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The Behavioral Health Oversight Commission met at 10:00 a.m. on Friday, February 9, 2007, at the Hruska Law Center, Lincoln, Nebraska, for the purpose of conducting a meeting. Members present: Gordon Adams, Mary Angus, Brad Bigelow, Susan Boust, Shannon Engler, Topher Hansen, Senator Jim Jensen, Linda Jensen, J. Rock Johnson, Senator Joel Johnson, Doris Karloff, Ronald Klutman, C.J. Marr, Bill Mizner, Howard Olsen, Joe Patterson, Mario Scalora, Cindy Scott, Barbra Westman, James White, and Daniel Wilson. Members Absent: Carole Boye, Ellie Tompkins, Karen Weston. []

JIM JENSEN: Good morning and welcome. Thank you all for coming on this snowy day. It seems like Nebraska is getting a lot of those. I certainly do want to welcome everyone. I'll just tell...first of all, we do have a coat rack out there, if you need to hang your coat up. It might make for a little more room for the chairs. And then just behind the coat rack, very important, the rest rooms are there, (laughter) and so if you need to. And if we do fill these chairs, we can get more chairs and put another row, certainly, over here. So welcome, and we do have a...I think probably a fairly heavy schedule this morning, so we'd like to start and get right into the issues. New member to the commission, kind of my job, is Joel Johnson. Senator Johnson...where did he go?

SENATOR JOHNSON: Right here. []

SENATOR JENSEN: Oh, there you are! (Laughter) []

SENATOR JOHNSON: I've never been so quiet. []

JIM JENSEN: And we certainly welcome him and his input, and Joel was one who went with us on the tours across Nebraska, and so he's very, very familiar with behavioral health issues, and certainly glad that he's in the position he's in, and commitment that he has to this very important issue. []

SENATOR JOHNSON: Jim, can I say one thing? []

SENATOR JENSEN: Sure. []

SENATOR JOHNSON: And what I'd like to say is, I've already done one of the more important things, and that is to ask Jim to stay on this commission and be the chairman, so... []

SENATOR JIM JENSEN: Well, thank you. []

SENATOR JOHNSON: ...we're awfully happy that he agreed to. (Applause) []

SENATOR JENSEN: It is a new experience. I get to fill out an expense sheet! (Laughter) Ah, never had that before. You have before you the agenda. Are there any corrections, additions to the agenda anyone would like to make at this time? If not, we'll proceed with that agenda, as presented. The minutes have been circulated. (Exhibit 1) Any additions, corrections to those minutes of November 9? Seeing none, they will stand approved, as presented. You have before you a number of legislative bills, and Jeff, would you like to give us a legislative update? []

JEFF SANTEMA: (Exhibits 4 and 5) Thank you, Senator Jensen. In your packets this morning there are a number of legislative bills, and there are a couple of other things I would just like to draw your attention to, for your further review and any additional questions that you might have at a later time. And there are several what's called green copies of the bills, or the bills as they were introduced in the Legislature. You have...there are four appropriations bills in that stack, and you'll notice that they are LB542, LB548, LB559, LB576. Just a very brief summary of the kinds of things that those appropriations bills are seeking to do, is transfer funding from the regional centers to the community-based programs for behavioral health services. It references...one of them references the bed allocation plan, which you'll hear more about this morning. There's...LB559, you'll notice, is unusual in that it has XXX in the amount where a dollar figure would normally be, just related to additional funding for community-based services, and LB576 relates to a rate increase for behavioral health services. There are two bills in your packet related to sex offenders--they are LB610 and LB670. There are two bills, LB616, which would remove the current exception, if you will, to the permission that behavioral health regions have to be providers of direct services. So LB616 would remove that grandfather clause, if you will, and would require that regions not be direct providers of services. LB617 is regarding children's behavioral health. It would create a position of coordinator of adult behavioral health services and a coordinator of children's behavioral health services within the Division of Behavioral Health, and it would require the development of a children's behavioral health reform implementation plan, if you will, similar to the implementation plan that was developed under LB1083. LB647 is behavioral health parity--that's going to the Banking, Commerce and Insurance Committee. You also have in your stack the actuarial study that was done on behalf of the Legislature by Milliman, Inc. LB666 and LB669 deal with Corrections--LB666 on public assistance for persons after they're released from incarceration, and LB669, dealing with jail diversion programming and planning. The other bill that I wanted to draw your attention to, which is not in a green copy, but which is in a black-and-white copy which says "Amendments to LB296," and that LB296 is the bill that relates to the Governor's proposal to reorganize the Health and Human Services System. And also in that packet you have a copy of a handout that Senator Johnson distributed to his colleagues in the Legislature, provided by HHS, related to that proposal. It's...on the front of it, it says Health and Human Services System Act to LB296, with Senator Johnson's initials at the top, and there's a PowerPoint presentation underneath that, so that you can further review that proposal, LB296. The final issue I

