words "I quit" were forming in her mouth. And I said I'll work the overtime. And she stayed and she still is there now. It was a 15-year span of time between these two incidents. This has been going on for years and we have come before many people and tried to emphasize the imperative nature of what this is doing to the staff out there. It's 15 years later and we're still having the same discussions. It sometimes feel like we keep trying to give the input to try and help correct situations and nothing really much ever comes from it. It's just sort of next day, same story. I had a young coworker here the other night that I was working an overtime with who got mandatoried and was bemoaning the fact that she had just been mandatoried a few days before that and she couldn't understand how it could be time for her to be mandatoried again. I explained to her that our staffing roster has so many vacancies on it that once they go into the mandatory aspect of the cycle, it comes

around again real quick, and that's how it would be, that she would be getting mandatoried so quickly after the last time. I tried to give her a little positive counsel and perspective about how she was going to have a lot of money from doing all this overtime. She is of that age where that stuff doesn't really matter to her. She has commitments, she's going to school, she needs to be able to leave when she's supposed to leave and not be told at the last second that your day as you had it planned out isn't going to happen because you're going to stay here and work. She didn't really much buy into that. She was just very disappointed that it was happening to her again within a matter of days of it last happening. I don't think it's realistic for any of us to expect that there's going to be a total elimination of the mandatory overtime, but it is imperative that it be decreased because it is having a very corrosive effect on the workforce out there. There's a lot of people that just are not going to do it and they quit and it puts us in the situation then of having to take new people and retrain them again, put them through the whole process, and you start off with new people again, and they work for a while and then they get burned out on it and they quit, and we have to go out and get another new person and train them. The effect being that you have this continual new guy thing going on with the staff, got people that aren't very experienced at what they're doing so therefore their effectiveness in dealing with the patients is "minimalized" and it just seems to go on on an never-ending basis of putting new people and having to train them and hope they stay for a while and then they leave. And something needs to be done regarding this situation. A previous speaker had mentioned the decrease of the effectiveness and the alertness of the people that are on duty after being mandatory. This is very true in the sense that someone that's been there toward the end of a 16-hour period of time in the forensics unit needs to really be on their toes and aware of what's going on and be able to read the patients and be aware of what things are saying and doing. And if you're tired, you just aren't as effective at those things. Another thing that was mentioned earlier was just recently they talked about how they said that their on-call personnel had all gone back to college. We have a major reliance on part-time, on-call staff and a lot of these people will go many, many days between when they work as on-call staff. So they're not getting any cumulative effect of

working with the same patients and getting to know them and becoming more comfortable in the environment because it might have been ten days or a couple of weeks since the last time they worked. So when that's your coworker that you're working with, you realize that this person is not really up to speed on what's going on around here because they don't work here that much. And yet they're the one that's supposed to be your backup or they're the one that's going to initiate the initial engagement with a patient and they might not do things right, they might not say things right because they don't have that much experience at it and they don't build on it. I guess also I wanted to comment something that Paul Versaw was saying when he was talking to you about the fear of people that work in the forensics unit to even speak about things like this for fear of repercussion or reprisal from it. You are very much in disfavor with upper management if you come out and say things like this. (Laugh) Sitting here saying this to you right now not gaining me any points, I guarantee you. But I felt like it was important enough to do it that I am here on my day off. I work 3 to 11 and was only bed since about 4:00 a.m. this morning. I have commitments after work that I had to do. So I hopped up and drove in here real quick to try and do this. But not without some sense of trepidation on my part as to whether I ought to even be doing this. But I think it's important to do because the consequences to the people that work in the forensics unit can literally be life and death situations, as we have unfortunately seen here recently. In the sad case of Dr. Martin's death, the only thing about that whole thing that was very surprising to me was that it was Dr. Martin that it happened to. That somebody got killed in our unit was something that we've all just been waiting around to see when that shoe was going to drop. But nobody was really surprised that it happened. It was just that it happened to Dr. Martin that was the surprising part of it. The incident of taking the patient and putting them on a bus and sending them out of state, that happened just recently and there was no one on the other end that knew he was coming. They didn't know that we were sending him to Louisiana. He's the kind of patient that could have gotten off that bus or seized it and taken them all as hostage at any point along the way and we had no one with him. He was under no sort of escort. He set a fire (laugh) within a few hours after he got there and was taken into custody

down there. I just can't even believe that we actually put him on a bus and sent on public conveyance out into the community with the hopes that he would go where we thought he was supposed to go and not really knowing whether or not he would. And...oh boy, I tell you. I'm sorry for not having this...because I'm kind of mixed up here between wanting to make comment to the things I've heard said to you already this morning and some ideas that I wanted to touch on myself. I guess basically I just wanted to emphasize the fact that the forensics environment is very volatile, very dangerous. We don't have enough staff working there and there seems to be major resistance on the part of our management to acknowledge that there are numbers of people that are the reason why things are the way they are rather than it being a situation of the staff that are currently on duty there abusing their sick leave, which seems to be on of their big...their explanations of things. As if we could address sick leave abuse, that would take care of the staffing levels. It's not that...there's not enough people on the roster and there haven't been for years. And that's directly related to money. They're not paying enough money to attract people to take the positions and then when they use this overtime, they're paying people at a rate of time and half. So you're paying three shifts' worth of money to cover two shifts of time. And this is gone ongoing for years now. So just monetarily we've never been able to understand how it makes sense to anybody to leave this situation as it is to where we're paying out that kind of money to cover the building when they could just hire the full-time employees and be doing it cheaper and have people that are there full time and gaining the experience and building upon their knowledge of how to work in a facility like the forensics unit. It was mentioned earlier by Paul about the riot that happened on the day after Thanksgiving this last year, which was exactly what it was. It was a riot. I had a very, very good friend that was on duty that night and was in the thick of it. He called me at home that night after he got off work and said, you know that thing that we've been trying to tell them for years is going to happen out there? And I said, yeah. And he said, it happened tonight. And he proceeded to tell me about the situation and how it was, in fact, a riot situation that was out of control. They were calling in people from other buildings, which never happens. We're the ones that go to other buildings, from security,

to help them gain control when they're losing it. We never call people into security to help us, but they were that night because they had to. And then eventually that didn't work and they had to call the State Patrol. And when the State Patrol came up the stairwell, the patients who were still in full riot mode at that point, assaulting their peer, assaulting the staff, saw the State Patrol come up the stairwell and that affected their attitude immediately. All of a sudden (inaudible) you want to inspect our rooms, we're going to our rooms. Because it was the State Patrol. When it wasn't the State Patrol and it was just us, they were ready to throw down and fight and kill people. They saw the State Patrolmen with the badges and they were like (noise) to their rooms. It was a very, very violent situation that night. A lot of people got hurt. And in the post-incident meeting that they had which they produced minutes of, one of the female employees who as up there that night was quoted as saying, I thought we were all going to die. Just to give you a little flavor of what was going on there that night. And yet, the portrayal of that incident by our upper management was that it was an altercation, that it was, well, a couple people got hurt but it really wasn't that big a deal and it wasn't really necessary to call the State Patrol; it was under control by the time they got there. Not true. It was necessary to call them and it was not under control before they got there. As evidenced by the statement of the one employee, she thought we were all going to die. You don't make a statement like that if things are basically under control. That's the kind of stuff that we're having to deal with. And it's been going on for a long, long time. That's all I have. [LR195]

SENATOR JOHNSON: Thank you. Any questions? Senator Stuthman. [LR195]

SENATOR STUTHMAN: Thank you, Senator Johnson. Jim, when you talk about putting a person on a bus and shipping them to no man's land or nowhere, is that a directive from upper management or where does that come from? [LR195]

JIM PETERSEN: Well, it certainly couldn't happen without upper management knowing about it and endorsing it. We certainly don't, at the lower and mid level, have no

decision-making capabilities along those lines. And based on his recent behaviors over a period of months leading up to that, no one would have thought of releasing him from maximum security. I mean, he was doing nothing but adding more and more reinforcement to the idea that he was right where he needed to be. And then all of a sudden he was leaving. [LR195]

SENATOR STUTHMAN: So it's not at your level when you say I just can't take this guy anymore, buy him a bus ticket and send him out? [LR195]

JIM PETERSEN: Oh, no, no. Basically at our level we just sort of had reinforced and inured ourselves to the fact that we were going to have to deal with this guy again. We'd had to...we had to call the State Patrol to come out to the regional center to go extricate him from his room twice in about a year period of time. In the entire...I started working there in 1981. We have never had to call the authorities to come out and deal with a patient before. We've always done it ourselves. And we've had some pretty tough customers to deal with, but we always did it. This particular individual had a good mind for...I'm sure he probably works well with puzzles, because what he did was barricaded himself in his room on two different occasions using his room furniture in such a manner as to make it absolutely impossible for us to get into the room. The doors swing both ways, which usually helps us as far as this whole barricade thing. Well, he knew that. So what he did was he set up his room furniture in such a way as he left us about a two-foot by two-foot gap that he couldn't block up with his room furniture, knowing that the door would swing out in the hallway. And we would have this much of a hole to come in through. And he had taken off a couple of pieces of angle iron reinforcement from around his window, had on his winter coat, and smeared himself up with Vaseline, had on his winter gloves and these two pieces of angle iron and made it known quite...very openly that whoever came through that hole first was going to probably die. And he was going to get the next one and as many as he could. And we couldn't put more than one person at a time through that hole. And this was like right before Christmas and we thought nobody is dying for this, call the State Patrol. And so they

came out, they went down to his room, announced to him that they were the State Patrol, and they came in with their guns which meant we had to evacuate the ward and put everybody down in the gymnasium because they weren't going to come in without their guns. We don't let people bring guns into the (laugh) security unit. They went up to his door, told him that they were the State Patrol. He wanted to know how the hell he would know that. The female officer stepped up to his door jam and took her badge and stuck it around the corner like that. And (clap) boy, he changed just like that. He was yes ma'am, no ma'am, what do you want me to do. Because he knew he was dealing with people with guns and badges, you know. When he was dealing with us, it was come on in, I'll kill you all. And he meant it. And that was the first of two times that we had to call the State Patrol to come get him. [LR195]

SENATOR JOHNSON: I'm interested in what you have to say but we're kind of getting in the same mode of saying the same thing. And it's extremely important that we hear what you're saying and I don't want you to think in any way that... [LR195]

JIM PETERSEN: No, I understand. [LR195]

SENATOR JOHNSON: ...that that's not the case. But we've been at...you've talked about 20 minutes and we've got about 17 minutes left to go. So I think we need to move on to the...because I think we've got at least two other people. So if we could. Thank you very much. You had a lot to say and we needed to hear it. [LR195]

JIM PETERSEN: Thank you. [LR195]

SENATOR HOWARD: Thank you, Jim. [LR195]

TED BURI: Well, Senators, thank you very much for your time. Thank you for the opportunity. I made a decision a moment ago to scrap my prepared notes and give my director a heart attack. (Laughter) You've heard a lot of things said today from both

the... [LR195]

SENATOR JOHNSON: Excuse me. Name and spelling, please. [LR195]

TED BURI: That's what happens when you deviate from the script. (Laughter) Thank you. Ted Buri, B-u-r-i. I am a contract administrator with the Nebraska Association of Public Employees. My duties involve primarily the handling of employee complaints, grievances, and appeals through the contractual grievance procedure. And I've been doing this in a number of locations for approximately 31 years. You've heard a lot of very good comments today from both the management perspective and from the perspective of line staff. And I just want to, rather than reading a prepared statement, amplify a few things that have been said here today. Chris Peterson mentioned early, and she's absolutely right. She talked about the family nature and the community nature of some of these facilities, particularly Beatrice State Development Center. And it's a fact that there have been generations of family members that have worked at BSDC, and at the other facilities that you've heard about today, particularly in the more rural communities. And you know that very well. And that's always been one of the strengths of those facilities in terms of being able to maintain appropriate staffing levels. But that's changed. It's not working and it's a situation that's getting worse every day. There's been discussion here today about new industry coming in to some of these communities, or it may be Wal-Mart. And it's a shame when state facilities such as Lincoln Regional Center, Beatrice State Development Center, and the others become a last resort for employment instead of a first resort. Historically, again particularly in the rural areas, they were a first resort. They were a source of pride and professionalism. But people don't view it that way anymore. Part of it, of course, does have to do with competition in those communities with industrial plants or Wal-Marts or whatever it might be, especially when Wal-Mart begins to get a little smarter and starts providing benefits. You know, the competition...that great advantage that state government had, or at least the perceived advantage of the benefits and the rewards of working with patients and clients, you know, it doesn't carry the weight that it used to. And that

interaction in the community that Chris talked about is still there, but what's happened is it's become a negative. Part of the problem, I assure you, in Beatrice and in the surrounding communities, and Director Houston had some of the same problem in Tecumseh, because of having an already very difficult work environment, it's a very difficult place to work in a 24-hour facility on the best days. And so you already have certain aspects of your job that are known in the community to be very difficult. But then you put into the mix mandatory overtime to the extreme. And then you put in...and you heard it from Mr. Petersen, you heard it from Mr. Versaw and some of the others, either a very real or a very well-imagined sense that they're being treated with a lack of concern and disrespect by their managers. And they talk to their families about that and their spouses talk with their in-laws and their in-laws talk to the lady at Wal-Mart. And there are no secrets in a community like that. And so what's happening out there on top of all the other difficulties that you have in maintaining appropriate staffing levels, these facilities are being discussed in a very negative manner. And believe me, that's happening. It shouldn't be that way. Staff, to the extent, you know, that they can control it should not obviously be going out of their way to say things that exacerbate the problems. But they're extremely frustrated. I really hope that you walk away from here today believing the voracity of what you've heard in terms of the frustrations and the anger and the nonsensical things that are happening. A word about emergencies, you've heard the term several times today. Staffing emergencies, we have an emergency. Well, the fact of the matter is you don't have an emergency. You certainly have a critical...a series of critical situations where you don't have appropriate help to provide top-level patient care. That's a fact. But using the term "emergency" is a very simple tool that very usually abused. If in fact you have an emergency, as Mr. Petersen has very accurately portrayed to you, you have an emergency that's existed for years. Talk to some of these long-term employees. And whether you're talking about 25 vacancies at a facility or 80 vacancies at a facility, they're certainly more acute, those problems are more acute right now, but it's not a new process. It's been going on for years and years. And so periodically you'll hear from the institution, well, we have a staffing emergency. And what that really means is that we know that you're working

hard, we know that you're volunteering on your days off, you're doing everything you can do to help us fix the problem, but we don't have enough staff. And so if we need to work you 3 consecutive 16-hour shifts in 3 days, we will do it because we have the right to do it. And we may need to go beyond that, okay? We understand you have a labor contract and we understand that there are limits to the number of hours you can work. Well, how do you deal with that? You declare an emergency, okay? And if you have a real emergency--and we all know, I think, what a real emergency is--the nature of which would be declared by the Governor, that puts a lot of authority into the hands of the individuals who declare that emergency. And it puts in question other legal and contractual relationships that you have that may otherwise be affected by this legitimate emergency. So we declare an emergency, okay? Give you an example. At the Grand Island Veteran's Home a few months ago, and this is almost daily at one institution or another, get a phone call while they've put us on a staffing emergency. Okay, what else is new? And so in some discussions we find out that it's an emergency but there's no other action being taken to give the appearance of an emergency. Vacations are not cancelled, and shouldn't be unless it's absolutely necessary. Found out that the acting director at the time, the acting CEO had gone on vacation that week for a month, after the decision to declare an emergency was made. So it's an emergency of convenience. It's a term that's very useful and it doesn't mean a whole lot. You know, if there's a staffing emergency at Lincoln Regional Center today, that's no different than yesterday. It's no different than it's going to be three weeks from today in any real sense. Yeah, you may hire one or two people, you may lose one or two people, but the situation is not changing. It's static, it's become the norm, and I call it institutionalized neglect. And it is. If Mr. Petersen is right, and I believe he is, and this has been going on for years, then all of us--me, Ms. Peterson, all of you--are guilty of neglect, okay? And let me tell you that understaffing, lack of appropriate staffing in a mental health facility or a developmental center is a heck of a lot more serious than in an employee who works on a ward in Lincoln Regional Center who is busy doing their assigned duties and a patient accidentally gets out of their room while they're not looking and gets into another patient's room, you know, and they're then charged with neglect and abuse and sent

home for two or three weeks while there's an investigation going on. Either they lose their job or they don't. But during that period, you're losing that manpower and you're exacerbating an already terrible situation. Now what can you do about it? Ms. Peterson--and bless her, she's one of the good ones, she really is--there was a question...good question earlier, well, can we pay some mileage? You know, what can we do to help? And the problem is that there's a mind-set that exists in the collective bargaining relationship here that I really hope could be fixed. And that is that it's a very stringent relationship. If the contract doesn't specifically say you can do it, well, we can't do it, okay? And a contract, any contract, is or should be a living document. And if there are things that we can do that are acceptable to the parties, we shouldn't have to wait for two years or three years until the next set of bargaining so we can sit down at a table and discuss it. You know, there shouldn't be a situation where the union says, well, you want to pay that group of people more money? Oh, we don't want you to do that, we want you to bring it to the bargaining table. Or a facility administrator, and they have, a CEO says, well, why can't I? Until we, just on a temporary basis, until we get up to, if not full, at least reasonable staffing, why can't I pay a little bit more money on shift differentials? Why can't I, if I've got a well-qualified person in Hastings who would like to come to Beatrice, why can't we pay him $1,000 to facilitate his move? But we'd rather pay $3,000 in overtime to try to cover that position. There are things that can be done that are running into rigidity in the system, okay? So there are some things that can be done. You know, it's money, it's a budgetary issue. But one of the issues I think is flexibility in the labor process and in the legislative process to facilitate that sort of thing happening. The last thing I would say to you, and I'm really reducing my remarks down here, is I really believe that the secret to fixing this problem does not lie--and not to take anything away from what we're doing today--the secret doesn't lie in recommended budgets. It doesn't lie in budgetary testimony, in committee hearings. There's stuff out there that I think would really help make decisions. I think a couple of the agency heads referenced today exit interviews. Okay, they're very, very telling. Nobody pays any attention to them. Half the time they don't even bother to do them. But I will tell you that in this agency, in this system, excuse me, there are piles of exit interviews that are very,

very telling that nobody ever looks at. You know, to the extent that time would allow it, maybe staff could obtain some of those and look at them. The other thing, and the last thing that I'll dwell on but I think it's extremely critical, and you've heard it from both sides today, and that is the issue of investigatory suspensions. A couple of months ago at one point there were something like 168 employees within this system that you've talked about today that were out on investigatory suspension. Clearly within those numbers there are people who have engaged in abuse and neglect. No question, okay, and those people should be dealt with effectively, fairly but effectively, and if they're real abusers they should be gone. There's no question about it. But the overwhelming majority of these investigatory suspensions--and assume that I'm lying to you, please--the overwhelming majority are situations where employees are making errors. Okay, errors of oversight. I gave you an example a minute ago. Somebody gets from one room to another, you miss it, not because you're sleeping but because there's so much to do and you just miss it. Very, very minor issues are leading to suspensions. They are, I will tell you that most of them are suspensions--I think there was a question, Senator Stuthman, earlier--suspensions that begin without pay. The first six days, under our contractual relationship you're suspended without pay. Then you're on suspension with pay. Well, from a management perspective, you know, that first six days, if I'm acting fairly and legitimately, I can understand that. That's not a bad business decision. But why am I going to pay somebody to sit home for 30 or 60 or 90 days with pay? Why can't I investigate faster than that? Okay? The Veteran's Home in Grand Island used to be--they're doing better--but they used to be famous for their rather than suspending people they would reassign you within the institution. Well, same difference, they take a patient-care person off the ward and let him work the dish machine in the kitchen. You know, three, four, five, six months later they're still in the kitchen. Okay? There's no excuse for that. If they're abusers, deal with them. If they're not abusers, put them back and let them earn their pay and let them take care of your patients. Okay? Please take a look at the investigatory suspensions. You can obtain from the agency the records of those investigatory suspensions. Don't take my word for it. Look at the type of suspensions. And allowing me some room for exaggeration, I believe probably at least

60 percent of the investigatory suspensions are situations where you don't really need to lose that persons' time. They can be--in a worst-case scenario, if it doesn't...if there's no demonstration of actual harm--they can work on another ward. Okay? If there's a demonstration of harm, obviously you have to be more careful with those. Maybe they need to be reassigned to the kitchen. Or...but again, if you have a real tangible evidence of abuse, that can't be tolerated. That person should be out of the institution. But that's the very small exception to these actions and not the rule. The other thing I would say to you, is I don't believe you've heard from anyone today who is not of good faith, you know, that isn't acting to the best of their ability to provide for patient care. But somewhere in the mix of personalities it ain't working. Okay? And help us make it work. Thank you. [LR195]

SENATOR JOHNSON: Thank you. And we're running behind time, so not going to allow any questions and we're going to go on to the next person. (Laughter) [LR195]

BETTY KORBER: I'm Betty Korber, K-o-r-b-e-r, and I'm glad to have you hear me. I won't take very long. I'm out at the Lincoln Regional Center and I've worked for the state for 23 years. And I joined them in November, two years ago. And I had the pleasure to go down and work in Beatrice, starting last November. And I think I've worked overtime every weekend except for like, three weekends out of the year. And in February I came back...I was up here and I decided to go over into direct care because of Beatrice. So I thank God for that. I've worked with some older ones...right now I've been over there since February and I'm the oldest person on the ward at night. So I'm not...got that much experience at night. And three of them...like last night, there's three, that's probably been there less than, like three months. So we're a pretty new crew. And we've got some one-on-ones and they need a lot of care. And so the overtime comes up and we have some really good ones and two of them in the last three weeks have went to on-call. They've given up their rights to insurance, benefits, vacation benefits, holiday vacations, everything. So that they don't get mandatory. One of them is an older gentleman and one of them is going to his masters. He's missed like at least six classes

that are important when you're going to get your masters. The sad part is he's in it for psych. He's in the right field. He's in the right place. And they won't let him off for school. So it's pretty sad. We got another lady that's got cancer and she's taking treatments, and she has to work her cancer treatments around the overtime. If she has to cancel, that's what she has to do. And that's not fair. I gave up...when I went over there...on the radio I wish they had pulled that one ad, like where you can get schooling, advanced schooling. They use that a lot on the radio. And I had signed up, I'm an LPN, and I had signed up for RN school, got accepted. And I quit that and didn't start that program because I couldn't know for certain that I'd be able to take those classes to get my RN. And the reason being is, that out there they don't hire LPNs except if you're on-call. They hire them as an on-call and they won't put an LPN position out there to be full-time. And I'm not going to give up my benefits. My husband and I, you know, we've worked like 55 years together with the state. And I'm not going to give up those benefits because they can't hire people that want to work. So it's like I'll work the overtime and I'm making more than an LPN any how. So it's like...that shouldn't be happening. So I just want to let you know what some of it is, you know, doing in building 10, and it's in all the other buildings too. [LR195]

SENATOR JOHNSON: The common theme really is that the overtime is just so much that it becomes crippling to the whole system. Is that the way you see it? [LR195]

BETTY KORBER: Right, I've made over 20,000 this year in overtime. And I don't make very much. And that's pretty sad. They could hire a full-time person. [LR195]

SENATOR JOHNSON: All right, thank you very much. [LR195]

BETTY KORBER: Thank you for listening to me. [LR195]

SENATOR JOHNSON: Yes, thank you. Now was there another person or...okay. Well, one of the things is...let me see, I had written down, oh yeah...I've got a short memory

any more. Oh, J. Rock, you got something to say? Come on up. [LR195]

J.ROCK JOHNSON: My name is J. Rock Johnson, J-o-h-n-s-o-n. Thank you, Senator and members of the committee for being so patient with this important subject today. I wanted to add that I've worked in the areas of the elimination of restraint and seclusion for many years. And I do know that there are forensic facilities--one is Mid-Hudson in New York, one is Taylor Hardin in Alabama--where restraints are not used. I cannot speak to their staffing or their policies or their practices, but I know that it's possible. I heard acuity as being a measure of hospital stay, of psychiatric hospital stay, which concerns me. I'm looking for a functional definition for individuals, for their rehabilitation, their recovery, their personalized care. And those seem to be two different points of view. And that concerns me. Also at the Norfolk Regional Center I did hear the testimony about the efforts that are being made to separate people on the floors. I did not...I was not told this directly, I was told it by a credible source, of a woman who sees across the yard a man who raped her. This is causing trauma. We, as a state, are causing trauma to that person. I know we're doing the best we can, but we can always do better as we recognize that there are areas that need help. And to echo Senator Schimek about providing continuous oversight, I think that's extremely important. It was quite almost happenstance that I learned that at least a million and a half dollars was being invested into the Norfolk Regional Center, that it might become a hospital. Well, now farther down the line they'll be probably nurses training there...but some continuous oversight over how buildings are used, how they are changed around, what the rehabilitation schedules are for our 24-hour facilities. Thank you. [LR195]

SENATOR JOHNSON: Thank you, J. Rock. Eric Evans, are you here? Yes, there you go. Yes. I thought that you had held up your hand earlier and then I didn't see it the second time. [LR195]

ERIC EVANS: I too will endeavour to be brief. However... [LR195]

SENATOR JOHNSON: Well, we're having a good discussion this morning and I think that's the important thing. [LR195]

ERIC EVANS: (Exhibit 4) Good afternoon, Senator Johnson, members of the committee. My name is Eric Evans, that's E-v-a-n-s, and I am the chief operating officer at Nebraska Advocacy Services, the Center for Disability Rights, Law, and Advocacy in Nebraska. And I too want to thank Senator Schimek for introducing LR195; and would just like to take a few minutes to share some of the perspectives and concerns of our organization regarding operations at the state's 24-hour care facilities. I'm going to start with Beatrice and I do want to note that after the CMS survey in the fall of 2006 we approached the department and asked to develop an access agreement. And that policy secretary Petersen and her leadership team worked with us very quickly to resolve that issue, to get it drafted and get it signed so that we have parameters regarding our access to Beatrice State Developmental Center. So again I appreciate the quickness with which that issue was addressed by the department. Since November 2006 we have been on on-site at Beatrice and during that time we have had a number of instances where we have done further investigation regarding allegations of abuse and neglect. At this time we currently have 16 cases in which we have allegations of substantial abuse and neglect at the facility. We consider the situation at BSDC to be grave. And we'll be issuing a report at the end of November which, I think, demonstrates the grim situation there. I can't share with you the specific details of the report today, but we believe it demonstrates a clear pattern or practice on the part of state officials over time that has resulted in the people living at BSDC being deprived of their fundamental constitutional rights under the U.S. Constitution. As I said, we anticipate releasing that report in the end of November and we hope that we will be able to meet with either you and Jeff and other members of the Health and Human Services Committee and at least give you a briefing on that report prior to our release of that report to the public if you are interested. In terms of the regional centers, again, the testimony today was quite compelling. I too, at one time, was a psychiatric technician at the Lincoln Regional Center and I did on a number of occasions receive bites and was beaten on a few

times. Although I'm not quite so sure that the felony approach, as was suggested earlier, is necessary the best way to resolve that particular issue in terms of patient-on-staff violence. Over the years we've been very concerned about the placement of sexual offenders in behavioral health facilities, particularly the regional centers. We're still concerned about that. We are very pleased to hear that the department and the leadership at the regional centers are working to address that issue. But we still have concerns about being able to maintain patient safety with the placement of sex offenders and people with mental illness in the same facilities. Another area that we see that might be helpful in terms of for you to look at is around what we see as lack of uniformity in terms of policy and practice across the regional center operating sites that primarily at Lincoln and Norfolk. One of those areas is trauma-informed care, and as you're aware, we've had litigation for...two major litigations on this area in regard to situations at the regional center and the rape and sexual assault of female patients. As a result of the most recent consent agreement, there's a requirement for trauma-informed services and care at the Lincoln Regional Center. However, that's not the case at the Norfolk Regional Center, even though we believe that the precipitating factors that led to the situation of the rape and sexual assault of women at Lincoln Regional Center are also present at the Norfolk Regional Center. So we encourage the department and the leadership of the regional center to work to ensure that policy and practice is uniform in this area. And if not, we are afraid that there will be a continued compromise of a patients' safety. Another area is patient advocacy, we are, again, very pleased to see that the Lincoln Regional Center has created a position of patient advocate, that position was created prior to our consent decree. And the consent decree does, however, give some additional parameters to that position. And we just don't understand why that same kind of position with an individual who is similarly qualified isn't available to people who are at the Norfolk Regional Center. And we encourage the department and the regional center leadership to move in that direction. Another area of concern that we have is around guardianships and again, our understand is that there's a situation at the Norfolk Regional Center, where people are required to have guardianships prior to being discharged into the

community, while there's not a similar policy and practice at the Lincoln Regional Center. We're not making...we do have concerns about that policy and practice at the regional center, so we're not advocating that that be a policy and practice at the Lincoln Regional Center as well, but this is just a question we have regarding the uniformity. Another area is psychiatric rehabilitation. And this is an area that we have been working on for twenty years. We've been before the Health and Human Services Committee on a number of occasions, involved in planning processes with the department where we have strongly advocated the adoption of psychiatric rehabilitation. We believe that it's a more evidence-based approach, that it's data-driven, and is superior approach to working with people who have severe and persistent mental illness who are in the regional centers than the traditional psychiatric approach. One of the advantages of psychiatric rehabilitation is that there's a team decision process, by which a team is looking at assessing, evaluating, and making treatment plans for individuals who are at the regional centers. And we find the team approach to be a much more dynamic approach and one that is more effective than the traditional psychiatric approach. The next area of our concern, and I think you've had a lot of information on this already is staffing. And while we are very, while we really feel for the staff who are involved in the situations that these kinds of issues have in terms of their personal lives, that all comes back to the people who are there, to the patients and what's the consequences of the staffing problems when it comes to patient care. And I think when you see our report on Beatrice you'll see the consequences in terms of individual persons and what happens when you are unable to provide adequate staffing levels. We also are aware that the State Ombudsman’s Office has been involved working with the regional center around problems associated with staffing. And we hope that the efforts and working with the Ombudsman’s Office will be shared with this committee as well. And we are hopeful that a report will also be issued by the Ombudsman’s Office kind of detailing what they have done. And finally a problem has been around for a number of years, has been the use of psychiatrists and psychiatric...the kind of psychiatrists at the regional centers, whether they're on staff for a full amount of time and how other outside consulting arrangements or positions they have may impact what they're doing at the regional

centers. And as you some of you may recall Senator Beutler did have a study of that. There was an audit report released. I'm not aware of what has been done to follow up on the audit report. But I would encourage you to make that part of your final report, to take a look at what has been done in that regard. Finally in regard to the regional centers, there's the regional center redesign. And again, we are very pleased to hear that the department and the regional center leadership is engaging in conversations with staff who are working those facilities. But since we're really talking about a behavioral health system, and the regional center is only one component of that system, we're concerned that that has been primarily an internal kind of conversation. And we understand that that might be a first step, but we hope that the department and the regional center leadership will open that process up to other individuals, such as the staff working the regional behavioral health programs; other providers; consumers, especially some former patients perhaps; family members; as well as other advocates. A final point...or next to the final point is correctional facilities, and again, we appreciate the comments today by director Houston. And we have been involved for a number of years looking at both what is going on in terms of behavioral and mental health treatment in particular in the correctional facilities as well as jails. Our research and over the years has led us to the conclusion that we also need to be working on the front end of the system. We need to be devising programs and services that will keep people from being...from ending up being incarcerated in jails and prisons. And there's a number of national models out there around those kinds of approaches. There's work being done here in Nebraska now: the crisis intervention teams, jail diversion projects, even some discussion around mental health courts. And again, we encourage the Legislature to look at how they can create mechanisms that will support and continue the work in this area. Again, this may be an issue around funding as well. One final comment: and I don't have this in the written testimony, and that is around the veterans' facilities. One of the things that our organization receives is a lot of information on veterans. And we do that because we're part of a statewide network of protection and advocacy systems for people with traumatic brain injury. And one of the things that is constantly coming over the listservs are articles talking about the high incidence of traumatic brain injury among

returning veterans from the Iraq conflict. And so we just want to encourage the Department of Veteran's Affairs and...to start looking at this early, because it may be a significant issue for veterans in the near future. And another significant problem area is around post traumatic stress disorders. So these are just two areas that we hope the Veteran's Affairs will be giving attention to. With that, I conclude my testimony and thank you for your time. [LR195]

SENATOR JOHNSON: Any questions? Eric, thank you. We've had a great discussion here this morning. One of the things...is Bill Gibson still here by the way? That...Bill, do you have any comments about things now or Scot has kind of a concluding thing and we'll call it a hearing. I shouldn't have let you bring up the chair because then you'll both sit there for a long time. (Laughter) Now we'll take whatever we want...or need and so... [LR195]

SCOT ADAMS: Gosh, what a morning of testimony, and let me say again that I appreciate your work. I appreciate the time and the effort everybody has taken to come in to talk about a variety of issues and things. Very frankly, this is not...I don't think a situation where we're here to point counterpoint. In fact, there is much with which we agree that has been said all morning long and after our testimony in particular. We're glad that this has been raised in many ways. And often times this is a situation of a both-and kind of dynamic. There are very interesting things. If you think back on the testimony you've heard, you've heard some people call for an increasing use of a correctional approach and incarceration. You have also heard of people saying restraint-free...restraint-free, let alone correctional facility. You have heard people talk about abuse, documented abuse in reports coming out. And you have talked about people saying that there is an overreaction to suspensions as a result of those very incidents and more. You have heard people talk about lack of oversight and the need for continuing oversight. And you have heard people talk about the Department of Justice, CMS, NAS, and others being involved with our work. You have heard people talk about wanting to make some behaviors of staff a felony behavior against staff. You

have felony behavior...you have heard others argue against criminalizing those persons who have behavioral health disorders. It's a fascinating world. And I'm not suggesting that one side or the other on those and other dynamics are right or wrong. It's a both-and situation. That's the nature of the work that we live with. That's the nature of the task; that's the nature of the people with whom we are entrusted to give care. It's a fine line. I'll be the first to admit in my six or seven months here that I've been here I've seen us go a little bit this way, a little bit that way. Sometimes we make the right call; sometimes I wish it had been a little bit this way or that way. We're not perfect. We're not perfect institutions. We work within a variety of interesting constraints and arrangements. Well, we have for instance, a contract. A contract: it's not an agreement, it's not a sort of a handshake situation, it's a contract with labor. The use of the word emergency, as Mr. Buri said, is right. That's the term of art defined in the contract. Both sides agreed to use that word. Is it the right word? I don't know. Today it sounds sort of silly, doesn't it? That's the word. That's what we call it. We both agreed to that. And those situations are known as that, and that is what triggers then the next series of steps to be able to afford a sufficient staffing level in many of our institutions to be able to carry on the work. To avoid the abuse that they very rightfully identified as a potential outcome of tired people. Imagine if the people weren't there. Spending money on the overtime, sounds crazy, doesn't it? I agree with that. I don't know that it is frankly a matter of additional resources from a financial perspective that are needed. Use of them and deployment in differential ways might be able to help fill particularly difficult spots. The Lincoln Regional Center competes with two hospitals in this city alone, private-sector cities. Nurses are tough to get, as one example. I want to say a couple of other things and I would like Bill to respond to in particular the allegation or the situation described about the bus, because that probably, in my mind anyway, was probably one of the more dramatic moments. And I'd like to offer the opportunity of the both-and perspective of the rest of that story, or the other side of that story. But I think a couple things are important here. There has been no hiring freeze, either informally and certainly not formally at any level. We have not turned anybody down who has been qualified for the positions in the regional centers' care, just haven't done that. We are

not not trying to hire positions. We are actively engaged in--as you heard throughout all of the institutions--efforts to try to hire the right people at the right time. I want to say with regard to the regional centers, we agree that this is dangerous work at times with some people. Much of the time it goes very easily. Most of the folks on the sex offender units, as an example, relatively easy to manage, relatively easy without incident. The data that I can provide you though, is that since Bill Gibson has been here as a CEO and instituted additional training, are reported and documented incidents of staff-to-staff and client-to-staff abuse and physical alterations and injuries have all fallen consistently and dramatically. We will send you the documentation and the charts on that. Is it sufficient? No, not yet, we're not done. Very frankly, Bill and I have been talking along with management team at both centers about the fact that there seems to be a group of people, who but for the grace of God could go into one system or the other. You won't hear these kinds of conversations around Corrections, because they have a very different set of abilities to manage behavior. They make you uncomfortable, but there is a group of folks who could go one system or the other. And easily could do that for whatever reason: they are violent, the are unpredictable. And one ends up in a hospital, the other in a correctional facility. I'm not arguing that they be within...that all folks with mental illness be in a correctional facility or attended to in those means. But I am simply saying that the work we do is to acknowledge that...sometimes dangerous. We work with many voices. We work with many constraints and dynamics. I want to ensure you that we are engaged and very much concerned with regard to the safety issue. We have formed a safety task force regarding the regional centers. We made--I alluded to in my testimony earlier--a visit to Larned, Kansas, as an example, just yesterday with a group of people to listen and to learn what they're doing. We have invited, in fact, contracted with a psychiatrist and a team of his from Georgia to work with us. We are having others in addition to regional center staff participate in the safety task force. And I hope that we will learn many good ideas to improve our care. I never want to have another colleague of mine assaulted. And I certainly never want to see another person killed as a result of their work with the regional centers. This is important to us. It is important to me. Now, with regard to the particular incident of a man, we believe that was sent to Louisiana, I'd

like to ask Bill to talk a little bit further about that point. [LR195]

SENATOR JOHNSON: And before you start, that was Scot Adams speaking and now our next person, Mr. Gibson. [LR195]

BILL GIBSON: My name is Bill Gibson, I'm the CEO of the three regional centers, G-i-b-s-o-n. I've been working with the state since 2001, first as the CEO at Hastings. And then in March of 2005 I took over Lincoln and maintained Hastings. And in March of this year I took over responsibility for Norfolk and Lincoln and Hastings. And so we've gone through this process. I guess in listening to the things that have been said today, and listening to what Scot said, I would like to add a couple things before I talk about the incident with the gentleman and a bus in Louisiana, because there was a little embellishment there. And I think you need to have the rest of the facts on that. But before I do that, I couldn't agree more with what a 26-year employee like Jim Petersen. This is not a new problem. This is something that continues, and its...I like to use the analogy with the regional center, especially with the Lincoln Regional Center, because it is a highly critical and dangerous environment in terms of the risks to the people that work there. This is like turning a battleship. And you can't do it quickly, and you can't do it as fast as some people would like to see. There are thousands of intricate parts when you change things. And what we learned in July of 2006 is when we change things too fast we overlook things and then what happens...at that particular time we ended up in immediate jeopardy because we didn't protect the patients enough. So it's like turning a battleship, and it's very slow and meticulous work. But we are making a lot of progress, like Scot alluded to, the incidence of you said staff-to-staff abuse, and I hope you meant staff-to-patient abuse which we don't have. But patient-to-patient abuse, people hitting one another, spitting on one another, those types of things, these are very difficult people, especially in the forensics area, to work with. And as far as the issues that Jim and Paul and Mr. Buri described, this is a vicious cycle. And at the Lincoln Regional Center and to some extent Norfolk, it starts with pay. I compete at Lincoln with the two other big hospitals for nurses. I have 54 nursing FTEs. I have 18 vacancies today. I can

hardly keep a nurse on each shift on each living unit, which is a joint commission and CMS requirement. I can't do that without overtime. I've got and I have had for the last two and a half years, anywhere between a 20 and 25 percent turnover. So if I have 500 employees, let's just call it 20 percent, I have 100 new faces each year. Today I am budgeted for 517 FTEs, I have 567. So just make the math, easy, that's 50 out of 500, that's a 10 percent vacancy rate. People come to work, people like Jim stay. People come to work, they work there for a couple times, they're the low man on the totem pole for the mandatory overtime, they get hit with a couple mandatory overtimes, and they say, the hell with this. It's interfering with my personal family life, and the cycle just keeps repeating itself. So if I keep having new people, we don't pay enough to compete with the other hospitals to get...I mean, it's not just a question of because we have to screen people out on the front end for any type of past criminal history, because we have to be very careful of the individuals that we hire to make sure that they have the proper credentials, it's not like we have this vast pool of people on prospector avenue that want to come to work for us. So when we do get the right people and we do hire them, and then we're competing with the other...with St. Elizabeth's and Brian LGH and their mental health unit at Brian LGH for pay, when people can go over there and they can get paid more to do the same job, that's what they do. So that continues the vacancy thing. You have to have the staffing levels, and you've already heard from Jim and Paul about how we're woefully lean on the staffing levels. And so when you add the vacancies then you got to hold the overtimes. The other thing that they left out that I haven't heard today that you need to be very cognizant of: the average age of the employee at the Lincoln Regional Center, the average age is 48 years old, the average age. So as those people...as these people start to age, this situation is only going to get worse unless there's a way that we can recruit younger people, not just to come to work. I mean anybody can come to work. But you have to have people like Jim Petersen that have a passion for doing this work, that will do it for 26 years. So we've got this huge dynamic happening among the staff. And, I mean, it creates the tensions that you've heard today. And then we're trying to blend a lot of different things, reduction in restrain and seclusion, but then when you put a criminal element in that, then that doesn't work

with them. So Scot and myself have been talking with director Houston about a better interface between Corrections and mental health. A couple of other things that you've heard in the last two about the felony piece, forensics is a very dangerous environment. It is a very high-risk environment, it's like working on the railroad, it's like working for the utility company and replacing electrical lines. There is always the opportunity for an accident and for somebody to get hurt. And in forensics, in security that comes from the fact that we have a lot of people there that have some type of criminal history with them. Two sessions ago Senator Jensen...it is a felony to strike a correctional officer, according to Nebraska statute. It's a misdemeanor to assault a mental health worker. Two sessions ago Senator Jensen introduced a bill at my request in the Judiciary Committee to make it a felony across the board. That didn't get out of committee. Last session Senator Flood had a similar bill in Judiciary and that wasn't advanced. So it's not like we're not trying to do something with that. But then when you'll hear from the other side, from people like J. Rock, rightly so, we have mentally ill people. So we have this mix of people and then we have this staffing dynamic that goes on on top of that. I know the time is late, so I will stop with that, but I just wanted to make those points. As far as the gentleman that we discharged from the Lincoln Regional Center that we sent to Louisiana, we did discharge him. He was a level three sex offender. He was not at the Lincoln Regional Center for sex offender treatment. He committed his offense, served his time, and was finished with all that before we enacted the commitment laws for the sex offenders. He was there for psychiatric treatment. He is a very challenging individual, and we did discharge him, and we did put him on a bus, sent him to his mother in Louisiana along with appropriate psychiatric, medical management follow-up, the appropriate case management follow-up, when he arrived in Louisiana to live in a treatment group home. So it's not like we just put him on a bus and sent him on down highway 29. As far as we know, there have been no issues with that individual in Louisiana. And we have followed up with that treatment group. But it does speak to the passion, especially when it comes...I can't speak to the Beatrice facility or the veteran's homes. I can talk a little bit about the YRTCs, because I've got 40 boys in Hastings that are from YRTC in Kearney. It's a passionate and it's a somewhat controversial area.