believe I want to bring to your attention is the issue of the Nebraska Health Care Cash Fund. As you know, since LB692 in 2001, the Legislature has appropriated $50 million a year, and as of just recently, $52 million a year, for health-related programs. That new biennium of funding allocations from the Nebraska Health Care Cash Fund will be discussed--deliberated by the Legislature this year--and at this point, I don't know of any significant changes to the current allocation of that funding. I believe there's a bill introduced to increase the amount of funding to $54 million a year, with that additional $2 million a year going to bio-medical research. And with that, I don't know if Senator Jensen or Senator Johnson has any additional comments regarding the legislative agenda. []

SENATOR JOHNSON: The only thing, and I'd welcome any comments on the other bills, what...the one regarding LB296 is what we presented to the Legislature, and it did advance without a negative vote. In fact, in yesterday's World-Herald the editorial said that we passed it without enough scrutiny. There's been quite a bit of scrutiny for the last six months, and including not only the immediate past chairman of HHS, but his predecessor, as well, have all reviewed this in detail, plus about ten other senators who were term limited out have gone over it last fall. So there were many, many meetings behind the scenes that the editor wasn't aware of, and that probably accounts for why it, theoretically at least, went through so smoothly. []

SENATOR JENSEN: Any comments from any commission members? It would certainly appear to me, as an outsider...and by the way, I'll have to confess. I did have the TV on one day, and I'm watching the proceedings and I'm looking for a button to push. (Laughter) So I'm trying to work through that. (Laughter) But only two days since, have I had the TV on. It would certainly appear that the Governor is...has certainly...well, he's got maybe many goals, but chief is tax reduction. And I don't know how all that...well, I think it's going to play into the total session, and we'll have to see how that all works out, but any comment on that? []

SENATOR JOHNSON: No, I agree that he's...I might not agree with the way he's going about or what tax reduction he has in mind. One of the things, when you start talking about tax reduction, so often it's a shift of taxes so that somebody else pays it, rather than who presently is. And there's a little saying that came to mind that if you borrow from Peter to pay Paul, you can usually count on the support of Paul. (Laughter) And we're seeing a little bit of that going on. []

SENATOR JENSEN: Thank you. Well, good. I think we're ready, then, to begin with the Item No. 5, LB1083 Implementation Progress Report, and is the department ready on that? Ron? []

RON SORENSEN: (Exhibit 2) Okay, I think all of you should have copies of the presentation (inaudible). []

JEFF SANTEMA: As long as we can get you near a microphone. []

RON SORENSEN: I'll stand by Sue. Okay, this is the table of contents, (inaudible). We'll talk about Medicaid real quickly; we'll talk about the services coming up in the community, as we usually do; and then we'll spend some time on some of the reports about EPCs, Mental Health Board commitments, and what's going on at the regional centers; and some of our plans there that we've been talking about the last few months. And we'll also talk about the Office of Consumer Affairs. So let's go ahead and get started. I want to make some introductions first, though. Two things: Lee Tyson has been appointed the interim deputy director of the division. Lee...I think you probably know Lee, but that's Lee standing over there, okay? And I think one of the things that Lee will be working on will be to give us more focus on the transformation-type activities, like evidence-based practices and recovery and so on. So that's an area we haven't had much time to spend on, and having Lee there and her background in that area will be a big help to us. The other thing, someone came to me and said, with the new organization that the Senator was just talking about, they weren't sure where the Office of Consumer Affairs was in the organizational chart, and just to assure you, the administrator of the Office of Consumer Affairs...where's...Joel McCleary is here some place--reports to me, the administrator of the division. So if there's any confusion about that, hopefully, that will clear that up. Okay, so let's go... []

J. ROCK JOHNSON: In terms of clearing up, will we have a slide that depicts the behavioral health administrator, chief clinical officer, Office of Consumer Affairs, and then... []

RON SORENSEN: We can get one, yeah. We don't have one. []

J. ROCK JOHNSON: But that this the configuration? []

RON SORENSEN: Yeah, right. Yes, it is. []