Scot and I visited Larned State Hospital down in Kansas yesterday. And I was in awe. This is a brand new facility, 270 beds, that was opened in 2005 and it cost the state of Kansas $55 million to build it. The forensic building that Jim Petersen and Paul Versaw work in was built in 1952. My boss just told me to stop. (Laughter) I'm sorry. I...(inaudible) [LR195]

SENATOR JOHNSON: Well and my goodness this has been a great morning I think. Yeah, we've been at it here for a little while, but what a complex problem this is and so on. I think the one thing that is mandatory that we do do is that we don't listen entirely to our successes but that we keep in mind and carefully listen to the areas that aren't going so well. So that we can, you know, jointly work with everybody such as what you're talking about as working with the correctional people so that there is a better interface, so that we get these people as best we can in one facility and not the other and so on. These are areas where, you know, I think things that we have to do and do our best job we can with them. Certainly the other thing that I got out of things here this morning is listening to the people that if we are going to lower this age of 48 down to a more reasonable number that we're going to have to find some way of getting younger people to stay committed for 26 years and so on. We have to get that process reinvented, if you will, and the constantly being--and it isn't anybody's fault in a sense--of not being able to know when you go to work whether you're going to get home and when is something that we obviously have to do a better job than what we are. So with that let's call it a morning on LR195 and thank you all very much for a great discussion. [LR195]

SENATOR JOHNSON: Could I ask you to have your seats and we'll go ahead and get started here this afternoon. Our hearings this morning started at 9:00 and ended up about quarter of 1:00. And we did have the type of problems that needed at-length discussion and particularly with state workers pointing out problems that existed in their fields and so on. So it went on for quite a while. We didn't hold people very rigidly to a time schedule, but...and I'm not going to do that this afternoon either, but I would ask

that you remember the people that are going to be taking part later in the day, that if you go on ad nauseam early, that you're really depriving these other people of having an adequate opportunity to express their opinions about things as well. So make your points but be brief as best you can. And one of the things that I must remind you of is two things that are kind of cardinal rules around here. One: is if you have a cell phone and it's still on, you are in immediate danger one way or the other. And secondly, when you do come up and testify, if you would please give you name and then spell it, so that the people transcribing these session can get that done accurately. With that, let's go ahead and get started. And the first one is LR205 and this is my legislative resolution and it's for the interim study to provide development of additional recommendations relating to the implementation of the Nebraska Behavioral Health Services Act. With that, I will change seats. Members of the Health and Human Services Committee, for the record, my name is Joel, J-o-e-l, Johnson, J-o-h-n-s-o-n, representing the 37th District in the Nebraska Legislature. LR205 was introduced to give members of the Legislature and update on the implementation of LB1083, passed in the year 2004. As virtually all of you know, LB1083 was the bill that established the Nebraska Behavioral Health Services Act and started on us a less institutional and a more community-based approach to the treatment of mental health and substance abuse disorders. There will be a variety of testifiers to provide perspective on this issue and suggest further steps that they feel need to be taken. As you know, our current structure involves the Division of Behavioral Health within the Department of Health and Human Services and six Regional Behavioral Health Authorities. You will be hearing from both the Division and the Regional Behavioral Health Authorities this afternoon. LB1083 also established the Oversight Commission. In 2007 the Legislature passed LB542, which created the Children's Behavioral Health Task Force. Former Senator, Jim Jensen, is the chair of both of these bodies and the principal author of the original LB1083. Senator Jensen will follow me this afternoon. (Laughter) One of the hallmarks of LB1083 was the emphasis on principles of recovery and consumer-driven care. We'll be hearing this afternoon from the Mental Health Association of Nebraska and Nebraska Advocacy Services on this issue. You will also hear from at least one regional consumer specialist, one of

seven who have been hired by the six Regional Behavioral Health Authorities. Much has been accomplished and I know that we would like to see even more accomplished. I know that the testimony this afternoon will be very informative and I know that we can trust that it will provide a helpful background for the introduction of appropriate follow-up legislation in this next year as needed. With that, we will ask for the testimony of those others. Is Senator Jensen in the room yet, Jeff? Okay. Jim, if you'd like to proceed. Were you walking in? I heard them giggling as I was saying...welcome. [LR205]

JIM JENSEN: Thank you. Senator Johnson, members of the Health and Human Services Committee, my name for the record is Jim Jensen, 10525 Mullen Road, Omaha, Nebraska. And it's a pleasure to appear before you and to relate at least the experience that I can impart on LB1083 and on the reform of behavioral health in the state of Nebraska. It's been a road that has that we've gone down that has had some bumps along the way but in all due respect I think it's been very gratifying to see the results of where we are today. And we're not there yet. There is much that still needs to be done. But since the passage of LB1083, we are providing about 14,000 more services to individuals that were not served before. That is per month. And we are providing services in areas that we did not, were not able to serve in the past. Things still to be done, certainly Norfolk with the Faith Regional Center now about ready to open, beds will certainly help in that area. In Region 6 in the metropolitan Omaha area about next March the Restored Hope Recovery Center will open, providing a number of beds: acute, subacute. As well as bringing in new treatment that we have never had before in the state of Nebraska. Along with that we are bringing in academia to help to counsel and will also be a clinic and a laboratory for those in that area to work with those suffering from mental illness and behavioral health issues, but also a training facility that is so desperately needed. Senator Johnson, the last time that I went across the state on one of the Health Committee tours, that was the theme that was brought out very evident, that there were not enough trained mental health providers, officials out there. And hopefully that facility will bring that about. There will be a collaboration between the University of Nebraska Medical Center and Creighton University as a joint

residency program for psychiatrists. It will also be a training ground for those in...social workers, those nurse practitioners who specialize in behavioral health issues. So we're looking for that to be a...come up and not only be a resource for Region 6 but also for the entire state. And I think it will certainly happen in that way. Also we have going on throughout the rest of the state and again, in Region 6, training of law enforcement people on how to deal with people when they have an episode, because there is various ways of doing that. We have involve consumers into this process, certainly never as many as we like or as fast as we like or as involved as we would hope, but I think that will happen to. And so I'm very optimistic about our future. I'm pleased with where we are today and how far that we have come. We knew entering into this reform...and reform is always difficult, that there would be difficulties along the way. But I think we've met a lot of the challenges and are working through those. I'm also very pleased with the providers and professionals that are providing service in this state, because they've had some struggles trying to work through different areas. But still the service, I think, has been very good. And like I said, I think we're involving more consumers all the time and will continue to do so. With that, I'd sure be glad to answer any questions that any of the committee might have. [LR205]

SENATOR JOHNSON: Senator Stuthman. [LR205]

SENATOR STUTHMAN: Thank you Senator Johnson, and welcome back, Senator Jensen. Those 14,000 new services, can you explain to me a little bit about what are these, because these are services that can be addressed in a community-based mental health rather than a regional base? [LR205]

JIM JENSEN: Yes, Senator Stuthman. These are individuals who are being served in community-based services. You know, there's...first of all, when we started LB1083, if we would have had several million dollars that we could have added on top of it, that would have made it much easier. We've taken the dollars that were there, added a few, but really a rather insignificant amount. And so what we've been doing is transferring

dollars that were being spent at regional centers at a much higher cost and putting those out into the community. And with that we've been able to treat individuals in the community at a lower cost, and I think even more effective. As we look also through our statistics, we find that we have fewer EPCs, we have fewer commitments to regional centers, and also we've increased diversions greatly, diverting people from ever going to that regional center. You know, there's one thing...if you were filling out a job application, and you have to give your resume on that, and many employers, I'm sad to say, if they see that there is a reference to perhaps some behavioral health problems, maybe they'll shy away. And I hope that doesn't happen, but it has happened in the past. And certainly it is the goal of mental health reform to allow individuals to find employment, to become trained, and to be productive citizens. That is what they want to be themselves. And so anything that we can do to help along that way, but these are individuals...the number that either were not even applying for services or were not receiving services. [LR205]

SENATOR STUTHMAN: So these individuals can be in the productive work setting and still be receiving some services, some assistance, medical or like that, right? And I think that's what, you know, when we had LB1083, that's what my goal was to keep the people in the communities, not lock them up in four walls and let them work but still continue to get some type of service. [LR205]

JIM JENSEN: Certainly, and from time to time they may need services. Again, for a short period of time until they can get back into a recovery mode and receive services and get back to that job that also enjoy working. [LR205]

SENATOR STUTHMAN: Thank you. [LR205]

SENATOR JOHNSON: Any other questions? Senator Jensen, thank you very much. [LR205]

JIM JENSEN: Thank you. [LR205]

SENATOR JOHNSON: Next on my list and we're going to make it so that people can...we want to get good representation but start out and go through the printed list I have...is Scot Adams is next. [LR205]

SCOT ADAMS: (Exhibit 1) Senator Jensen used the word optimistic. I'd like to add encouragement and hope as good words for this hearing. Good afternoon, Senator Johnson and members of the Health and Human Services Committee. My name is Dr. Scot Adams, A-d-a-m-s, Director of the Division of Behavioral Health of the Department of Health and Human Services. [LR205]

SENATOR JOHNSON: Scot, since you don't know how to spell your name, why, maybe you better spell it for the...(laugh). [LR205]

DR. SCOT ADAMS: S-c-o-t A-d-a-m-s. I'm here today to provide information from the department's perspective with regard to LR205. In 2004 the Legislature passed and then-Governor Johanns signed into law landmark legislation LB1083. This bill replaced the statutory language previously authorizing mental health, substance abuse, and gamblers' assistance programs. The new language: created the division and several new administrative provisions; established a new administrative function of the office of Consumer Affairs and created the position of administrator; required the expanded involvement of consumer and family members in the planning and delivery of services; included procedural language for creating services in the community and reducing services at the three regional centers; identified recovery-based services, utilization of evidence-based practices, and research as fundamental to the system; and required the integration of behavioral health services within then HHSS. LB1083 also established the mission of the behavioral health system. And under current law the system is required to ensure: first of all, public safety and the health and safety of persons with behavioral health disorders; secondly, statewide access to behavioral health services; thirdly,

high-quality behavioral health services; fourthly, cost-effective behavioral health services. In order to implement LB1083, the department established an implementation plan focusing initially on creating community-based are and housing, the reduction of the census of behavioral health patients at the Hastings and Norfolk Regional Centers, expanding consumer involvement in service planning and delivery, and integrating programs funding behavioral health services. We have had a number of successes I'd like to speak to. The division and the Behavioral Health Regions have realized a number of successes. First, over $21 million a year has been moves since July of 2004 from regional center operations to the regions to create services, new services in the community. This funding now supports all levels of services in the community, from hospital inpatient services to support services that assist consumers remaining in their homes and with their families. The need for these services is best demonstrated by the growth in the number of persons being served in community services. During fiscal year 2004, 33,124 persons were served in community-based services. In the last fiscal year, 2007, 42,915 unduplicated persons were served. That's an increase of 9,791 people, or a growth of more than 29 percent in the community-based service delivery system. The number of consumers now receiving inpatient services in regional centers has been reduced significantly. In March 2004 there were 375 beds in the three regional centers serving behavioral health patients. On October 29 of 2007 there were 160 beds in Norfolk and Lincoln. Adult services have been closed at Hastings. Consumers needing inpatient services who were formerly served in regional centers are now served in local hospitals. They now are served closer to their communities and families and are returned to their homes in a timelier fashion. The reduction in the need for regional center services is also demonstrated by the fact that in FY 2004, 741 persons were admitted to the regional centers for behavioral health services. Last year only 273 persons were admitted. The addition of services in the community has also reduced the number of persons needing to be put into emergency protective custody, or EPC. In five of the six behavioral health regions we are able to track all EPCs. In Region 6 we can trace many of them, the EPCs admitted to Immanuel Hospital, but not all of them, because of reporting requirements. In the five regions where we are able to effectively

track the total number of persons needing to be in EPC dropped from 2,601 in FY 2004 to 2,336 in FY 2007, a decrease of more than 15 percent. A major goal of LB1083 was to expand the availability of funding for community-based services, by utilizing funds transferred from the regional centers then to be used as Medicaid match for the Medicaid Rehab Option, or MRO services and substance abuse waiver services. During the last three fiscal years, funding for MRO services have grown from $11.6 million to $15.6 million, while funding for the substance abuse waiver services has grown from no Medicaid funding to $2.5 million, a total increase of $7.5 million in federal funds. Consumer input has been expanded by providing for consumer specialists in each of the regions. These individuals are responsible for expanding consumer involvement into planning and service delivery. The consumer specialists have developed consumer advisory committees. They have been trained in Wellness and Recovery Action Plans, WRAP trainers, conducted WRAP sessions, and established a Consumer Advisory Team at the Lincoln Regional Center. A critical element in assisting with consumer recovery is the availability of housing. Consumers frequently describe how the loss of or lack of available housing impacts their ability to void the need for emergency or inpatient care. The availability of housing is also critical when a person is ready for discharge from inpatient or residential services. LB40, which was enacted in 2005, has had a significant impact in providing appropriate housing for persons looking for a place to live. During fiscal year 2007, 557 persons were able to access housing as a result of this current law. That's no small deal. These are a few of the successes resulting from the enactment of the landmark law. A number of system challenges remain. Some of those: difficulty in accessing hospital beds has resulted in some law enforcement officials spending time attempting to find available beds, and in some cases traveling a substantial distance to admit a person who is under EPC to a hospital. The situation is impacted by the fact that in 2004, the division had planned for and contracted for an additional seven beds at Faith Regional Hospital. Those are not yet operational though they are to be within about a week to two. Mary Lanning Hospital in Hastings also did not increase bed capacity at the time. In addition, Cuming and Douglas County hospital were closed for renovation over the past seven months, taking some beds out of

service, complicating the situation. They are to come back on. The issue of access to hospital beds is currently being addressed by involving law enforcement officials, providers, elected officials, and consumers in discussing to analyze the causes and to develop solutions. The division, as part of what we have called the "EPC Roadshow", is visiting each region to discuss with these stakeholders the issues and possible improvements to the system. In addition, a statewide meeting with stakeholders and federal resources will be held on November 15 to develop alternative solutions to these problems. A number of individuals needing behavioral health services are now living in nursing homes or assisted living facilities. Some of these facilities are experiencing a need for more support in serving behavioral health consumers. For some this is a new consumer for them. There are currently two projects underway, one related to assisted living facilities and one relating to nursing homes. These projects are focusing on determining the types of services and supports needed to help facilities in providing safe and comfortable living arrangements for their customers. As discussed above, housing is a critical element in keeping persons with behavioral health issues in the community and out of inpatient services. In 2003 a study funded by the Department of Economic Development identified the need for more than 12,000 housing units for adults who are extremely low income and with serious mental illness. The Housing Related Assistance Program, LB40, was implemented to address this need. In fiscal year 2007, 557 approved consumers utilized the program to assist in obtaining and retaining suitable housing. The success of the LB40 housing assistance program has become a model nationally for how to provide support in housing to consumers. Beyond those items of deep significance, there are the items that hold deep, meaningful significance. In today'sOmaha World-Herald there was an article by Robert Nelson, a columnist who I admire, taking us to task on the Hastings cemetery question. And I want to just make a brief remark on that as well. I understand the feelings of those folks who have been truly maligned by this lack of respect over the years. Mr. Johnson also notes that this is from another era. We want you to know that while we are standing up for the current law, we stand ready to work with others, including the Unicameral, to change the existing law that may allow for other kinds of resolutions to this issue. It's an important and

meaningful issue for many families, but so were the reasons...so are the reasons for which the law was originally enacted. And I wish you well in discussing that issue as you choose to. Finally, Senator Jensen did speak to being optimistic. I added the words encouraged and hopeful. Frankly, I'm probably too new and too stupid to become discouraged at this point, but I think there are good things going on in Nebraska in behavioral health. Thank you for your time; I'm happy to respond to questions. [LR205]

SENATOR JOHNSON: Senator Stuthman. [LR205]

SENATOR STUTHMAN: Thank you, Senator Jensen...Senator Johnson. (Laughter) [LR205]

SENATOR JOHNSON: You just about upgraded me, you know. (Laughter) [LR205]

SENATOR STUTHMAN: In your success portion of your statements, you know, from the $21 million that were moved from regional centers to the community-based services, is that the total amount that we can move, or can we move more money from the regional center to the regions from it to the are for community-based? [LR205]

DR. SCOT ADAMS: We expect that there will be another substantial infusion of monies of operations coming into the system in the current fiscal year. We are having final conversations with the Legislative Fiscal Office on exact numbers in terms of perspective of what has moved. As an example of sort of what is the exact number conversation, we're looking at the expenses incurred. In April of this year we shut down Adult Services and laid off a number of people and persons at the Hastings Regional Center. A number of those expenses, of course, continued on with regard to just length of service and things like that, and the bumping situation. And so we are coming to a near final conclusion on those, but the number will be a significant number. I believe. [LR205]

SENATOR STUTHMAN: Okay. Thank you. [LR205]

SENATOR JOHNSON: Any other questions? Just one little note: a couple of months ago I was on Mount Vernon, and talk about different times as far as the cemetery is concerned. Within 200 yards of where George Washington slept, is the slaves' graveyard-- scores of people buried there, and only one marker without any names on it. So thank you very much. [LR205]

DR. SCOT ADAMS: Thank you, sir. [LR205]