J. ROCK JOHNSON: All right. Thank you. []

RON SORENSEN: Well, and it also includes the other...regional centers and so on, in that slide. []

J. ROCK JOHNSON: Right, but those are underneath... []

RON SORENSEN: Yes. []

J. ROCK JOHNSON: ...and are reported (inaudible) regional centers and community-based (inaudible) report to behavioral health administrator. []

RON SORENSEN: Yes. []

J. ROCK JOHNSON: Thank you very much. []

RON SORENSEN: Yep. Okay, it's kind of hard to see on the wall there, but the Medicaid report is a report we've brought you each time we've met. I think the significance is always that we continue to expand the Medicaid rehab option program. The fiscal year '07, of course, is based on projections about the current rate of spending. We'll see almost a million, maybe $900,000 worth of growth in that program, and the substance abuse program, we expect also to see continued expansion of that. If anybody has any more direct questions about that, Mary Steiner, the Medicaid director, is here, who can explain this much better than I can. So anybody have questions about that? []

DANIEL WILSON: Ron,... []

RON SORENSEN: Yes? []

DANIEL WILSON: ...just a...would it be possible to, in the future, identify some sort of emergency room cost, as distinct from in-patient? Is that data that... []

RON SORENSEN: Mary, is that something you can do? Emergency room data? []

MARY STEINER: For behavioral health... []

RON SORENSEN: Specifically, what... []

MARY STEINER: ...diagnosis, or what would our definition for...? []

DANIEL WILSON: Yes. []

RON SORENSEN: Yeah. []

MARY STEINER: Okay. But yeah, we could probably do that. []

RON SORENSEN: So emergency room data relating to diagnosis on... []

MARY STEINER: That would be real helpful, okay. []

DANIEL WILSON: Well, pertinent, you know. That should be helpful, I think. []

RON SORENSEN: All right. Yes, Shannon. []

SHANNON ENGLER: I don't know if you can answer this, Ron, but Mr. Nelson had talked about the, I believe it was the Medicaid clawback for the expenditure of drugs. And on this chart, of course, it looks like we're having a decrease in expenses in drug. []

_____: Significant decrease, yeah. []

SHANNON ENGLER: But from what I understood, then, the fed was pulling some of that back, probably from another account. Do...is there... []

RON SORENSEN: Can you help us with that one, Mary? []

MARY STEINER: Yeah, that was true. The...when Medicare took over the payment of the drugs and Medicaid no longer had that expense, we are paying the federal government every month the state's share of what we would have paid under the old arrangement. So this is the amount that we're actually paying directly for drugs. As you can see, it's gone down substantially, and will...last fiscal year, it affected half of the year, and this fiscal year will be a whole fiscal year. Be...rest assured that the state is still paying at least what we would have paid for drugs. []

SHANNON ENGLER: Okay, and that was my point. So we're really not realizing any decree in expense here. []

LINDA JENSEN: You are...what percent are you paying--is the state paying? []

RONALD KLUTMAN: Yes. How much is going to the federal government? I don't know if you can pull that out right now. []

MARY STEINER: Let me think if I can (inaudible) off the top of my head. I think we pay them about...this is just behavioral health drugs right here. But for all of the drugs that went over to the Part D, we're paying about $3 million a month, which comes out to almost $40 million in a year. The amount of money that they took over from us, in terms of total funds, about $100 million. We were spending the $36 million as our share, so we're continuing to pay it, except that it is a monthly check we write out to CMS, instead of paying for the drugs themselves. []

LINDA JENSEN: So is that a certain percentage of the total cost? []

MARY STEINER: It started out as 90 percent of the estimated cost that we would be at, and then it drops a couple of percent. I think we're at 88 percent, or something like that, of the estimated amount, except that CMS estimates how much we would have spent on drugs, and the inflation factor that they used was 6 percent for this current calendar year, which is pretty much compared to our drug expenditures. So we think we're paying

probably about as much in that clawback as we would have paid, if we were paying drugs directly. []

RONALD KLUTMAN: I hate to belabor this, but just to clear it up in my own mind, so this is just for behavioral health drugs you got up here? []

MARY STEINER: That table is, right. []

RONALD KLUTMAN: Because it becomes important, as we've instituted the things to take a look at people on two or three psychotropic drugs, to see if there's a savings to the state. Plus I just noticed that the percent of dollars going to pharmaceuticals nationally has dropped in three years from 14 percent down to about 5 percent this year. So I guess I look and see if we're getting any savings in all these things that we're doing right now. []