SENATOR JOHNSON: Next on my list I have three regional behavioral health people listed. And as you're coming to the front, let me just kind of challenge all six regions about something that I need to know. And what it is is this: is that as we have gone from a facility-based mental health system to a community-based, I don't think that there is any question that we have increased the need for mental health workers of all types. Not just psychiatrists, but the whole gamut of workers, there is now a greater need than there ever has been in the past. If we are going to be able to correct this need and make a worthwhile supply change, we have to at least have estimates as to what our need will be. And from that need, then we can make some determinations as to how we might go about encouraging this supply to increase. And our first thoughts are something like the rural health plans in the past to get primary physicians to rural areas by loan forgiveness and these type of programs. So I think that might be our starting place, but we need to know what these numbers are, so that we have some sort of basis, because funding comes into this as well. One of the things, and Senator Jensen mentioned of the facilities and the cooperation between Nebraska Medical Center and Creighton regarding this facility in Omaha, this can be an important tool, but not the only tool in providing these workers. You know, we're talking lots of different facilities for the different types of workers that we're going to need, but we need to kind of get a handle on this, so I'm going to challenge all of the different regions to help us in this endeavor. And then one other little thing that I just kind of want to mention while we have a large

group here, because it kind of caught my fancy, I guess. And I was at a meeting this last week, and there was a person there from Australia who talked about a new class that they were putting together to teach what we might call first responders only first responders for mental health. And basically what it did was of course to raise the awareness of lots of people among us as to what might be impending mental health problems or crises. And they had devised a 12-hour course and thought that it was so successful that now Scotland is going to implement their course as well. It kind of struck my idea that maybe there's a place for us to do this same thing, particularly with the situation that we have now with our law enforcement officers often being the first ones on the scenes of crisis mental illness. And so should we be teaching this type of course to these people? I can also think we might do it through our EMT associations and first responders and so on. So just a little something that we might want to keep in mind as we devise this system, is we can't be worried just about what the top group, but maybe for the common citizen who leaves the gas station and goes on a run with his rescue squad or whatever, that maybe this might be helpful to them as well. So with that, excuse me for becoming a preacher here for just a little bit. With that, let's go ahead and... [LR205]

KATHY SEACREST: (Exhibit 2) Thank you, Senator. I'm Kathy Seacrest, K-a-t-h-y, S-e-a-c-r-e-s-t, delighted to speak before Senator Johnson, members of the committee. I've handed out a very brief synopsis of the implementation of LB1083 in Region 2. Since its inception, we have been able to create many services that we were not able to provide previously. Chief among them are emergency services. When we talked with folks around our region, with law enforcement, hospitals and so on, they asked us for three things: access to medication, access to transportation, and one phone number to call when there was a behavioral health emergency. Through our emergency support program we have been able to answer all of those things. We have instituted a way for law enforcement, when they have an EPC, to call one number. And we will facilitate access to a hospital. We have a contract with our local hospital to take all of our EPCs. If they should be full we will provide the ability to facilitate getting someone in

somewhere else. But we've been very fortunate that we've been able to do that. We've also, by having that call made, we have an opportunity to divert folks. Emergency protective custody is kind of a thing of last resort, because it is, of course, the most restrictive thing. So we're able to send out someone to asses and help law enforcement make a determination if they would like that. We're able to divert between eight and fifteen EPCs a month. So folks who, a few years ago, would have been automatically EPCs, now have an opportunity to access services in other ways. And so we see that as an excellent opportunity for consumers to get the care they need without the excessive use of emergency protective custody. We've also been able to follow every commitment. Anyone who enters our hospitals in EPC, if the EPC is dropped, we've been able to connect with that person and be sure services are in place for them. If it goes to a mental health board hearing, then our support workers work with that client all through the process so that we never go from the level of needing hospitalization to no care available. So that has also been an excellent opportunity to work with mental health boards so that that system of care remains seamless and so that the consumer accesses services at every level. We've been able to, in relation to commitments to regional centers, we've contracted for over two years with our local hospital. We've not had any patients in the Norfolk Regional Center for over two years, and we have not any admissions to Lincoln Regional Center for over a year. In fact, it's a year this month, so we're pleased about that. And continue to work on, we have currently five people in the Lincoln Regional Center we're working on discharges for them. Medications are extremely important to folks. You can read here the things that we've put in place to make sure that we can facilitate access to medication for people. And then the other opportunity we've had is to increase services across the range of services that we provide. And I've listed those there. A couple that I missed, and as Senator Stuthman, you were asking about the employment piece. And we have 28 people through our supportive employment program now working. And we didn't have funds for that before and we do now. So it's an opportunity for consumers to be working and receiving services, of course, as the same time. So we have been able to that. Our consumer specialists are out in our region, visiting with all of our consumers. And we've been able

to use 39 vouchers to help folks with the housing piece, which is critical. One of the things that we all heard as LB1083 is happening is that it's more than just mental health services, it's basic human needs that also have to be met so that we can prevent crises. The gaps that remain, I mentioned here medical detox, some services that we still need to purchase. I was thrilled to hear Scot say that some more funding might be becoming available, because we definitely have services that we have learned need to be in place to really balance all of the services that we've put in place. And the children's piece, I know the Legislature is working on that, that certainly remains a problem. In relation, Senator Johnson, to your question about workforce and where we are with that: yes, we need more psychiatrists, there's no question. But we need all the other levels as well. And I would hope that somehow we can form some alliances and allegiances with higher education to help us with that in terms of the folks that we need, say, at the masters level and Ph.D. level. But we also need a whole cadre of people for support services, our community support programs, those kinds of services that I would love to see our community colleges create a two-year program to help have a degree that fits that support level of work that we need desperately. So I think it's on every tier. And of course, our consumer specialists and others are working on peer support services, which are also crucial to our system. So you're absolutely right, and I think numbers-wise we can help think through that and look at that, because that's definitely a need, but at every level. I would hate to see us put all our energy into professional-degreed people, because I think we need folks at lots of levels. The other thing you mentioned about first responders, you know, through the disaster grant deal we did do training for what is called psychological first aid. So that in the event of a disaster, folks are trained to go in and do that very first level of psychological first aid. I can see that training expanding to the exact kind of training you're talking about for folks who...front line, there's a behavioral health emergency, they might need some kind of connection to that. So... [LR205]

SENATOR JOHNSON: That meeting I was at was sponsored by the Milbank Foundation and I would imagine that that will come up on their web site probably within

the next week or two. And so we'll all have access to it at that time. [LR205]

KATHY SEACREST: So anyway, I'd be happy to answer any questions. I didn't go through all of the testimony, because you can read that. [LR205]

SENATOR JOHNSON: Senator Stuthman. [LR205]

SENATOR STUTHMAN: Thank you, Senator Johnson. Kathy, in your reach in all of your counties, I don't know how you handle all the phone calls. Say, in one county there is a phone call: a person that is having a problem and maybe is suicidal, needs to be EPCed. Who does he call or what...explain how you do that in your region. [LR205]

KATHY SEACREST: We have a person who answers the phone 24-7. [LR205]

SENATOR STUTHMAN: Have you got one person for your whole region? [LR205]

KATHY SEACREST: One person mainly, but she can hand it off to other folks. But it's always one phone number, so that they dial one number and that person knows. [LR205]

SENATOR STUTHMAN: For your whole region, not each community? [LR205]

KATHY SEACREST: No, the whole region, because being as far-flung as we are and we want some resider of that knowledge about what to do to have immediate response to that law enforcement. [LR205]

SENATOR STUTHMAN: And that's a 24-7...and then that individual either tries to talk them down or gets them to someone? [LR205]

KATHY SEACREST: We'll make the connection, whatever is needed. Usually on that

particular number, it will be law enforcement calling and saying, here's the situation, I think if you send a therapist out we can...then we'll do that, or do it by telemedicine, or do it by phone, whatever will work for that situation. If they do want to proceed with the EPC, then we will make sure that the hospital has all the information, is ready to receive the person as soon as they get there, and there's not the long waits. [LR205]

SENATOR STUTHMAN: Have you found this to be a lot more rewarding than the process prior to implementing this? [LR205]

KATHY SEACREST: Yes; yes. Definitely. And the ideas really came from our community forums and folks telling us what they needed. [LR205]

SENATOR STUTHMAN: Okay. Thank you. [LR205]

SENATOR JOHNSON: Other questions? C.J., I've got you on my list. Okay, Beth, you're going to be next? Get close enough to the microphone that the...so we can get it recorded. [LR205]

BETH BAXTER: (Exhibit 3) Senator Johnson and members of the Health and Human Services Committee, my name is Beth Baxter, B-e-t-h B-a-x-t-er, and I serve as the regional administrator for Region 3 Behavioral Health Services, and really do sincerely appreciate the opportunity to share with you some of our successes and identify some challenges that we see yet to come. To begin with, I just wanted to outline that there really are two significant positive outcomes that we've experienced in Region 3, and Region 3 is the central part of the state. From the beginning of reform through the end of last fiscal year, we have seen a 73.5 percent decrease in the utilization of regional center beds. When we started with the behavioral health reform there were 49 individuals from Region 3 who were residing at a regional center, and there currently are 13 individuals either at the Lincoln Regional Center or the Norfolk Regional Center. And we've also experienced a 45 percent increase in the utilization of community-based

services. I think that's probably very consistent across the six regions. I've provided a chart that just outlines the new and expanded services that we have been able to develop in partnership with providers and consumers in our area, and so I'll just draw your attention that that's the last page on my handout. There's been a significant increase in funding in Region 3, and that's been greatly appreciated. Those fundings, I think we have to remember that they also include regional center transfer funds, but they include the ongoing emergency protective custody or the emergency funds, and we've had a significant rate increase throughout the years within our system, and that's been very appreciated as well. Some of the other highlights, obviously that have been talked about is the consumer voice and the improvement in that. And one thing I just want to highlight, in terms of how I see our community-based providers really stepping up to the plate, wanting to improve consumer inclusion and the infusion of recovery principles. In Region 3, we have six consumer peer specialists within our region. Only one of those positions is paid for at the provider level. And the other positions are, is a commitment that providers have made to providing peer specialists on their staff, and working with the consumers they serve. Another important aspect that we've seen is the decrease in the average length of stay, the utilization of inpatient services within our community hospitals. I know that was an issue earlier on that we had individuals in our community-based hospitals, we felt like too long of a time, and that was worrisome for the hospitals, as well. So we've worked hard in partnership with the hospitals to reduce that average length of stay, and have those additional step-down services for people to move to. Another highlight is really the last adult service that was provided at the Hastings Regional Center. We were able to work very closely with the Hastings Regional Center and South Central Behavioral Services, a community-based program, in transitional the assertive community treatment team to the community. We made that transition in August of this year, and we were able to do that collaborative effort and have a smooth transition of both consumers and some of the staff who wanted to...who are very committed to the program, and moved to the community with the program. And so that was rewarding. Just some, briefly, challenges. Kathy mentioned the access to affordable medication. Another area I think that was briefly mentioned was the nursing

home level of care. I mentioned that we have 13 individuals residing in regional centers at this time. Eight of those individuals need a nursing home level of care. And so that's over 60 percent of our folks need to be in a nursing home that can meet their level of care, and we're having difficulties in supporting nursing homes to do that. I think we're challenged on a daily basis and would like to see an improvement in a management information system for the public system to utilize in managing our everyday efforts. We've increased capacity in a variety of services, but still are challenged; need additional capacity for certain services. And then, and Scot mentioned this, is just our ongoing work with assisted-living facilities and working with them to identify ways to help support individual who live there and provide meaningful behavioral health resources. I would be happy to answer any questions if you might have any. [LR205]

SENATOR STUTHMAN: Beth, is the law enforcement in your region content with your EPC process as far as where they have to take them and the availability of beds? [LR205]

BETH BAXTER: Are they content every day? No. No, they're not. Most days I think that they're content. But we have experienced days when...but we contract with two community-based hospitals. We have experienced times when both of those facilities have been full and they've had to transport individuals to North Platte or Lincoln, and that's been worrisome. We had to do that periodically before behavioral health reform, as well. We've worked with law enforcement and do training, ongoing training with law enforcement. And we have, over probably the last 10-12 years, have regular meetings with what we call our emergency psychiatric system stakeholders, with law enforcement, county attorneys, mental health boards, public defenders, and providers, as well. But we have some work to do in that area. [LR205]

SENATOR STUTHMAN: Is there any way or any method that we could improve it in the future so that there were beds available? [LR205]

BETH BAXTER: Well, what we've done, and we haven't had an opportunity to see the impact upon this, we have...Mid-Plains Center for Behavioral Healthcare in Grand Island just opened the crisis stabilization unit which provides an additional 12 beds. Eight are what we call crisis stabilization, and four are medically supported detox. And that's been a long time coming, and we identified the need for those services probably ten years ago, and reform really provided an opportunity to move that forward. So what we haven't been able to see yet just because the program has only been up probably three to four weeks, is the impact. We believe that law enforcement will...they can take individuals through the triage center and utilize those beds rather than EPC'ing certain individuals. So we see that as an complement, an enhancement to our emergency system. [LR205]

SENATOR STUTHMAN: Thank you. [LR205]

SENATOR JOHNSON: I might say that within the last few weeks I had a tour of Faith Regional in Norfolk, and my, what a beautiful facility, and that's going to be a great addition. State of the art, as I understand it. [LR205]

BETH BAXTER: And I hope you'll have an opportunity and I'll make sure you get to go over and see the crisis stabilization unit, because it really is an array of emergency services under one roof. They have a triage center, a crisis response team that actually was started before reform, and they have urgent outpatient, urgent medication management. And one other comment I just wanted to make regarding the behavioral health work force. I think your ideas are extremely appreciated in terms of how we might improve and increase our work force. But I do want to just point out that providers have been very diligent in recruiting behavioral health professionals and being able to retain those individuals, and I think you can see with the array of services, there's been challenges in getting them fully staffed all the time. But providers have worked real hard and I think they've been successful in doing that, and so the additional training and recruitment of behavioral health professionals will be very helpful. [LR205]

SENATOR JOHNSON: C.J. [LR205]

C.J. JOHNSON: (Exhibit 4) Good afternoon, Senator Johnson, members of the Health and Human Services Committee. I'm just here for cleanup, I guess. I'm not going to go through all the, we've accomplished this or created this. I do want to point out...oh, by the way, my name is C.J. Johnson. I'm the regional administrator with the Region V Systems. That's C, period, J, period, J-o-h-n-s-o-n. Did I get that right, Senator? [LR205]

SENATOR JOHNSON: I believe so. (Laughter) [LR205]

C.J. JOHNSON: I want to just talk about one statistic that I think is important to note in Region V is, in our emergency system with emergency protective custody, you know, we can debate, a number of people would debate whether somebody ever needs to be placed on an emergency protective custody holder or not. The reality is, that probably happened...that does happen and probably will continue to happen in the future at some number. In Region V, what we find out though is, once somebody has been placed under emergency protective custody hold, we have gotten to the point where only 14 percent of those individuals...so, you know, approximately 1.5 out of every 10 individuals...I mean, how do you get 1.5? But about one individual out of every ten that come in there actually end up requiring a little longer acute hospital care. So only about 1 out of 10 actually end up on an inpatient commitment. The remainder of those individuals, within a very short amount of time, generally four days on average, will either stabilize and subsequently be allowed to then develop services for themselves and leave the crisis center within four days, with never having to go before a mental health board. Those services generally are emergency community support kind of services or other kind of supportive services in the community. The remaining individuals, anywhere from, right now...well, it's about 38 percent of those individuals actually also have to go before the mental health board; it's felt that they need to go before the mental health board. Maybe they're not quite as accepting of the need for

continued treatment, those kind of things, and therefore they receive an outpatient commitment. What I would like to say about this that kind of shows how the services have expanded and how we have continued to increase the access to services, is that those individuals, once they are placed on that outpatient commitment, do not remain in our crisis center longer than half a day, on average. This means that, you know, if they go before the mental health board on a Thursday, they're in that service on a Thursday, getting those treatment needs. So we've seen a good expansion of services. We've seen a huge reduction in individuals requiring to be placed at state hospitals for inpatient care. And so from that standpoint, we've seen a number of successes. Hearing what Scot said earlier about the housing, a variety of those kind of things is absolutely true. We have just seen an incredible amount of resources developed over the last three years in relation to supporting individuals who have severe behavioral health disorders that may interfere with their ability to carry out their daily functions in a variety of areas. What I do want to speak to is the workforce development, and Kathy and Beth felt the need to do that, as well. Absolutely, we need to recruit professionals in the field of behavioral health. I have no...there is no doubt about that. Actually, in our region, which is interesting since it's the second largest region, we have difficulty recruiting psychiatrists on a regular basis for, like our assertive community treatment teams, and for other services. There is also a shortage of other professional levels: Ph.D. clinical psychologists, master's level social workers. But I do want to reemphasize that there is a whole workforce out there that is yet untapped in relation to behavioral health reform, and that really is peer providers. We have a number of areas or gaps that we've been able to kind of identify over the last three years, which we really believe that putting some effort and training and setting up the correct parameters, if you will, that we can have a significant impact on our waiting lists for those individuals waiting for a variety of services. We can have a significant impact on individuals who, at times, kind of recycle through our emergency system. We believe that we can also deal with the first responder area where we could have peer providers readily available to meet with individuals who are experiencing an acute mental health episode, and could receive that kind of support. So there's a lot of areas that we see that, if we really look in the world of

those individuals who are working on their recovery, who are at a point where they are now ready to help others and provide that kind of training, we can increase our workforce significantly with...at that level, as well as the professional level. And when I say, as well as the professional level, that's not to discredit, that the peer provided services are not professional in any way. I just want to point that out. So I think that's an area we really can...you have to look forward to. We, too, see some gaps that have developed. There is a need to continue to develop information technology systems, data systems. One of our rural providers who has 15 satellite locations throughout our region, just got connected to the Internet in the last six months. We have spent a significant amount of money through obtaining grants over the last couple of years to evaluate what our information technology needs are throughout Region V. We've received a grant where we subsequently were able to develop a regional health information organization, or known as a RHIO. We have been told by the feds that that is the first total behavioral health RHIO that's been developed in the United States; in other words, focused on behavioral health information sharing amongst providers. And that was in collaboration with mental health providers, as well as hospitals throughout the region. Lastly that I wanted to speak to, and everybody will hold their breath on this, is the issue of funding. We have been able to identify a number of gaps over the last couple of years. And in some ways the good thing is that there has been kind of a discussion about what funding is left in relation to behavioral health reform, because at some level, had we gone out there and spent it all, so to speak, all the potential money that was coming out of the state hospitals and everything, we probably would be going back and saying, woops, we probably didn't need to put money here; we probably shouldn't have put money there. We probably would have been backing out on some services that we developed. The good news is, we've been able to sit down and reevaluate and really look at this process. And the other good news is, there actually is funding available, left available through this process. I'm going to throw some figures out there. I know some people might contest those in some way or another, but these are numbers that I have, as frequently as September 28, when I was involved in a meeting that involved some of Senator Johnson's staff, former Senator Jim Jensen, members of

the Oversight Commission, representation from the Department of Health and Human Services, the Legislative Fiscal Office, as well as regional administrators, and consumers. And that is, that there is a one pot of money that's one-time funding, and when we say one-time funding it's just money that's kind of accumulated over the last couple years as services got started but didn't have to spend all the money on any given year. That particular pot of money, the figure that we have been told, is $10 million; that there's $10 million in a pot that could be utilized for one-time investments and/or investments that could be done over the next couple years that could enhance the system. The other figure that we heard was that there is at least $7.9 million that remains to be transferred out of the state hospital funds through the reduction of those. That's been contested that there may actually be a little bit more, but we were informed at the time by Department of Health and Human Services representatives that they had at least $7.9 million available. The good news is, that's a pretty significant amount of money to let us continue on with behavioral health reform, to really take those gaps that we've evaluated and really now enhance the process that's been going on the last three years. With that, I will end my testimony and entertain any questions. [LR205]

SENATOR JOHNSON: Senator Hansen. [LR205]

SENATOR HANSEN: Thank you. C.J., I see in your second page there, you were really questioning the Governor's decision to hold that $18 million over. Have you come to your own conclusion of why you did that? [LR205]

C.J. JOHNSON: Um, no. And I would... [LR205]

SENATOR HANSEN: It's probably the budget. [LR205]

C.J. JOHNSON: Well, yes, it's probably the budget. I think the thing that is concerning to me, and I'll just share this from my perspective, is that LB1083 was very clear in what its intention and what its purpose was, and it's very clear in the bill that all regional center

funding, as it's reduced, is to be used for the development of community services. The reason I question any delay at this point is that we have been, over the last three years, really evaluating this process, and we have had numerous focus groups, we've met with a variety of groups, and I think each of the regions, per se, are very ready to make recommendations as to how to move forward. And so any delay, because services take awhile to get going or training peer providers takes awhile, any delay just means that kind of delay in relation to money that was clearly ear-tagged for this process. So my question is, coming from my perspective, is what question is there about getting that money allocated out to get those things going? That's my question. [LR205]

SENATOR HANSEN: It's gets in to fiscal year 2008 instead of 2007. [LR205]

C.J. JOHNSON: Yeah, the money is...I mean, the money is here now...there now, and so that's my only question. [LR205]