MARY STEINER: Yeah, let me make a note to do that the next time. What we can do is, we can take a historical expenditures for behavioral health drugs by whether people are Medicare covered and not Medicare covered. So you can see the drop-off on the Medicare side, but on the non-Medicare, you, you know, hopefully we are moderating that growth a little bit. []

RONALD KLUTMAN: Okay. Because it's just important to see... []

MARY STEINER: Okay, yeah. []

RONALD KLUTMAN: ...what we're trying to do, if it's working or not. []

MARY STEINER: Yeah. Okay. []

RON SORENSEN: Thank you, Mary. Anybody...Topher? []

TOPHER HANSEN: Question on the...just in the ball parks in the columns. Is it heading in the direction that you've projected, or is it above the line, below the line? We've been trying to say we'll pull X amount of money out of the regional centers, we'll put that into community-based service, we'll leverage in the Medicaid as much as possible. Here's our projection. These numbers, you know, I see, but I'm not sure how that relates to anything that we've planned. Can you do that off the top of your head? []

MARY STEINER: Well, we looked at that--I don't know, maybe it was six months or a year ago,... []

TOPHER HANSEN: Yeah, it's been a few months ago. []

MARY STEINER: ...and we were trying to compare back to the original plan, which, of course, was...you know, who knows off the top of the head. []

TOPHER HANSEN: Yeah. []

MARY STEINER: But we came pretty close on the rehab option, especially if you include substance abuse with it, because when we do the substance abuse, we are gaining the federal share on that, and we're just a little bit short of that. But then, in the model we had like all of the days out of regional centers by now, too. So it's probably pretty consistent, in terms of the ratio of reduction on the regional center side and the increase over here, to get federal money. []

RON SORENSEN: Yeah. We're getting there, like Mary says. We still have...well, we'll go through this later, but we still have 55 behavioral health people in Norfolk and Hastings total, and some sex offenders who are under LB1083, as well, at Norfolk. So there are still people at the regional center who we have not got out back into the community, to contribute (inaudible). []

TOPHER HANSEN: But in terms of the equation, a piece of the equation is that we use community-based services, we ramp up a bunch of community-based services to meet the need, and we get a portion of those Medicaid connected, so we're leveraging federal money. And so what I'm hearing is, we're on track with projections and what we wanted there. I mean, I understand this is just a piece of the entire equation, but... []

RON SORENSEN: Okay. []

TOPHER HANSEN: Okay. []

RON SORENSEN: Okay. I'm going to let Lee take the community services part of this. []

LEE TYSON: How do you get the little thing to move forward? []

RON SORENSEN: Oh, I've got that. (Laughter) I hate to give it up, but I will. []

LEE TYSON: You can tell how technological I am--"that little that you click and it moves forward." Okay, and you move forward by doing that. Community services. As you can see, there have been a number of increases in the number of people served. One of the services that is not listed up there is emergency community support, and there's been a substantial increase in the number of emergency community support workers and their caseloads, as well. Dual residential--a fairly sharp increase there. Another...the trend line is fairly steep from (inaudible), as well. Community support--there's a little dip. I don't know why that is. It could be a seasonal thing, because as you noticed in this same rough time of the year, in '04 and '05 there was a dip, too, but that's something I

think we ought to pay attention to. Okay, community support substance abuse--same thing. Trend line continues to go up, and that's good, but we've got to watch that little dip there and make sure it doesn't continue. Short-term residential, again, you know, it's interesting that we had a fairly large increase in the number of people served in dual, and then we have this little bit of a dip in just straight short-term residential. Day rehab--psych residential rehab, that's decreasing; that's a good thing. That's where we want to be. That's excellent. Okay, and this is the total people served in community services. I think...oh, yes, J. Rock. []

J. ROCK JOHNSON: I just want to make a comment on Slide 11, that people served per month in psychiatric residential rehabilitation, and that means two things. One is that they have a home, and the other is that you're receiving rehabilitation-oriented services. And I'd like to know more about that. The service definition isn't sufficient for me to be able to ascertain what rehabilitation means in (inaudible) context in this state. []

LEE TYSON: Okay. Would you like for me to talk about that now, or just get you some information in the... []