SENATOR HANSEN: But that's probably the reason you hesitated on...I think it'll get there, but it's just going to wait until January. [LR205]

C.J. JOHNSON: And I totally would support that, as well. [LR205]

SENATOR JOHNSON: Okay. Any other questions? C.J., thank you. [LR205]

C.J. JOHNSON: Thank you. [LR205]

SENATOR JOHNSON: Now, on my list I have Alan Green, Eric Evans, Ginny Wright, J.Rock Johnson, and John Pinkerton. Do we have any other people besides this? One, two. So that gives us about seven or so, and we have another hearing that starts at 3:30 p.m., so...okay. And then we also have testimony here by Patti Jurjevich, I believe she pronounces it, the Region 6 Behavioral Healthcare administrator. (Exhibit 5) [LR205]

ALAN GREEN: (Exhibit 6) Good afternoon, Senator Johnson, members of the Health and Human Services Committee. My name is Alan, A-l-a-n, Green, G-r-e-e-n, and I'm executive director of the Mental Health Association of Nebraska, which is a consumer-run statewide organization that provides education and advocacy and services to consumers. I feel it's important to also note that all our programming is consumer-run and consumer-developed and consumer-staffed. My testimony starts out...I first want to thank you, Senator Johnson and committee members, for providing the time for public comment on this reform. Since its passage, the Behavioral Health Reform Act of 2004 has had substantial direct and indirect impact on how and where behavioral health services have been designed and implemented, including: supportive housing assistance for individuals living with severe mental illness; recognition of evidence-based practices, including supporting employment; increasing recognition of the quality and value of peer-provided services; establishment of the Nebraska Office of Consumer Affairs; the hiring of regional consumer specialists; the increased investment in wellness education; support for consumer/family advocacy organizations, both by the state and the regions; the development of crisis intervention teams; the development and expansion of assertive community treatment teams; mental health jail diversion programs; and legislative and public oversight of DHHS Division of Behavioral Health. The recognition of the need for reform and transformation in the behavioral health services is just not a Nebraska phenomenon. The need for systemic reform and the recognition of the rights of persons living with mental illness began over 25 years ago, and has since become a national civil rights issue. Consumer-directed treatment plans, the development of peer-to-peer services, and the mental health insurance parity are just a few of the issues that remain on the forefront of national healthcare reform. The development of the reform movement in Nebraska parallels the national movement in many ways. In 2003, the Presidents' New Freedom Commission released its report entitled "Achieving the Promise: Transforming Mental Health Care in America," which stated that mental healthcare must be consumer and family driven, and that it is necessary to involve consumers and families fully in orienting the mental health system toward recovery. In 2004, the Nebraska Behavioral Health Reform Act was passed,

which recognized that services needed to be consumer and family centered, and that consumer involvement was a priority in all aspects of service planning and delivery. In 2005, the Center for Mental Health Services, CMHS, published its "Federal Mental Health Action Agenda," which declares that people with mental disorders have a vital role to play in our families, our neighborhoods, our communities, and our country. Their ability to participate fully can no longer be derailed by outdated science, outmoded financing, and unspoken discrimination. They demand better, they deserve better. Putting children and their families, adults and older adults with mental disorders at the heart of the healthcare system must be accomplished now. And in 2006, with the passage LB994, that stated the primary duties of the Mental Health Advisory Committees are to provide advice and assistance to the Division of Behavioral Health Services, relating to the provision of mental health services in Nebraska, including but not limited to the development, implementation, provision, and funding of organized peer support services, and to promote the needs and interests of consumers and their families, including but not limited to their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research. Although much has been accomplished to date, far more still needs to be done for us to honestly declare that our mission is accomplished. Number 1, Meaningful Consumer and Family Involvement: More work needs to be done to ensure that consumers are active partners at all levels of service delivery as outlined by Nebraska law. The Division of Behavioral Health has been reluctant to include consumers and families in the development of policy and programs, instead relying on a small network of governmental and quasi-governmental consumer-employees to fulfill the requirement for complete inclusion. When nonemployee consumers ask questions and voice concerns, they are labeled as being as radical or in a vocal minority, and they are placed on a list of troublemakers. When the division sponsored public process to being the development of state strategic planning for the reform of behavioral health, it end in 2006 because of a lack of funding, Nebraska Department of Health and Human Services director, Christine Peterson, later stated that the new DHHS division directors, appointed by Governor Heineman, are excited about working on strategic planning

processes. The division will identify priorities, set the goals, and establish performance measurements. Nebraska law is very specific in its language concerning consumer and family involvement, yet actions to date have done little to meet these requirement. Number 2, Transparency and Accountability: AS a code agency, the Department of Health and Human Services is only directly accountable to the Governor, with advisory boards providing limited input at each division. The Division of Behavioral Health Services has provisions for advisory committees on mental health, substance abuse, and problem gambling. In addition, the Behavioral Health Reform Act provided for the establishment of ad hoc Behavioral Health Oversight Commission to specifically monitor reform efforts in the state. Beyond the formal requests, both the advisory committees and the Oversight Commission have no real authority to obtain information necessary to ensure transparency and accountability, and members of the Oversight Commission recently voiced their concerns about the inability of the division to provide timely and complete information when requested. Without access to information these groups need to carry out their duties, their activities are token, at best. Another example of the division's inability to provide necessary information to ensure meaningful oversight and accountability can be found in the fiscal year 2008 Community Mental Health Block Grant Application. With its commitment to system reform, CMHS tied the block grant application directly to the findings of the New Freedom Commission's report. Table 4, which is in your packet, entitled "Transformation Expenditure Reporting Form," requests information--let me find it here; it looks just like this--requests specific information on the state's plans to allocate dollars for specific activities. However, the state declined to provide this information requested, and stated that the state was not currently capable of tracking fund allocations as requested. And in his written comments attached to the application, which is also in your packet, Division Director Adams recommends that CMHS eliminate Table 4 because tracking transformation activities as outlined are tantamount to unfunded mandates and places an unreasonable burden on states by forcing the division staff to guess where funds should be allocated. As CEO of an organization that survives both on state and federal grants, I wish, took there was less paperwork, but I also see it as the necessary cost of doing business.

Recommendations: As stated above, good and meaningful actions have come about because of our reform efforts. However, the job is far from complete. Therefore, I respectfully submit the following recommendations for your consideration. Number 1: Reauthorize the Behavioral Health Oversight Commission and give them the authority to obtain any and all information they need to provide adequate and accurate oversight of behavioral health reform efforts, including how, where, and for what purpose the funds are allocated. The commission is the eyes and ears of the Legislature, and as such, is the only vehicle available to ensure transparency and accountability. Number 2: Clarify and strengthen the language in LB1083 and LB994 so there is no confusion over the meaning of consumer and family inclusion. Presently, it is defined to best serve the status quo rather than encouraging participation and true reform. And Number 3: Clarify and strengthen the commitment to true system reform as promised in the Behavioral Health Reform Act. Changing the existing paradigm of service design and delivery requires the commitment of all stakeholders: public, private and governmental. The present system is overburdened. Individuals seeking necessary care and treatment face long waiting lists if the services are available at all. But merely increasing the capacity of the existing system to meet the service shortages will not solve the problem alone. We need to encourage the development and implement programs and services that address prevention and intervention. Dr. Dan Fisher, MD and Ph.D., and also a member of the New Freedom Commission, has stated that the growing need for acute care reflects a failure of the system to provide adequate front-end services. Achieving true system reform requires a change in the way that we identify our priorities. We need to provide a wide range of services that provide necessary individualized care. Prevention, wellness, and intervention activities are proven to be safe, effective, and cost much less than high-end acute care. Division Director Adams states, in the block grant application, that it is his vision to see Nebraska recognized as one of the top five states providing behavioral health services. By having the courage to work together in meaningful activities that involve all stakeholders, we can meet and exceed this dream. And now, quick, in the packet that I prepared, and I apologize for maybe not having enough of them, I have a copy of the letter that I wrote and attached to the block grant application

when it went in, in August; a copy of the executive summary of the New Freedom Commission's report on mental health services; and the folder from CMHS that talks about the National Consensus Statement on Recovery; and then finally, I also included copies of information that I gleaned in a project that we had in Nebraska Advocacy Services in providing education to consumer members of the different state committees and advisory boards, that basically shows how the dollars are allocated, both through state contracts and regional contracts. This information was gleaned from block grant applications and implementation plans. And at least for the block grant application, it is current through 2006. I think what's interesting to note in that, is that less than...I think it's less than 1/10 of 1 percent of the dollars allocated go to consumer-based recovery programming. With that, I want to thank the committee for providing this opportunity, and I will entertain any questions. [LR205]

SENATOR JOHNSON: Alan, thank you. Any questions? I guess you answered. Yes, well done. Thank you. Next I have Eric Evans. [LR205]

ERIC EVANS: (Exhibit 7) Good afternoon again, Senator Johnson, members of the committee. My name is Eric Evans. I'm the chief operating officer for Nebraska Advocacy Services and that E-r-i-c E-v-a-n-s. I, again, appreciate the opportunity to come and speak to you about behavioral health reform in Nebraska. We believe there's been a number of significant accomplishments, positive significant accomplishments that have occurred as a result of the passage of LB1083. But we do see a way to go yet in order to achieve the vision and promise that was contained in the Behavioral Health Services Act. I would just briefly review with you what we see as positive accomplishments, and I'm not going to go into any significant detail, but we do see the reduction of regional center beds and the closure of the Hastings and Norfolk Regional Center units as being a significant accomplishment, along with the development of the capacity to serve individuals in community settings. Although there have been significant problems in this regard, we do feel that the department and providers and the regional administrations have really worked diligently to resolve these problems. A

second positive accomplishment is, in terms of the management of the regional centers, and you heard some of that this morning, but in particular we're talking about the fact that instead of what used to be, basically, three independent fiefdoms out there, there has been an effort to create a management structure in which there is a single chief executive officer responsible for the operations of all the regional centers. This is a marked improvement in accountability. And we're also pleased to see that they have initiated a planning process around the future role, mission, and responsibility of the regional centers. The third positive accomplishment we see is the Office of Consumer Affairs. We are very pleased with the strong advocacy part of Senator Jensen to ensure that consumer involvement and the establishment of an Office of Consumer Affairs was part of LB1083. In addition, not only has the department moved forward and hired a program administrator for the Office of Consumer Affairs, but they have also retained the two consumer liaisons that they had previously hired and have been employed for, oh, gee, maybe 15 years now, or so. So we're pleased to see that there's been a commitment to the employment of consumers within the Division of Behavioral Health. However, we are concerned that after almost two years now since the hiring of the program administrator for the Office of Consumer Affairs, there is still not a lot of clear direction as to what the office should be trying to accomplish. And we'll respond to that issue a little bit later. Also the regional consumer positions, even though we were somewhat concerned about the process that the department used in moving forward with that idea, we're very pleased to see that all regions now have a consumer strategy coordinator or specialist or something like that on staff, and we are concerned however that because of the lack of clarity with the Office of Consumer Affairs, that might also spill over into what the regional positions will be doing. And hiring a director of behavioral health is also an accomplishment we're very pleased that Governor Heineman and Ms. Peterson has hired Dr. Adams as the director of the Division of Behavioral Health. We feel that he comes to this position with a knowledge of recovery, even though that may be focused primarily on substance abuse, but we feel that he will help implement recovery-based approaches within the behavioral health system as a result of his experience in that area. There are a number of things that we think we need

to continue working on. As I said, we've made some substantial progress, but we're not finished yet. And we offer these suggestions in the spirit of initiating a discussion and dialogue. So under each of the particular areas, you'll find italicized language that we would like to suggest as an initial start at having a conversation about making some specific changes to the Behavioral Health Services Act. The first is in regard to the behavioral health system purpose statement. And while the purpose statement is a good start, we would like to strengthen it, especially in terms of the emphasis on recovery and consumer inclusion. So we have a number of suggestions there that would, we feel, might help strengthen that. We, in particular, feel the need to have a statement regarding what consumer inclusion means. So that could either be in the definition or in some other part of the act, and at least enough of a clarification that guidance is given to the department and the division in regard to the expectation of consumer inclusion under the reform effort. We would also like to see a statement of legislative findings, and we think that would just be good, again to help set the context for the continuation of behavioral health reform. All right? Again, we've made progress. The initial findings were pretty much related to the need to close the regional centers and develop the capacity of community programs, and we would like to push that a little bit further in terms of meaningful consumer involvement and recovery issues. We also have a section there that talks about meaningful inclusion, (inaudible) inclusion which frequently gets translated as input. So it means there might be an opportunity to participate in a survey or to participate in a focus group, but we're looking at there being consumer involvement across all that litany of service design, planning, implementation, etcetera, and how do we go about achieving meaningful inclusion of consumers. As I indicated, one of our concerns was around the lack of clarity of the role, purpose, responsibilities of the Office of Consumer Affairs. There is a substantial number of states that have offices of consumer affairs; most states have some version of an Office of Consumer Affairs. And we've looked at a number of those offices; we've looked at the statutory language establishing the offices; we've looked at the Web sites that have been created by the offices, describing the nature of the work of these offices. And in addition, the National Association of State Mental Health program directors in, oh, I

think it was in 1999 or 2000, commissioned a study of Office of Consumer Affairs, and prepared a report outlining what offices of consumer affairs should be doing. And we have based our suggestions for language on that research. As was mentioned earlier, the department started a strategic planning effort, gee, in 2006, was that correct, in which we participated. Unfortunately, with the untimely death of John McVay, that process kind of wound down a little bit, and nothing, at least to our knowledge, nothing substantive has happened since that time, even though this went on for about five or six months, and a lot of us volunteered our time. We don't know what happened to the document, and if there are any plans to do anything in that regard. So we feel that there needs to be greater specification in terms of expectations around comprehensive planning on the part of the department. So we provide some suggestions there. As Alan Green mentioned, accountability and transparency is something that we want to see increased. And there has been a clear increase in transparency and accountability, but we think there are some things that can be done to improve that, and we're offering that, both in terms of increased accountability and transparency at the state level in terms of the utilization of quality review teams, as well at the regional behavioral authority level, and we have some suggestions in that regard. Finally, we have some suggestions regarding a revision to the requirements for the regional advisory committees that are contained in LB1083. Again, to emphasize consumer inclusion and involvement, in particular we believe that if somebody says that they are serving on a committee to represent the interests and be the voice of people with mental illness of consumers, and if they are a consumer, they should be willing to self-identify themselves as a consumer serving in that capacity. So that would be one thing that we strongly would like to see, is that there be, when we're talking about consumers serving on advisory committees, state commissions and boards, we want those individuals to be self-identified as consumers. We also would like to see a threshold amount in terms of the number of percentage amount of consumer and family members serving on those advisory committees, boards, councils, etcetera. That concludes my testimony and I would be happy to answer any questions. [LR205]

SENATOR JOHNSON: Okay. Any questions? Senator Stuthman. [LR205]

SENATOR STUTHMAN: Thank you, Senator Johnson. Eric, with all your suggestions for trying to improve it, is the end result going to be any better? [LR205]

ERIC EVANS: Well, I started out as a psychiatric technician working at the Lincoln Regional Center in 1974. In my 33 years now in working in behavioral health, and in particularly in mental health, I thought we would be a lot farther along than we are today. But I do believe that we have made progress and we have consistently made progress over time. One of our biggest challenges, and not just in behavioral health but when it comes to public policy in general, is that our approach tends to be disjointed and incremental. So we do little changes that we don't really think about what the impact of those little changes are going to be on the larger system. And then as a result of that, we find out that we now have problems that we didn't anticipate we were going to do. So we make more incremental changes to try to deal with those problems. I think the promise of behavioral health reform initially was a kind of a larger vision, and the belief that if we can free ourselves from the habit of thinking disjointedly and incrementally about things, we can achieve significant positive improvement. I think these suggestions, while they may be somewhat incremental again and somewhat disjointed, will move us forward. [LR205]

SENATOR STUTHMAN: You also made the statement that you had thought we would be further along than we are now, but if we continually do this, we get further behind. [LR205]

ERIC EVANS: Well, again, again, after 34 years, I don't think we're further behind. I think we are ahead of where we were 35 years ago. I think the pace at which we go or are able to achieve those changes moves slowly. Sometimes I feel as though we are able to change things are geologic speed. Okay. [LR205]

SENATOR STUTHMAN: Okay, thank you. [LR205]

SENATOR JOHNSON: Thank you, sir. Ginny Wright. [LR205]

GINNY WRIGHT: (Exhibit 8) I have copies of materials for everyone. Thank you so much, Senator Johnson, and the senators on the Health and Human Services Committee. I especially appreciate your extensive work evaluating the progress of the Nebraska Behavioral Health Reform. My name is Ginny Wright, G-i-n-n-y W-r-i-g-h-t, and I'm the Region V consumer/family...the consumer/family coalition has asked me to represent them at this hearing. The recommendations and discussion were developed after the coalition meeting on October 9, 2007, and the intent of LB1083 has begun. First, all of the coalition recommendations assume that recovery-oriented services, philosophy, and techniques will be implemented throughout the behavioral health system. The five bedrock principles of consumer wellness recover are: hope; personal responsibility, which can also rightfully imply partnership with providers and professionals; education; self-advocacy; and support. The nine recommendations made here support and promote recovery-oriented service delivery as the necessary next steps in the reform process. On October 10, 2007, Keith Schafer, Ed.D., director of the Missouri Department of Mental Health, described how the consumer/practitioner relationship is being redefined across the country. It is essentially the acceptance of consumers of behavioral health services as fully vested citizens deserving of appropriate, effective services rather than the historically segregated services and stigmatized regard. People with mental illnesses have a right to pursue their dreams, including life, liberty and happiness. He said consumers have the freedom to pursue it. [LR205]

SENATOR JOHNSON: Ginny, could I interrupt you for just a second? You know, as I look at this, we're going to use up the 20 minutes that we've got left. [LR205]

GINNY WRIGHT: No, sir, I promise I won't. No, I have been watching mine also.

[LR205]

SENATOR JOHNSON: Okay, thank you, because we want to protect the people behind you, as well, and I was just kind of adding it up in my head. So thank you. [LR205]

GINNY WRIGHT: Yes, thank you. He said consumers have the freedom to pursue this, and the new terms are used regularly that illustrate this change of relationship and perception of consumers, which is an essential part of understanding behavioral health reform, is the change of relationship between providers and consumers. Examples include: customer service, vouchers, service brokers, procovery, service underwriters, consumer-directed services. Further evidence of the progress made across the nation and being pursued in Nebraska is the statement by Terry Cline, Ph.D., administrator of the federal Substance Abuse and Mental Health Services Administration, SAMHSA. He said, current systems are primary crisis management and cannot be sustained financially. The evidence from recovery-oriented systems shows he wisdom of the originally LB1083. And as we are perceiving the transformation, it is comprehensive, it is throughout the service delivery system to the recovery philosophy and techniques. The recommendations therefore that the consumer/family coalition developed are number 1, develop a variety of community-based services that support individual recovery. This is a focus on wellness and recovery, not symptoms. And on the...in your packet you have a single sheet that has a paperclip on the right side of it, which I think is very helpful for understanding the difference between the recovery way of providing service and the traditional way. And the recommendations made, the changes made, etcetera, need to be consistent with what's on the left side of your paper, the recovery-oriented, rather than trying to fit in new ideas into the old systems, the old structure. Such consumer operated services could be the warm line, respite drop-in centers with diverse services, hospital diversion locations with a variety of wellness and healing options as well as just quiet and medications, peer counselors, peer support 1:1, life planning, life skills training, library and literacy services, unlimited possibilities for consumers to move toward wellness and a quality of life of their choosing. This again is a big change in our

thinking, number 1, to assume that recovery is possible and that a system that works well for all concerned, including the budget people, is that all people can achieve a degree of recovery. That is not routinely thought or taught now. Number 2: Implement consumer choice program, also called self-determined care. Vouchers or money managed by the consumer for selecting their providers and services. This recommendation partially addresses the disparate regard for consumers and families and employs traditional market dynamics for quality, effectiveness, and relationship. Number 3: Expand housing alternatives. And think of all housing, think of community inclusion, not just community support, which implies you always need something. Community inclusion should include supports, but also a variety of housing alternatives that prevent little institutions from developing in the community. The one statement there allowed jumping over continuum steps, I think is really important, with consumer-developed solutions or supports as needed. Sometimes consumers are kept in the system because they haven't met certain criteria to go to the next level of housing. Solve the problems where they are. Come up with creative solutions so that they're not kept in the system. There are examples given there, and numerous consumers can give you others. We need to cause the system and all of us involved in it to adopt recovery-oriented thinking, which requires creativity and acceptance of all of us as human beings. Number 4: Pass comprehensive insurance parity bill. The current discrimination shifts costs to the public sector and interferes with the timely, appropriate preventive, diagnostic and treatment care which is less expensive and more likely to support recovery. Comprehensive, available health and dental care is part of the solution to the expensive, unsustainable crisis management mode. Additionally, I would suggest that no insurance coverage should be provided, nor taxpayer dollars used if the treatment or service is coercive, punitive, or involuntary. Parity in combination with other system changes will likely minimize the revolving door of crisis, hospital, home, crisis, hospital, home. Number 5: Require the Nebraska Department of Health and Human Services, Division of Behavioral Health, to regularly include the skills and knowledge of consumers and/or family members as equal members of review teams, adult teams, and other such meaningful activities for system change. And there now have been

developed and implemented numerous evaluation tools, system change tools, that are available that Nebraska to take advantage of. We don't have to invent the wheel. I won't read the rest of it but it is available for you however. Number 6: All services should be provided and service providers, skilled, knowledgeable, and practicing the latest verified science of the brain, pharmacology, techniques, and strategies that are trauma-informed and recovery-oriented. Trauma-informed is a huge concept in a skill and knowledge area that all practitioners probably should be using. And the very EPC system that is dependent on now, is retraumatizing, and another example of how unhelpful that is. I have four letters attached to my materials that are from people who have experienced the service delivery system, and that's where the rubber hits the road and where you can really tell if something is helpful and healing to someone or if it is not. The Omaha center is a perfect example to start the professional preparation trainings for social workers, doctors, all down the line, in the recovery-oriented system, philosophy. It's different from what everybody is doing now. And I think most providers and professionals do...you know, they go into this wanting to be helpful. And the recovery way really matches that and the joy of seeing so many more people becoming well, finding their wellness, and a quality of life, is gratifying to everybody involved. Number 7: Discontinue the practice of waiting lists. Being on a waiting list means not being served. Waiting lists cause people to become ill again, or more ill. More beds is not a solution in a recovery-oriented system. We would be providing services, interventions, including with consumer-operated services or consumer specialists, all down the line before you get to this severe end over here. Number 8: Collect and analyze recovery outcomes at the state and regional levels using a research-based recovery-oriented services instrument. This may also take federal legislation to reconcile differing data requirements. Nevertheless, we are not collecting what we need to know about recovery. But there are numerous tools available for providers, for administrators, for consumers, for how to develop recovery-oriented systems, and we need that kind of data to transform the system rather than just the accounting kind of data. And number 9: Establish a timeline and criteria for implementation of the intent of the behavioral health reform to the recovery and community integration models,

including meaningful consumer and family involvement in all levels of the service delivery system, and in all activities, but not...you know, including but not limited to evaluation, strategic planning, service delivery, etcetera. The Region V Consumer/Family Coalition again expresses appreciation for the political will to being this effective, humane, cost-effective transformation of the behavioral health service delivery system. And we thank you for your effort. Now, in the materials on the left side, you have another clip, and those are the four letters that were written by people describing their experience, and they did that through a writing workshop that Region V Coalition offered to people. And then this is one of many materials that have been made available to the state, the regions, etcetera, from...and it's just one example of what we know. People have done it successfully all over the country. And I think the sooner we begin with real recovery systemic change, the more efficient and effective the system will be to everyone's pleasure. I would be glad to take questions or comments. [LR205]

SENATOR JOHNSON: I see none, Ginny, and didn't mean to be hard on you. If I was going to be hard on anybody, I probably should have spoken up earlier in the afternoon to ask people to be more concise and precise. [LR205]

GINNY WRIGHT: Thank you. [LR205]

SENATOR JOHNSON: Next please. J. Rock. [LR205]

J.ROCK JOHNSON: My name is J. Rock Johnson, J-o-h-n-s-o-n. Senator Johnson, I will be delivering additional materials, suggestions for changes in statutory language, structural changes, and policy issues, subsequently. I like this metaphor: You can't take a grape, run it through a dish of water, and call it grape juice. (Laughter) But that's what we've been doing with consumer involvement for nearly 20 years. It says so clearly, consumer involvement is a priority in all aspects of service planning and delivery. Well, it all depends on how you define it. And involvement means inclusion. It means interaction, intersection, any way that you can figure out that people can relate.

Because if I may address you, Senator Stuthman, your previous question, we're not giving up and we're not going away. And if you want to see things change, just follow what I have to say. That includes the fact that I am very pleased in the three and a half years at the housing that's critical. My joke is: Housing--don't leave home without it. We also have supported employment. And another critical mark was the advisory committee, which also includes the planning council for the federal block grant. Five members, five consumer members of that committee filed an American's with Disability Act request for reasonable accommodations under Title II because they wanted to get their 150 pages of material in ten working days rather than five. And the department was able to connect them with computer, through computers, through Web site that the federal government has. And they could have done that a year ago, but they didn't, but they are to be praised for having done that. But this also raises the questions that is become associated with me, is who's got the computers, where are we going to get the computers? We are a very...we are becoming an electronic government, increasingly, and a lot of people are living in poverty. What are we going to do about this? I've noticed that the state was empowered to develop rules and regulations pursuant to this legislation. However, I've only seen two hearings, and I may have missed them, others, but for restraint and seclusion that wanted to remove a requirement that there be accreditation of juvenile treatment facilities or...psych under 21 is what they're known...that has not been resolved yet. The other one was the definition of subacute. So to the best of my knowledge, in three and a half years to implement this legislation, those are the only two actions that have been taken. There is something that I want to emphasize, and that's the fact, because we have in this legislation the working with primary care, people with severe mental illness are dying 25 years earlier than the general population--25 years earlier. Perhaps our chief clinical officer needs to develop a relationship with public health on this. But this is very, very serious, and it's not often discussed. There is discussion of the monies that may be coming from the state. I think the place those monies need to go is into the training and development and placement and employment of consumers who want to work. The money, so far, primarily, with the possible exception of really emergency services that started out in Region I, has gone to

expand the same services that we've had all along, for the most part. And if you want to make a change in people's lives, Senator Stuthman, it's getting peers working with peers, and that's what's working all over the country, and we can do that here. And I heard people talk about that. I really appreciated that. I would like to see an annual report from the department, the continuation of our oversight and the accountability commission, so that we can continue, and even with greater strength and vigor to have accountability and transparency as we move forward into where the rubber hits the road, where the rainbow hits the road. Thank you. [LR205]

SENATOR JOHNSON: Thank you. J. Rock, would you come back please, and I would appreciate not having any applause. [LR205]

J.ROCK JOHNSON : I was hoping. I'm sorry. [LR205]

SENATOR STUTHMAN: You were hoping that you could get out before I asked you a question. (Laughter) You're not that lucky. [LR205]

J.ROCK JOHNSON: Neither admit nor deny. [LR205]

SENATOR STUTHMAN: I think you were involved in the testimony when we had LB1083... [LR205]

J.ROCK JOHNSON: Yes, sir. [LR205]

SENATOR STUTHMAN: ...at that time. Did you bring some of these issues to the table at that time, already, with the consumers being involved into in what you're talking about now? [LR205]

J.ROCK JOHNSON: Yes, I did. [LR205]

SENATOR STUTHMAN: Did you feel that we did not address those in LB1083? [LR205]

J.ROCK JOHNSON: I feel that much of this was new to many, many people. And when you've only heard something once, it doesn't sink in until you've had the opportunity to talk with other people, to talk with other people, to talk with people who have had the experience. So I think that's what's happened in the last three and a half years, is some of these ideas were mere seeds at the time. And they've grown. Now some of them have grown into weeds, I've got to allow you that, but some of them, we're making great progress. And I think we've got good partners at the state to work with. [LR205]

SENATOR STUTHMAN: I'm sure we have too. I've been with the mental health issue for 11 years already, working as a county supervisor on a region mental health group, and then five years on this. So, you know, this is not new to me either, so. But I thank you for your comments. [LR205]

J.ROCK JOHNSON: Well, what I really truly appreciate, as I said at the very beginning, is you can't stop someone...maybe I said something different. No. It's my Texas phrase: You can't stop someone who tells the truth and keeps on coming. And that's what you've been doing. [LR205]

SENATOR STUTHMAN: Well, you also stated you were going to keep coming back. [LR205]

J. ROCK JOHNSON: Yes, sir. Thank you, Senator. [LR205]

SENATOR STUTHMAN: Okay, thank you. [LR205]

SENATOR JOHNSON: Thank you. On my list I've got John Pinkerton. Is there anyone else? Okay, one, two more. Okay. And John, I don't want to...you've come a long way and we're not going to cut you off, but you can see the bind that we get in of those of

you that testified earlier in the day. And we're going to start the next one at about 4:00 p.m, and you know what's going to happen to those people. What we ought to do is for those of you that talked at length to start with, we should make you stay till the last person testifies at 6:00 p.m. (Laughter) And take your time. You've come a long way, and so. [LR205]

JOHN PINKERTON: I'm a man of few words; you know that, Senator. [LR205]

SENATOR JOHNSON: Sit down and make yourself at home. [LR205]

JOHN PINKERTON: (Exhibit 9) John Pinkerton, J-o-h-n P-i-n-k-e-r-t-o-n. And I want to right a big injustice. Nobody should have to pay $1,500 for a Hannah Montanna ticket. I don't care what anybody...(laughter). Oh, wait, wrong committee. Let's see here. C.J. had a good term here, kind of coined a new word there: oops. And LB1083 has a huge oops in it. According to Jeff Santema, our legal counsel here, it was not in there originally, but it was put in by some special interests, or allowed to...promoted by some special interests. And it's a form of inclusion actually. It's including conflict of interest in a law; it legalized conflict of interest. And conflict of interest does not work anywhere. It allowed a few people to build an empire at the expense of behavioral health consumers and the taxpayer. My little article here about, I think is an example of what happens when you let special interests and conflict of interest rule the making of laws. If you read this, emergency support in Region II says they provided this person with transport to Lincoln, and he was in a deranged state at the time. Emergency support in Region II is a region-provided service. It used to be privately provided, or by...or contracted out. It no longer is. This is one of the results. The other one is a cut throat by somebody who cut somebody's throat. Double homicide in North Platte this year. This is just in Region II, by the way. I don't know about the rest of the state...or the rest of the regions. But these things have gone on in Region II since emergency support has been taken over by the region and done that service, instead of contracting it out. The regions providing services, I sure appreciate Tom's efforts...and you sure look good today, Tom; a great

haircut. Tom was the only person last year that supported LB616, which to a point, would have limited conflict of interest. But I think this group of legislators, HHS legislators, needs to go much farther, and I mean eliminating the regions providing any services. They should contract them out or do not provide them, period. Otherwise you have conflict of interest. And if you think conflict of interest is good, talk to Governor Dave Heineman. This summer, he doesn't want even a hint of conflict of interest anywhere in state government, and I agree with him fully. It hurts small business, it hurts the consumer, it hurts the taxpayer greatly. And that's all I've got to say. Appreciate the time. Any questions? [LR205]

SENATOR JOHNSON: Well, thank you. Seeing one, John, thank you. [LR205]

LINDA JENSEN: (Exhibit 10) I'll be real brief. I'll just hit a few items, okay? I'm Linda Jensen, L-i-n-d-a J-e-n-s-e-n, representing NAMI-Nebraska, which is the largest mental health organization in Nebraska, with 11 affiliates across the state. Basically, the information I brought...I'll give this to you...is to expand on the report card on America's Health...on Nebraska's Health Care System for Serious Mental Illness, which was part of a report published by NAMI in 2006. Some of the things...Nebraska received a D, which is a better than F, which some of the states received. A unique part was a test drive survey in which people unfamiliar with the state used...like if you were moving into the state, how would you find services? If you didn't know anything about the state, how would you find services. But on the other hand, if you do know something about the state, how do you find services? Do you know that there...you have to call a region? Or, you know, should you look under R, should you look under M, what should you look under? How would you really find services if you had...if you were a person with serious mental illness or you have a family member. So just try that out sometime. Another part of the report card where Nebraska failed was establishing consumer and family monitoring teams; the whole area of outcome monitoring; studies even regarding causes of death. And I think that was a point that was brought up by some of the others as far as the idea of perhaps establishing consumer and family monitoring teams.

Cultural competence, of course, scored a low. And maybe that hasn't been mentioned but it is an area that needs to be addressed. Adding other evidence-based services, including consumer-based; services for cooccurring disorders are lacking; jail diversion programs are lacking in most areas in the community. Mental health services, of course, weren't included in the reform planning, and we hope that that will be taken care of next year. So there is...we...NAMI sponsors family-to-family classes and support groups, and across the state there's a lot of other services we would like to be involved in helping with, such as other education for families and consumers so that we can be more...we can help ourselves more, I guess, is the idea. So that's all I have to say. Any questions? [LR205]

SENATOR JOHNSON: Thank you. I'm not going to even ask him, see. (Laugh) Thank you. [LR205]

TOPHER HANSEN: (Exhibit 11) Good afternoon, Chairman, members of the committee. My name is Topher Hansen, T-o-p-h-e-r, Hansen, H-a-n-s-e-n, and I come here today on behalf of NABHO, the Nebraska Association of Behavioral Health Organizations. Recently, I read an article by a consumer that started out saying she was on the street for ten months, mentally ill, addicted, with two children, and was waiting to get into services. My...I've been in this business a long time, but I sat back in my chair and I thought, you know, this is a societal crime against the person. We can't set up a society and have communities that have people waiting on the streets, ill, without services, with two children, because the system is full. We need to respond with a better system. We have come quite a long way in the last years, as has been mentioned here today, in providing services and developing our continuum. But we're still behind the curve. We started out way behind the curve. We were pretty much last in the country in terms of per capita spending on mental health and substance addiction services. And we have moved forward on that list with our efforts of LB1083 and the tobacco settlement funds, but we still have a long way to go. We shouldn't be settled until we achieve at least average status in trying to serve people with such illnesses in our

community. One of the issues that NABHO has in that regard is the woman on the street and the concern that she brings us, which is access. And access to services can only be addressed if we expand our capacity. We need to grow the ability of our system to respond to the people that need our services. And access and capacity are the key issues that all providers face. When we sit down, when my board sits and has a discussion, when our regional provider group sits and has a discussion, or when the Nebraska Association of Behavioral Health Organization has a discussion: capacity, capacity, capacity, is the issue. And the formula that we know about is that if you're going to allow access, you have to develop the capacity, and to do that you need to be paying for the services. You need to develop the continuum and pay for the services so providers can offer the access, otherwise it doesn't exist. So we need to look at how we're going to do that. It's a problem that we all face: providers, consumers, the state, the Legislature. But what we need to do then is sit down and solve that problem in the way that we would be expected as a provider group to solve our problems, and that is develop our strategic plan on how we're going to get this job done. And so I would suggest that we all need to sit down, and we need to talk about what the issues are, and we need to talk about our strategic initiative to accomplish those issues: what we're going to do, step by step, to get down the road. LB1083 has taken us to the place that we are today, and many more consumers are being served in more humane and community-based organizations, no question about that. But we have a ways to go. So we need to figure out how we're going to take those steps in our strategic initiative, operating at the state, the regional, and the local level, in order to achieve that access. So I encourage you all to look at the thing that plagues us as providers, consumers, and persons involved with the system, which is the capacity. And urge you to look at the rate system that helps providers get the costs that they need to meet their expenses. I can speak as a personal provider: every state rate that I receive for services I provide is under what it costs me to do the business I do. I need to layer my system together, patchwork quilt it together, if I'm going to meet my expenses. That's the only way you get through this system, is if you get creative and layered in your approach. So we need to look at rates that pay the services. We need to give the systems, that is the regional

systems, the funding they need in order to respond to the constituents in their area. Each region has its unique characteristics and needs to develop unique responses. We have done that thus far, but each will tell you that they're under capacity in what they're able to do, and that they struggle. So I would suggest that the next steps in LB1083 are that we develop the strategic plan, and in that we identify these issues, pay the rates, allow the regions the capacities they need to develop their system, and that will all translate into consumers receiving the services they need to address the issues they're facing and have a better access and a better quality system. [LR205]

SENATOR JOHNSON: Topher, thank you. [LR205]

TOPHER HANSEN: You're welcome. [LR205]

SENATOR JOHNSON: I see none. Thank you very much. Anyone else? Anyone after this young lady? Okay. [LR205]

AGNES BIRCH: Hello. My name is Agnes Birch, A-g-n-e-s B-i-r-c-h. I'm a consumer of mental health in Lincoln. I'm here to talk about the police versus the crisis intervention team, that I feel the city of Lincoln and also the smaller districts, I guess, need. Somebody who has been trained to deal with the mentally ill. As it is now, anybody in the area responds to calls dealing with the mentally ill, and then there is...you know, there's domestic disputes, there is murder investigation. They have their own area, they respond to those calls. But no one deals with the mentally ill as an individual. The mentally ill are required to stay inpatients to properly evaluate the situation. A calm negotiator would go a lot further in a touchy situation with a psychotic person than the rough handling many have received. If the police and their representatives don't want to fund a CIT team, I feel it would be in our favor, as a group, to fund a team trained to deal with the special needs of the mentally ill. I'm not saying that the police don't have the budget for it, although they probably don't, but I'm saying that the interests of the mentally ill is better served if we take it over and make it our own...our own...I don't

know, campaign, for...you know, they think they're handling it very well, and I've heard them say it over and over, that the classes that they're taking as a group is fine. That's not true. Nobody would send a rookie cop into a situation to evaluate a murder in 15 minutes, fill out the form and it's done, and that's how they're dealing with the mentally ill right now. They evaluate them in five to ten minutes. They ask two questions: Are you going to hurt yourself or hurt somebody else? And then, if they answer the question negatively, they walk away. Now I understand that that's an important question to ask and the answer is the legal definition of what you have to do in those situations, but there is a third question and that question is: Are you hearing voices that are telling you to hurt yourself or hurt somebody else? And in that situation there needs to be somebody that sits down and talks to that person and says are you willing to admit yourself to the hospital. The extra 15 to 20 minutes spent with facts about what will go on in that hospital maybe...because hospitalization for especially the first time is very scary, even the thought of being hospitalized. They're afraid of institutionalization. They don't know what's going on. A psychotic person, for the first time in their life, finds themselves going crazy and not knowing why. Their families, you know, (inaudible) an alien force against them and they don't understand what's going on. And when the police come and ask you two questions, well, no, I'm not feeling suicidal and, no, I'm not psychotic or I'm not going to hurt anybody, but if you're hearing voices over and over and over, telling you to do those things, eventually you're going to hurt somebody or hurt yourself and somebody needs to assess that situation differently than they are currently. Because by the time they come back to your house for the second time after you've committed one of those acts, it's too late. You've lost your family. You've lost your friends. You've possibly lost your home and your support system. And being mentally ill and having a support system is so important. We're not just people that are left to the system. The family structure and the friend structure help keep us stable. And to lose that because we're left out of the system too long, I'm just saying that a CIT team would be better responsive, because they would see the repetition of problems and not just see a person that's freaking out and needs to be taken to the hospital immediately; that they could talk to the person who says, no, I'm not suicidal and, no, I'm not going to

hurt anybody, but is hearing voices over and over and over telling them that they might or that they should. In the beginning, there wouldn't have to be a big team. There could be an evaluation time to show how much this team is needed. If we had our own representative in the police force, the officers would be able to sit and talk about self-admittance to the hospital and facts about what would happen in the hospital. A person could ask that third question: Are you having voices that tell you to harm yourself or others? With experience, they could evaluate a person and prevent the second visit where the person commits an illegal act and is sent to the crisis center. By that fate-changing second visit, a person can do a lot of damage to family and friends relationships. And is there any questions? I'm kind of... [LR205]

SENATOR JOHNSON: You're done? You're fine and I think there's no question you're talking about something that needs to be done. We've been taking baby steps and we've got to do better than that. [LR205]

AGNES BURCH: Well, I just think a CIT team would be helpful in dealing with...the just one or two people coming to the house instead of, like, the whole police force whenever they feel like it. [LR205]

SENATOR JOHNSON: I agree. Thank you. [LR205]

AGNES BURCH: Thank you. [LR205]

SENATOR JOHNSON: Now, anyone else? With that, that will conclude the hearing on LR205, and let's take about four or five minutes to stretch. [LR205]

BREAK []