J. ROCK JOHNSON: No, and I think we might all want some information. You could talk about that later. []

LEE TYSON: Okay, I'd be happy to talk about that. One of the things that I'd like to say is that in the past, we have heard incorrectly...we have heard that what we were intending to do is just fund more of the same old services, and they were the same old services that were keeping people in these high-end levels of care--you know, the psych residential rehabilitation, the in-patient facilities, and that sort of thing. And I'm happy to say now that there is a significant trend towards doing different things. In each of the regions now, you will find that they're doing really innovative things to improve services on that community level that J. Rock was referencing. Region V has a wonderful program. It's blended community support. You know, it's just exactly where we want to be, and all the different regions are coming up with these innovative, new and creative services that get more into partnering with consumers and less into these high-end levels of care. So that's a good thing, and that's something that we'll be talking about more in the future, as these programs continue to grow. I think that finally we're tipping over to the new and the innovative and the creative, rather than relying on the same old, same old that we have for so long. So that's excellent. Okay, did this one, and that's it. Yeah? []

SUSAN BOUST: Before you go on, in this list of services, do most regions have a medication management piece? []

LEE TYSON: I think all regions do, yeah. []

SUSAN BOUST: It may be helpful...are those maxing out, are those growing? I think it's important as we think about LB1083, shifting from a hospital level of care to community services, that some place we need to keep track how these people's needs for medication management is being addressed. []

LEE TYSON: I would imagine...I mean, I know that it's grown everywhere, but to quantify that, yes, that's a great idea, and we can start collecting some data and maybe report on that the next time--the numbers in medication management and emergency community support, which is near and dear to my heart. []

SHANNON ENGLER: Excuse me, Lee. []

LEE TYSON: Yeah. []

SHANNON ENGLER: Before you go on, we have page 12 in our packet, with total people served duplicated per month in community services,... []

LEE TYSON: Um-hum. []

SHANNON ENGLER: ...which is nice, because that's an aggregate chart. As I look at the chart, it looks to me like, really, we've been pretty flat since March of '06. Now while you've highlighted some specific services that we've had an increased number of clients in, overall, we're pretty flat. In fact, that's maybe even going down a little bit. Is that indicative of, there's no more money for additional services, that we don't have clients going into available...what does that mean? []

LEE TYSON: I would imagine...you know, and there is that little bit of a dip there at the end, although the trend line continues to increase upward. I...I mean, but I hear what you're saying, Shannon, I really do,... []

SHANNON ENGLER: Um-hum. []

LEE TYSON: ...and it could be that we have reached the maximum benefit of those same old services that we've relied on for so long, and that now we're at a point where we need to start looking at different and more creative ways of solving some of the problems that we have, so. []

SHANNON ENGLER: (Inaudible) and this...correct me if I'm wrong, wouldn't this be inclusive of all the new services that we've brought up? []

LEE TYSON: Yes and no. Some of them are very new, and so we haven't really had the chance to see what kind of impact they'd have on numbers. []

DANIEL WILSON: Shannon, you really can't determine whether specific individual numbers of people are changing in an aggregated chart that uses duplicated data. []

SHANNON ENGLER: Right. []

DANIEL WILSON: If some...for example, there may be a narrowing down of service for individuals who had multiple services a year ago and now have just one or two services, but they're doing okay. That's one possibility in this. []

LEE TYSON: Um-hum. []

DANIEL WILSON: I'm not saying that that's the case. []

SHANNON ENGLER: Um-hum, yeah. []

DANIEL WILSON: This doesn't really tell you how many particular individuals are getting community services, because it's got redundant information. []

SHANNON ENGLER: Um-hum, it's duplicated, yeah. []

LEE TYSON: The other thing is that this does include those high-end services like psych residential rehab, which we're hoping to get away from a little bit, so maybe that indicates some success in that area, that we're utilizing those services less than we did before, so. []

SHANNON ENGLER: Well, Dr. Wilson makes an excellent point. Is there a way we can get an unduplicated chart? Because that would be excellent information to know. Are we effecting change in reducing...in changing the need for multiple services for individuals? Because otherwise,...I am also looking at this in relationship to our "through-put" issues. If that's not the case and we're maxed out and we don't have additional appropriate community services, then we've got a big problem. []

LEE TYSON: Um-hum. []

SHANNON ENGLER: But I don't want to jump to that, because that's a very good point. This...we probably need to see an unduplicated service chart. I mean, that would be helpful for me, so. []

LEE TYSON: Okay. Could we maybe get together and you could tell me exactly what it...how you'd like to see that, and we'll see if we can work on that. []

RON SORENSEN: Yeah, we can check on that. []

SHANNON ENGLER: Okay. []

RON SORENSEN: I mean, there is another factor in this, and that's sometimes a delay in information. We find ourselves, for instance, this month going back and finding corrections to previous months, because the data comes in late. []

LEE TYSON: Yeah, that's true. []