SENATOR JOHNSON: This is LR204 and LR153. Members of the Health and Human Services Committee, for the record, my name is Joel, J-o-e-l, Johnson, J-o-h-n-s-o-n,

representing the 37th Legislative District. LR204 was introduced to provide the committee with an update of implementation of LB463, passed by the Legislature this past session. As you know, LB463 recodified the uniform licensing law governing the licensure and regulation of healthcare professions and occupations. The bill becomes effective December 1, 2008. One of the issues that received a great deal of attention during and following the debate of the passage of LB463 was the disciplinary process for healthcare professionals. This issue was especially highlighted in LB194, introduced by Senator Pahls, which, at this time, is still held by this committee. I might say that one of the things that we asked people to do this last year, because LB463 was such a complicated bill and had been worked on for approximately eight years in its writing, that we asked people to wait until this was passed so that we had a uniform starting point for the uniform credentialing process. We said at that time that we would give opportunity for changes after this process itself was implemented. This is the start of that process and so I want to personally thank all the people and all of the senators who were most cooperative in bringing this about. You'll be hearing this afternoon from Dr. Joann Schaefer, the state's chief medical officer, who will give us an overview of the current disciplinary process and an update on LB463. Testimony will also be from the state Attorney General's Office, and you will also be hearing from the State Board of Health and from private citizens. They may suggest changes in legislation. We look forward to their testimony and I hope it will be a helpful basis for introduction of any appropriate legislation this coming January. With that, Senator Stuthman, would you like to follow me, as we have two bills or resolutions that are being discussed at the same time? [LR204 LR153]

SENATOR STUTHMAN: Thank you, Senator Johnson. Senator Johnson and members of the Health and Human Services Committee. For the record, my name is Arnie Stuthman, S-t-u-t-h-m-a-n, and I represent the 22nd Legislative District in the Nebraska Legislature. I am here today to introduce LR153. LR153 sets out to examine the procedures used by the State Board of Health within the Department of Health and Human Services when disciplining medical professionals, or allowing medical

professionals to practice in the state of Nebraska, and also examines the membership of the State Board of Health. The study includes the following issues: the need to obtain information regarding applicants wanting to practice medicine in the state of Nebraska--is there enough transparency to the public regarding the competency of persons engaged in the practice of medicine in this state to assist citizens in making informed healthcare decisions; the need for patients to be able to obtain information relative to a medical professional's history with regard to his or her practice of medicine and other conduct--have healthcare professionals in this state been disciplined previously, whether it be in Nebraska or in another state; whether the membership of the State Board of Health should be limited to those who do not have a past record of disciplinary action against them; the need of representation of a victims' advocate to the State Board of Health; the need for medical professionals to be held accountable for acts of negligence or other offenses. Nebraska State Board of Health background: The State Board of Health was created by the Legislature in 1981. The board appoints members to 24 healthcare professional licensing boards, and actively recruits applicants. The board reviews initial credentialing and scope of practice, practice changes of health professionals prior to final consideration by the Legislature, which is known as the 401...no, 407 process, credentialing review. They also review rules and regulations. The Governor appoints 17 members to the board, with approval from the Legislature, with terms that last five years. Members include two medical doctors, two nurses, a hospital administrator, a dentist, a veterinarian, a professional engineer, a pharmacist, optometrist, a... [LR204 LR153]

SENATOR JOHNSON: Podiatrist? Podiatrist. [LR204 LR153]

SENATOR STUTHMAN: ...podiatrist, an osteopath or osteopathic surgeon, a chiropractor, a physical therapist, a mental health professional, and two people representing the public. There are many good healthcare providers in Nebraska. This study is just to examine the procedures that are in place when disciplining medical professionals and admitting those professionals into Nebraska for practicing medicine. I

had an individual that was planning to testify today, but she was unable to attend this hearing. Her mother suffers from a brain tumor that was misdiagnosed and is now not treatable. There are also stories of doctors facing disciplinary action that move from state to state to avoid prosecution. In some cases, these doctors end up harming other people. The purpose for this study is to find out how medical professionals are screened when they come to Nebraska to practice medicine. Also, when an investigation is conducted by the department, are they required to give an explanation as to why they feel disciplinary action is not necessary? I look forward to the discussion this afternoon and hope to come up with some type of a conclusion as to whether we need to pass any legislation or leave it as status quo. Thank you. [LR204 LR153]

SENATOR JOHNSON: Yeah, thank you, Senator Stuthman. Let's proceed then with, I think, Dr. Joann Schaefer, and I have a list but we'll expand that list as desired by anyone in the room. So with that, welcome. Now she will remember to spell her name as well as give it, and the rest of you had better turn off your cell phones. [LR204 LR153]

JOANN SCHAEFER: (Exhibit 1) Good afternoon. My name is Joann Schaefer, S-c-h-a-e-f-e-r, M.D., and I am the chief medical officer and director of the Division of Public Health for the Department of Health and Human Services. I'm appearing today to provide information on the...and update on the implementation plan of the Uniform Credentialing Act, otherwise known as the UCA, which was passed by the Legislature in 2007 as LB463, and to provide information on the health professionals discipline process. Also, I have provided a number of attachments in your portfolio and I will go through those. With reference to LR204, first permit me to again express my sincere thanks to all of you in the work that you put in on this. LB463 was quite a large bill, took a lot of work, and I do appreciate the work that was put forth on the. Of course, we all know that it takes effect on December 1 of 2008. We've put a lot of work into making sure that we have an implementation plan that is ready. That will be available for you, a copy of the actual plan. Until such time, I actually have a time line here on all the

regulatory processes that need to be put in place and that's this colorful grid that's here. And the reason why we did that is it takes about...there are about 70 chapters of regulations covering 300 different types of credentials, addressing things such as fees, fees regulation, and the credentialing of all professionals. Those obviously will be established and published in one chapter to allow for better calculation and representation of the total cost of the credentialing system and the generation of revenue from credentialing fees to cover this cost. Fees will be established with input from professional boards and credential holders in all professions and occupations, including providing testimony on fees during the public hearing which we have targeted to occur in late December of 2007. We have much work to do and we are well on our way towards being able to implement the UCA on December 1 of 2008. This work is involving the department staff of 30 professional credentialing boards. All regulatory changes will be subjected to much scrutiny throughout the entire process, with approval required from respective credentialing boards, the State Board of Health, the chief medical officer, the Attorney General, and the Governor. I believe we have put the right process in place to achieve the goal that the Legislature delineated in the UCA, and we would be glad to provide periodic updates on the process, because we know that this is cumbersome and there's a whole lot of information in there for you to dissolve, lots of regulations that will be going on. Now I'd like to turn my focus over to LR153 to talk about discipline for a moment. I handed out a number of charts for you to look at. First is the simple chart. Senator Johnson, I know you have a copy of this in your office, but you'll want to replace it because we've just made some clarifications in here and we have an updated date on it. Likewise, we have an update date on this. We call it the Easter egg chart, just because of the colors that highlight the process. None of these are meant to be all-inclusive of the entire process, but we tried to get that down as simplified as possible so at a glance you can kind of understand the idea of where we're going. And so someone can have easy assess to where they are in the process, and where they are likely to go next. The next chart is the investigations unit and it's the cases. The complaint is received, the case is opened, the case is completed, and the total FTEs over the time frame, and that tracks back to the year 2000. And then quite a

bit of discussion was had last year over licensing investigations and complaint surveys. Now this is not the end-all, be-all of customer satisfaction surveys, but it was important for you to see that it was very important to me that investigators were professional on the job when they were doing it. It's an adversarial relationship from the git-go when someone shows up in your clinic or in your place of work that you are going to be investigated. That's never a good situation for the person, we realize that, but it doesn't need to be an unprofessional one ever. And so questions, such as, were the processes explained clearly, were they professional, were they given...did they give you an opportunity to answer questions, did they answer your questions completely and to your satisfaction, did they provide you telephone contact numbers, where they on time for their appointment, did they not interfere with your job or business of the day when they were there, and did they return your phone calls within a reasonable amount of time, those things are very important to me to know that the investigators were doing, and we implemented that process over a year ago. We've had...or, I'm sorry, not over a year ago, but at the end of...I'm sorry. I'll have to check the date on that of when that was, but it was in the winter of last year, the exact date. We've had a 27 percent response rate, which is fairly respectable for a survey. They're anonymous. And we're actually...I was...I'm quite happy with the results that we've had with them. And, you know, we'll continue to work to make sure that we're hitting the right target, the right questions, and we're not missing anything. And it's absolutely important to me that the employees are professional. Now again, I'd like to go through some concepts. Although LR153 pertains to the discipline of medical professional, the state of Nebraska has long recognized that the common process for disciplining all types of professional licenses has certain benefits. This recognition is evidenced by the current existing Uniform Licensing Law, which had its beginning in 1927; overtime has undergone various changes, however. Many of these changes relate to the discipline process on the grounds to which the state may discipline a health profession's license. A single discipline process for all professions and occupations that provide a health or health-related service has been worked on and continues to work successfully due to this process being well-thought-out and based on fundamental principles which form the foundation of an

effective and legally sound system. We have three fundamental principles that I'm just going to touch on. One is the balance of power, and I think if you take a close look at this chart you'll see...you'll see that displayed for you. There are three essential entities that have been statutorily empowered to carry out certain functions. The Department of Health and Human Services, the Attorney General, and the professional boards. The department has the authority to issue the discipline and the licensees therefor. In the discipline process the department has been given the authority to determine what complaints are investigated and, in doing so, the department provides boards and Attorney General information on any and all complaints received. The second fundamental provision...or, I'm sorry, principle is that of the division of power. Again, this chart shows how the power is divided up between the entities that have been given statutorily that responsibility, and among those entities it provides for fairness and impartiality by dividing that. No such division of power would be maintained if any one entity on this chart or in our law were in total involved in the investigatory phase, the hearing phase, the decider of fact, or the decision-making phase. The third fundamental principle is that of due process, which provides licensees an opportunity to be heard and, in a matter of fact, give their side of the story in a manner that is consistent with that which is provided in the administrative law that we practice by. I have been informed that one of the pieces of information you wanted me to comment on which was in the NCR, the credentialing review recommendations related to the things that were in the discipline recommendations but not included in LB463. Of those, two recommendations...there were five recommendations and, of those, two were included and that is elimination of the letter of concern and then, number two, the department has amended the mandatory reporting regulations to remove reporting of malpractice payments of the health professions and the health profession's malpractice insurance carrier to eliminate duplicative reporting. The letter of concern was eliminated because it was a lack of due process, and we also had recently a record in federal district court agreeing with that. The remaining three recommendations that were not included in the UCA, and those included the burden of proof used in professional/occupational licenses, a license discipline case, should remain clear and convincing evidence.

However, a minority version of this recommendation was that the burden of proof should be lowered in the professional/occupation discipline cases and changed to the preponderance of evidence. It remains at clear and convincing evidence. The department and the Attorney General...this is number two, the department and Attorney General's Office should implement a process for addressing complaints that includes voluntary quality assurance, assurance of compliance in discipline actions, and then that the board should authorize to seek voluntary assurance as an option to address issues, that do not rise to the level of licensure violation, to address issues that facilitate quality improvement and promote best practice. While in theory these sound great and in some aspect are even practiced on the discipline side, the issue of voluntary quality assurance comes up with you either did something or you didn't do something. And to have the risk to the professional be on their record or accessible by anyone could have harms to them that were not otherwise intended for things that did not rise to the level of...and there was quite a bit of discussion and the bottom line was that over a long time, over many, many professionals looking at this, many board representatives, community members weighing in on the decision over several years, they could not come to agreement on the bottom line of which was the better course to take, and they opted not to put those in there. So I would submit that much further discussion and consideration should occur before those are put into law. Although the department has made several improvements to the complaint handling and investigation process, we are committed, deeply committed, to further improving in order to effectively and efficiently address the growing number of complaints and protect the public. In closing, I wish to again express my sincere thanks to the committee for providing a forum for discussion of professional licensure issues, including discipline, given the importance of the issue and the protection of the public. And I'd be happy to answer any questions. I have a few staff here that can fill in the gaps should I not be able to. [LR204 LR153]

SENATOR JOHNSON: Senator Hansen. [LR204 LR153]

SENATOR HANSEN: I have a question. Thank you, Senator Johnson. Dr. Schaefer, I

have a question, but I got to ask my Chairman first. [LR204 LR153]

JOANN SCHAEFER: Sure. [LR204 LR153]

SENATOR HANSEN: How do you want to do two of these at one time? I have a question about the credentialing, but not the discipline. Can I make that question clear? [LR204 LR153]

SENATOR JOHNSON: Well, let's just... [LR204 LR153]

SENATOR HANSEN: You don't know? [LR204 LR153]

SENATOR JOHNSON: ...work our way into it. [LR204 LR153]

SENATOR HANSEN: Okay. [LR204 LR153]

SENATOR JOHNSON: I don't know how to answer that any better than you, Senator Hansen, so... [LR204 LR153]

SENATOR HANSEN: This sheet... [LR204 LR153]

JOANN SCHAEFER: Yes. [LR204 LR153]

SENATOR HANSEN: ...particularly, I was contacted by a constituent this year that was rather upset that he could not use technology, that the department didn't want to use technology to renew his asbestos license, and asbestos is on the second sheet here. And he thinks that in western Nebraska that we should be able to do some of those things, similar to what the real estate...or the realtors do. They take their tests, they take their relicensing by the Internet and all that. Will you start to use some technology in...when we do? You have dates on here when these licenses need to be renewed.

[LR204 LR153]

JOANN SCHAEFER: Oh, we have a tremendous amount of licensing on-line and they have actually, because of the cost that it brings into the licensing information system and the software that it takes to support, we've had to stagger in over time. So it was a question of the number of individuals that are licensed and the time frame of which we could afford it, over time. So it's staggered in. It would be monumental to...and a huge cost on all the fees to insert it all at once and, quite frankly, I'm not quite sure that would be doable in one fell swoop across the board to convert them all. It is not mandatory. People can still do a paper license, although more and more people are shifting to the on-line licensing, absolutely. People prefer the technology. But eventually, that's where we're going, yeah. [LR204 LR153]

SENATOR HANSEN: Yes. Well, a lot of these dates are pretty soon,... [LR204 LR153]

JOANN SCHAEFER: Yeah, we've been busy. [LR204 LR153]

SENATOR HANSEN: ...right, yeah, right after the first of the year, except on page 3 or 4. The one I was quite concerned about here, about the body art and practice of body art. It's not until '09. So you put down the... [LR204 LR153]

JOANN SCHAEFER: That, you know, I'd have to check on that, but that may be because that is not due... [LR204 LR153]

SENATOR HANSEN: The tattoo parlors get a pass for a couple years? [LR204 LR153]

JOANN SCHAEFER: They may not be due until then, but I don't know. If I can ask my staff that... [LR204 LR153]

SENATOR HANSEN: No, that's fine. I was more worried about the asbestos. [LR204

LR153]

JOANN SCHAEFER: They go through cycles and so some of them, we're trying to match their cycles, but I can...I'll follow up with that with you. [LR204 LR153]

SENATOR HANSEN: That's fine. Thank you. [LR204 LR153]

JOANN SCHAEFER: You're welcome. [LR204 LR153]

SENATOR JOHNSON: Okay. Any other questions? Dr. Schaefer, thank you. [LR204 LR153]

JOANN SCHAEFER: Okay. Wonderful. Thank you. [LR204 LR153]

SENATOR JOHNSON: I have someone from the Attorney General's Office next. Okay. Didn't see you sitting there. You're being the chair. [LR204 LR153]

LYNN FRITZ: (Laugh) Okay. Senators, my name is Lynn Fritz, F-r-i-t-z. I'm an assistant attorney general and chief of the Public Protection Bureau in the Attorney General's Office. One section of this bureau, consisting of three assistant attorney generals, is responsible for disciplinary cases and credentialing appeals involving professionals that are licensed by the Department of Health and Human Services. Since LR204 and LR153 involve the disciplinary process for professionals, including medical professionals, under the uniform licensing laws, I'm here to testify about the role of the Attorney General's Office in that disciplinary process. I'll keep my comments brief this afternoon, as Dr. Schaefer did a good job of explaining the current disciplinary process. As she noted, the process grants specific authority to several different entities, including the department investigative staff, the independent professional boards, the Attorney General's Office, and the chief medical officer, and then ultimately also the courts in the state. The balance of power, as she spoke about, between these entities, which is

currently found in this disciplinary process, operates for the benefit of all interested parties, including the licensee, the complainant, the public, and the professions. No single entity controls the process which contributes to its inherent fairness. Each entity contributes to the process in the area of their expertise. The Attorney General's Office appropriately fills the usual prosecutorial role in the disciplinary process. This prosecutorial role can be described in several parts. First of all, it involves reviewing the evidence that's presented by department investigators; considering the recommendations of the appropriate professional board, based on its review of the investigative report; thirdly, determining whether the available evidence warrants proceeding with the case in light of the required burden of proof and the applicable statutes and regulations that define the misconduct; fourth, presenting the case at a hearing for the determination by an impartial decision maker or, alternatively, negotiating an agreed resolution of the case which is also then subject to the approval of an impartial decision maker; and fifth, handling the appellate process through the courts as that may be necessary in any particular case. The role of the Attorney General in filing license disciplinary proceedings against health professionals has a long history, beginning in 1927 and continuing through the first comprehensive revision of the Uniform Licensing Law in 1976, when the Attorney General's authority, role, and involvement in the disciplinary process was expanded to its current status. Similar to the judicial process which divides authority between investigators, prosecutors, and judges, the professional license disciplinary process also contains the protections that are inherent in this kind of a balance of power. The Attorney General functions in the role of an independent prosecutor, whose duty it is to protect the public and to enforce the disciplinary violations that are defined by the Legislature and by the agency regulations. We believe this well-established disciplinary process that's in place at the current time effectively protects the multiple and sometimes conflicting interests that are involved in this area. If you have any questions, I'll try to respond to them at this time. If not, I, too, thank you very much for your efforts in reviewing this matter which is so important to the professionals and to the public in general. [LR204 LR153]

SENATOR JOHNSON: Any questions? Senator Stuthman. [LR204 LR153]

SENATOR STUTHMAN: Thank you, Senator Johnson. Lynn, in Dr. Schaefer's comments, she said there's a growing number of complaints. Is this true? [LR204 LR153]

LYNN FRITZ: Yes, it is true. It's reflected in the chart that she provided you. We find a growing number of investigative reports that are forwarded to our office also. I don't have those specific figures with you. I'd be glad to provide those to the committee, if you'd like that. But, yes, definitely we do find our caseload is growing. [LR204 LR153]

SENATOR STUTHMAN: Okay. Thank you. [LR204 LR153]

LYNN FRITZ: Uh-huh. [LR204 LR153]

SENATOR JOHNSON: Are most of them, and I'm just kind of going by what's in the newspaper, secondary to substance abuse? [LR204 LR153]

LYNN FRITZ: I don't know if I could say most of them. We do have a lot of disciplinary actions that involve substance abuse. You know, how that quantifies or breaks down, you know, I don't...I can't tell you, sitting here today. But we do see that quite a bit. And again, if you'd want specific numbers, I could provide those. [LR204 LR153]

SENATOR JOHNSON: No, no. Yeah, I just kind of bounced that one off you because I kind of remember seeing that in the paper that sometimes there's a pretty good list in the paper of actions that are taken and so on, and most of them aren't through your office, obviously, but... [LR204 LR153]

LYNN FRITZ: It is a problem area. [LR204 LR153]

SENATOR JOHNSON: Yeah. Okay. Anyone else? [LR204 LR153]

LYNN FRITZ: Any other questions? [LR204 LR153]

SENATOR JOHNSON: I don't see any. [LR204 LR153]

LYNN FRITZ: Okay. [LR204 LR153]

SENATOR JOHNSON: Lynn, thank you very much. [LR204 LR153]

LYNN FRITZ: Thank you. [LR204 LR153]

SENATOR JOHNSON: Next, I have Robert Sandstrom, State Board of Health. Welcome, sir. [LR204 LR153]

ROBERT SANDSTROM: (Exhibit 2) Thank you, Senator. We do have some written testimony today that we developed this week that we'd like to share with you, so...and I know you've had a long day so I'll try to skip ahead a little bit... [LR204 LR153]

SENATOR JOHNSON: No, we'll take as long as necessary, so... [LR204 LR153]

ROBERT SANDSTROM: Yeah, and we'll just try to hit the high points. [LR204 LR153]

SENATOR JOHNSON: This is just as important as things were two hours or six hours ago, so... [LR204 LR153]

ROBERT SANDSTROM: Okay. Well, thank you very much. Members of the committee, my name is Robert Sandstrom, S-a-n-d-s-t-r-o-m, and I am here today representing the Nebraska State Board of Health to testify on the issues raised in these two resolutions, LR153 and LR204, specifically related to the Board of Health involvement in disciplinary

actions of healthcare professionals in Nebraska. I am a physical therapist and representing the board as its secretary, and I have served on the board since 2000. Senator Stuthman did a great job of talking about what our board...who are board is and what they do, so I'm going to skip that whole section and just kind of move ahead a little bit. I'd like to address four issues related to functioning of licensing in Nebraska that's been observed and discussed in our board in the last 18 months. The Board of Health monitors licensing procedures through its appointment process to professional boards, attendance at professional board meetings, periodic meetings with professional board chairs, and discussions with leadership in Health and Human Services. For two of the issues today we really do have some recommendations that we talked about this week, since we were invited to this meeting today, that we think maybe should be considered for statutory change. The first issue, I think just in response to the resolution, is just to clarify, which I think has already been already expressed very clearly by Dr. Schaefer and the Attorney General's representative, is that the powers of the licensing boards in Nebraska are advisory to the Division of Public Health and the Attorney General. It is important to recognize that with the exception of reinstatement of a license, the powers of professional boards in Nebraska are advisory only in professional discipline. The power to act on complaints rests with the Attorney General and the Department of Health and Human Services. It is our sense that in those cases where advice is requested that our advice is taken seriously by both entities, and it's also, I think, very important to recognize that professional boards, including our board, are the only step in the complaint investigation process where public members are able to review and understand the nature of disciplinary complaints and actions against healthcare workers. The second issue we want to just bring up today is the Board of Health access to information related to malpractice, complaints against, or investigations of applicants for board positions during the appointment process is limited. The Board of Health takes it's appointment process very seriously. Applications are received by the department and screened by the board's professional boards committee and the executive committee. We have developed screening criteria and, based on this review, selected applicants are invited for an interview, and at the interview we assess their

qualifications, motivations for membership, and experience. Also considered are recommendations from the professional organizations in the state, department staff, for reappointments, and the community. We're also quite sensitive to the geographic distribution of board of appointments so that it is representative of Nebraska. Now in certain cases we have more than enough applicants for positions; in other cases we do not have enough. And I will inform you today we do not currently have enough public member applicants and we are currently (inaudible) appointing in about two weeks and we're looking for public members to serve on professional boards. In the last five years we have probably made over 200 board appointments, and I just to...do want to talk with you about two cases in our process that we did not believe it didn't work very well. The first case had to do with receiving criticism from a party in the state involved in a professional malpractice judgment against a professional who was appointed to a professional board. Now the person appointed to a professional board was not appointed to a board overseeing their occupation or profession. In response to that, we did inquire of the department of the ability, at least in certain professions, to inquire of the malpractice history, using a national practitioner databank. This is similar to the procedure used by hospitals, which background check the malpractice history of professionals applying for practice privileges. It was discussed. I think, to summarize it, due to cost, perceived low incidence of problems versus number of delay in the process and the difference between the malpractice standard and the professional discipline standard, that we did not change any procedure there. The second issue that has come up in the last five years is we made one board appointment where, after the fact, it became known that a complaint investigation of this appointee was ongoing during and after this appointment, and this was to the professional board that this appointee was appointed to. Again, we discussed the situation with the department and we were informed that these matters of complaints and investigations are confidential, and we do not have access to this sort of information. We do routinely receive records of completed disciplinary actions against board applicants during our selection process, and I believe we've used this information responsibly when making board appointments. There is a legitimate concern about potential misuse of the complaint process to unfairly

affect an otherwise qualified applicant for a board position. As a response to this situation, we have changed our process and we do regularly ask all interviewees whether they are aware of a complaint or an investigation against their license at the time that we're interviewing them for a board position. We believe that if the applicant is untruthful and it comes to light, that we may have grounds at that point to remove the appointee from the board. But we do have two recommendations. We would recommend that we be allowed to obtain malpractice history, at least on certain professions and certain applicants to professional boards positions. We're open to negotiate the parameters of this authority and to what extent. We understand there's cost issues and there are probably (inaudible) doesn't apply to every occupation, but that might be appropriate. The second thing, we do believe we should have access to information related to complaints and investigations of persons who are applying to be on boards, and that should be made known to us by the department and that should not...we believe we can handle that information responsibly, and that's currently not permitted. The third issue that I want to raise today, it's come up in the last 18 months, is that...and I heard Dr. Schaefer a little while ago talk about the complaints issue that the boards do receive information. We have been hearing information from boards that all complaints within the department are not reviewed by a professional board. There's also been a couple of very isolated, a couple cases, of cases seem to be incomplete, sort of have been dropped, or sort of maybe taken over a couple years to be disposed of. And recently now the department has limited staff member time at professional board meetings. It became apparent to us about 18 months ago, after attendance at board meetings and listening to the discussion, that it was no longer required to have a member of a professional board screen all complaints received by the department. That was our understanding. This change was made without consultation and discussion with the boards, including the Board of Health, about the reasons why or the parameters for this decision. There are also isolated reports of some cases taking over two years, but I would not consider this to be more than a couple, more kind of anecdotal information we have heard from board members. More recently, concerns have been relayed to us by a board that investigative staff attendance and time at their meetings is being curtailed,

and that this is negatively affecting their work. We have responded to this situation. We have met with the leadership in the department and it's really apparent to us that the efficiency of the department has increased and the number of complaints and the number of completed cases has increased. I do have a copy of their annual report which we received. It's about doubled. I think the number of complaints in the last four years have doubled and the number of completed cases are up probably 60 percent or so. I mean they're working very, we think, very, very hard. The number of investigative staff positions has not increased accordingly with the workload. At times, we've learned the investigation staff has been shorthanded. They had a death, I think it was of an investigator, which caused them, you know, to be shorthanded, and the recruitment of ideal candidates for new positions--probably health professionals with some experience--is limited by what they can offer for pay. The department division has responded to this increase in complaint demand by prioritizing their workloads. I think we recognize that it's reasonable that not all complaints have to be reviewed by a professional board. There's probably some that are clearly, yes, obvious; there are others that are probably clear, obvious doesn't meet the statute. But there appears to be no consensus about the types of the complaints that must be reviewed by professional boards, or a requirement to report to the boards about the number or types of complaints that are not investigated. Now a little earlier Dr. Schaefer said that they are doing that, so that's good. The leadership in the department has informed us that these reports are in development, in some cases had been disseminated, but we would recommend you consider that to require professional board review for certain types of complaints, and that the department report annually of the number and type of complaints that were not investigated. And we're open to negotiating the specific parameters. I think this affects a relatively small number of boards and probably those boards need to be involved in the process, if that's what was decided to go forward. The final point we want to make today is the leadership in the division is committed to addressing any issues of harmful healthcare practice, including standard of care cases. And we do have questions whether or not they have adequate resources in which to investigate and act upon complaints. We've met in meetings. Was very apparent to us

that Dr. Schaefer is dedicated. She's a hard worker, she has many cases each day or each week that she must think about and decide to dispense with, and she has and will act to discipline healthcare workers to protect the public as needed. We've also met with Dr. Acierno, and he's new on board, and he's also very concerned and I know is doing a good job. We are concerned about the adequacy of the investigative staff to meet current demands. We understand the need for boards to work efficiently and effectively with the department, and this may not be occurring in certain cases and we're...what we can do, we'll help to work with that. We think there is a continuing need for the department to communicate and consult with professional boards; that that is an important role that the professional boards...the professions need to be involved with the process. And I think the all boards meeting is an excellent example. It was just held in August in Omaha and it was a really very good, well-run meeting by the department; I think a very positive meeting for all the professional boards that attended, and that could be built on during the year. So want to thank you for listening to us today. Have any questions I can respond to? [LR204 LR153]

SENATOR JOHNSON: Well, I'm going to throw one at you and this...I'm going to make it kind of anecdotal as well. But I just remember, and it's several years back now, that there was a physician that the board felt, you know, ought to lose his license. In fact, I think he had lost it in another state before he came here. The board felt that this should go through. It then, as I understand the process, went to the Attorney General's Office, and that was the end of it. Now let's just make that totally anecdotal... [LR204 LR153]

ROBERT SANDSTROM: Right. [LR204 LR153]

SENATOR JOHNSON: ...and not...is do you and your board feel that this is the right process where they are the decision-making group, or...and I'm just trying to feel my way through this, because you then become really just an advisory board and is that strong enough for your board, I guess, is a way of putting it? [LR204 LR153]

ROBERT SANDSTROM: Well, we've had... [LR204 LR153]

SENATOR JOHNSON: If you were king. (Laugh) [LR204 LR153]

ROBERT SANDSTROM: Yeah, we've had no discussion about any major changes in the process in our board, so I think...I know we...we also hear anecdotal reports again of similar...of board recommendations but they're not being perhaps follow through, but there are other reasons for that. There are legal reasons. I don't know. But I think... [LR204 LR153]

SENATOR JOHNSON: Okay, so... [LR204 LR153]

ROBERT SANDSTROM: But I think we don't...I do believe that from time to time the recognition and involvement of professional boards and consultation with them and been, you know, lacking a little. I mean I think some of the issues that we've been hearing about, I have not listened to a professional board chair yet who's been...who we've asked them about the change in the review of complaints, who has been, like, I think that's a good idea. They've been uniformly saying that they didn't understand that. [LR204 LR153]

SENATOR JOHNSON: So, as you see it, and from your board's perspective, and I realize you're kind of speaking for yourself,... [LR204 LR153]

ROBERT SANDSTROM: Right. Yeah. [LR204 LR153]

SENATOR JOHNSON: ...as opposed to for the whole board, but you do not see a problem in this regard. [LR204 LR153]

ROBERT SANDSTROM: No. [LR204 LR153]

SENATOR JOHNSON: Okay. [LR204 LR153]

ROBERT SANDSTROM : I have confidence in the system. [LR204 LR153]

SENATOR JOHNSON: Okay, that's what... [LR204 LR153]

ROBERT SANDSTROM: But I do have confidence in the system, but I do believe we need to make sure that we're using the professional boards appropriately and that everybody understands how complaints are processed. Because, I'll go back to the public member again, the public member who sits on every professional licensing board is the eyes of the person not in the department, is the eyes of the nonprofessional, is the person who is watching to make sure that everybody is appropriate. And so when we make decisions that we're not going to have complaints, you know, viewed, screened, at least if they understood the rules, the parameters, for example, well, you know, there's some that are just not even close to statute or just...and we all understand that, but there doesn't seem to be that understanding. And I think it was...I don't think it was a bad intention. I think it was just really responding, my judgment, in workload, to really, they're really working hard. [LR204 LR153]

SENATOR JOHNSON: Okay. Thank you. [LR204 LR153]

ROBERT SANDSTROM: Yeah. [LR204 LR153]

SENATOR JOHNSON: Any other questions? I see none. Thank you very much. [LR204 LR153]

ROBERT SANDSTROM: Yeah. You bet. [LR204 LR153]

SENATOR JOHNSON: Next on my list, I have a Dr. Andy Stadler. [LR204 LR153]

(UNKNOWN): I don't think he's here. I don't see him. [LR204 LR153]

SENATOR JOHNSON: Okay. And a Patricia Samuels. Okay, great. And welcome. [LR204 LR153]

PATRICIA SAMUELS: Thank you, Chairman Johnson. [LR204 LR153]

SENATOR JOHNSON: And let me tell you, I don't care if it late. We're here to hear what you have to say. [LR204 LR153]

PATRICIA SAMUELS: Well, I appreciate it, because I understand you've been in session all day and I know that it's... [LR204 LR153]

SENATOR JOHNSON: That's fine, but... [LR204 LR153]

PATRICIA SAMUELS: ...it's gorgeous weather outside. [LR204 LR153]

SENATOR JOHNSON: ...we want to finish strong here, so... [LR204 LR153]

PATRICIA SAMUELS: (Exhibit 3) And that's fine. I will be brief. I think my comments are condensed down here. My name is Patricia Samuels, S-a-m-u-e-l-s. I direct these comments to Chairman Johnson and committee members. I appreciate the opportunity to speak and voice my concerns. I am very grateful to the Department of Health and Human Services for the work that they perform, and especially to Dr. Joann Schaefer for the efforts that she has put forth in the changes in the Uniform Credentialing Act. I would also like to acknowledge Speaker Mike Flood and his staff for the concern that he has shown for his constituents. I reside in Norfolk with my husband, who is an orthodontist. I have experience working in his office in several areas, including that as office manager. But I am a licensed attorney and I currently work in a general practice law firm. I'm not acting as an attorney for any individual or group at this hearing. My

comments are predicated upon my firm commitment of the need to safeguard the public in their quest for quality healthcare, but I do also believe that a balance can be achieved between the public's safety and procedural due process protections of the credential holder under the UCA. One issue that causes me great concern is that evidence of a prior act by a credential holder not named in the original complaint to the department can be and is discovered in the investigation, is considered by the appropriate board in its review and decision of whether to forward the case to the Attorney General's Office for filing the disciplinary petition. In essence, there is no statute of limitation. A purpose of a statute of limitation is to have any litigation concerning a matter addressed in the appropriate forum in a timely matter with fairness to all the parties. Underlying concerns are also that the evidence is timely, relevant, that knowledgeable witnesses be available for both sides in the matter, and that remedial or disciplinary actions be appropriate for the harm caused. There are various statutes of limitation for private causes of action, as well as for criminal charges. And I understand that great latitude is given to the agencies under administrative law, but I would urge reasonable restraint and balance in all issues. Perhaps this can be dealt with by rules or provisions which would clarify the prosecutorial discretion allowed when comparing issues of actual or potential public health and safety to minor violations by the credential holder. Another issue that I feel needs to be brought to your attention is the difference in notice to the department and the credential holder when a hearing is scheduled on a contested case. I draw your attention to Statute 38-188 and the subsequent Section 38-189 of the UCA. Reading from Statute 38-188, upon presentation of the petition to the director, an order fixing the time and place for the hearing shall be made fixing the date no less than 30 nor more than 60 days thereafter. In Statute 38-189, it is stated that notice is to be given to the credential holder and it only has to be made ten days before the date of the scheduled hearing. Nebraska Revised Statute 84-913 states that all parties shall ahve opportunity for hearing after reasonable notice. And the United States Supreme Court has addressed this issue in Landon v. Plasencia, and I have the cite there, where they held that notice in an agency hearing must be timely, allowing that such notice must give the individual sufficient time to prepare the case. Under the Uniform Credentialing Act, the

credential holder is only entitled to a 10-day notice of hearing, when the department will have had 20 days lead time and, in addition, has had the advantage of seeing the record develop. I would offer that ten days is certainly not adequate time to sufficiently prepare a case when one's ability to retain a credential is at stake. Response from the department on this concern has been that the credential holder can always ask for a continuance and it's usually granted. My question is, why is the burden shifted to the credential holder to ascertain that his due process rights are being protected? At a minimum, I propose that Statute 38-189 be amended to add the fact that a continuance may be requested, but I feel the better option would also be to have this same 30-day notice in both Section 38-188 and 38-189, with the addition that a continuance may be requested in accordance with Nebraska Administrative Code, Title 53, Chapter 4, Section 6.03. Under the Uniform Credentialing Act, an opportunity exists for a disgruntled employee or a former employee to retaliate against the credentialed employer. Among credential holders, there is sometimes fear that if an employee is terminated, and regardless of the basis--if it's incompetence, dishonesty, personality differences, whatever--the discharged employee may retaliate by filing a complaint with the department. And if we combine this with an overzealous investigator, we have great harm to the credential holder that is possible. Even if the investigation results in no petition being filed, the disruption to the life of the credential holder, the disruption of the delivery of healthcare to the public and the potential harm to the credential holder seem disproportionate. I compared this policy of not allowing the complaint maker's name to be known to the credential holder to those of our neighboring states, and I found that Iowa, Kansas, Colorado, Wyoming, and South Dakota each allow for discovery of the identification of the complaint maker in some way, either through discovery of the complaint file or in the notice to the credential holder that a complaint has been filed. And several of these states specifically apply immunity from civil liability to the complaint maker when such is made without malice and is made in good faith. An unintended result of the complaint maker's identity not being revealed fosters the retention of incompetent employees who would otherwise have been discharged from their positions. Such a complaint would have much more validity, I feel, if the identity of the

complaint maker was discoverable, yet any retaliation was prohibited and immunity for any civil liability extended to the complaint maker when appropriate. I believe that we can begin to see the benefit of very early dialogue between the department and the credential holder in most of these investigations. And that leads into the next point that I want to make, that when I read the supportive document to the Uniform Credentialing Act, and this was a credential reform of 2000, this is the document that helped lay the groundwork for LB463, it is found in there, the recommendation is made, that when a complaint or other information enters the system a letter is to be sent informing the credential person of the complaint and to request a written response, unless the complaint refers to a matter of sex, drugs, or recordkeeping. This may be found, and this is the cite for if you want to follow up on this, in paragraph D4 of the compliance assurance process recommendations. I believe that it is, indeed, appropriate and the professional manner in which to begin to resolve most complaints. The recommendation of the credential reform 2000 was only partially followed in the actual Uniform Credentialing Act. Section 38-1,104 directs the department to notify the credential holder that a complaint has been filed and will be investigated unless the department determines that such notice will prejudice the investigation. The opportunity for the credential holder to respond was not included in LB463. I think it's very appropriate to have this hearing on LR204 in conjunction with that of LR153, and after comparing concerns that I have previously shared with Dr. Schaefer and the language in the Uniform Credentialing Act, I believe that some of the issues can be appropriately remedied by departmental oversight into the investigations. Regardless of whether this monitoring takes place through amendments to the statutes or through properly promulgated rules, the various board should be consistent and reasonable in their recommendations and procedures. Some of my concerns can be answered by having a standard, established method of dealing with complaints and investigations, and if the rules and regulations need to be promulgated in dealing with these areas, then let's have the process begin. Incorporate the comments of individual credential holders who have been through the investigation process and the discipline process in order that the goals of the department may proceed to protect the public and ensure fairness to the

credential holders who provide the valuable healthcare in this state. I thank you for your time. [LR204 LR153]

SENATOR JOHNSON: Very good. Any questions? A very nice presentation. Thank you. [LR204 LR153]

PATRICIA SAMUELS: Thank you for the opportunity. Appreciate it. [LR204 LR153]

SENATOR JOHNSON: Do we have anyone else that wishes? Ron, welcome. [LR204 LR153]

RON JENSEN: Thank you, sir. Mr. Chairman and members of the Health and Human Services Committee, I'll be even more brief than usual. Here...I'm Ron Jensen, J-e-n-s-e-n. I'm a registered lobbyist, appearing before you on behalf of the Nebraska Optometric Association. Some of you may recall that in the 2007 Session the Optometric Practice Act was overhauled in and of itself, in addition to the changes that were brought to it by the comprehensive ULL rewrite. That process probably has led to at least one glitch in the new law which the Board of Optometry recently became aware of and let us know about, and we will plan to take advantage of the Chairman's offer to clean that sort of thing up in the '08 Session before the law becomes effective. So I just wanted to let you know that we probably will be bringing a very brief piece of legislation to the Legislature in January to speak to that. [LR204 LR153]

SENATOR JOHNSON: Thank you. And, you know, I think with the previous testifier, why, those are the sort of things that now is an appropriate time to look into them and see whether they should be and so on. And, Ron, I know that you were very cooperative amongst many people in staying away from this till now, and... [LR204 LR153]

RON JENSEN: Sure. [LR204 LR153]

SENATOR JOHNSON: ...it really was important. This was the largest, physically, the largest bill ever to be passed through the Legislature. It was 1,053 pages and, it's my understanding, took over eight years in preparation. So just to get everything in order regarding the licensures is a major task and I think everybody in the room and lots of others are to be complimented for doing that. So I'm sure there's things that need to be tweaked, but that was a... [LR204 LR153]

RON JENSEN: And we may find another one before January, but at least that one will be forthcoming. [LR204 LR153]

SENATOR JOHNSON: Yeah. Yeah, sure might. So all right. Thank you very much. [LR204 LR153]

RON JENSEN: Thank you. [LR204 LR153]

SENATOR JOHNSON: Do we have anyone else that wishes to speak? If not, that...we'll call it a day and thank you all very much for coming. (See also Exhibit 4) [LR204 LR153]