RON SORENSEN: So some of it, in the more recent months, is a reflection of the data collection and the entry process, as much as all the other variables we've talked about. []

LEE TYSON: That's true. []

SHANNON ENGLER: Thank you. []

LEE TYSON: Sometimes it takes that long to get the data in, yeah. []

RON SORENSEN: J. Rock. []

J. ROCK JOHNSON: Yes, I believe in the past there's been a request for the data group to be set up. Some of us will remember that early on we did have such a briefing. And if it would be the sense of the body, what I'd like to see first would be the division putting together a small report, in terms of what kind of data systems exist, and kind of some of the pluses and minuses, and how that all works, because there's the regional centers, there's just a number of different actual software vendors that I believe are involved. Also, (inaudible) this is (inaudible), but the question comes to mind is, Dr. Shindu Watanabe-Galloway, I believe, had contracted through UNMC Epidemiology last year to develop a tracking system, and I think we found they were able to track about one-third of the people who came out of the regional centers, and I believe that contract was renewed. So I just would like a report,... []

RON SORENSEN: I think that... []

J. ROCK JOHNSON: ...and that may be in conjunction with this other report, (inaudible) sense of the (inaudible). []

LEE TYSON: That information is still being collected. []

RON SORENSEN: Yeah, the report is final. We're reviewing it. So when we're satisfied with the results of the report, we'll present to you, like we've done in the past. I may have misheard you, but I think you said you can only track a third of the people coming out of the regional center. []

J. ROCK JOHNSON: That's was my recollection. []

RON SORENSEN: I think we're tracking essentially everybody, except we have had...last time I saw was in the mid-20s, in terms of people who we couldn't find anywhere in the system. []

J. ROCK JOHNSON: Yeah, I apologize, and that's what that was, that came from an early report. []

RON SORENSEN: Right, right. []

J. ROCK JOHNSON: And we when realized that we could only track people who were in the system and who we could track in the system. Am I correct that that contract was renewed... []

RON SORENSEN: Yes. []

J. ROCK JOHNSON: ...for this fiscal year? []

RON SORENSEN: Yes. []

J. ROCK JOHNSON: And what would we expect--can we get interim reports? []

RON SORENSEN: We do. Let me deal with your first question, because it sort of relates to this. We have in the Watanabe-Galloway project we have four data systems. We have the N-FOCUS system, which relates to many of the social services projects, or services and programs; we have the...one...we have actually two different regional center data bases. We have the AVATAR system, which is the new system now offered at in the Lincoln Regional Center, and then we have the AIMS system, which is the old legacy system which is no longer being supported, at Norfolk and Hastings, and they'll be moving into AVATAR. The other one is the Magellan system, and one of the great discoveries in bringing in the Watanabe-Galloway project was the--how can I say this?--the fact that some of the data just wasn't there, or wasn't entered in the right place. Typically, that's what you get in a data system where people aren't required to enter that data as part of their job, and sort of will say, I'll got to do this sort of thing. So part of it is we spent a lot of time cleaning up the data, and we continue to do that. We had to go back and take codes from the old system, codes from the new system, try to determine what unit that referred to at the regional center. So it's been a prolonged process with our staff and with the people working with those software programs and with Watanabe-Galloway to sort through that. So that's some of the issue that we have here. And I'll address your other question, too. We are, in fact, working on, with our IS&T people, we put a team together that is working through exactly what you're talking

about. What are the data needs for future? What are the data needs now? What systems do we have? How do we work into the future to meet federal requirements, our requirements, and so on? So that team is operating within HHSS. So... []

LEE TYSON: And I can add that we're also working with the Justice system and their computer. []

RON SORENSEN: Right, right. []

LEE TYSON: It's called CYBOL, and we've been making inroads into that software, as well. []

RON SORENSEN: As you know, the federal government will be requiring more information about people in the criminal justice system, and so we'll be looking at how we roll that data into what we've got, as part of the reporting process. []

J. ROCK JOHNSON: What's the role of the Nebraska Information System? Is that... []

RON SORENSEN: NIS? []

J. ROCK JOHNSON: Yes. []

RON SORENSEN: NIS is basically an accounting system. What we use that for, all employee records are on there,... []

LEE TYSON: Payroll. []

RON SORENSEN: ...payrolls, all the contracts are listed in there, and that basically tracks contract and expenditures on contracts. So it's something all of us have to enter data into and get reports back, basically on the financial elements of what's going on in the state. []

J. ROCK JOHNSON: So that's fiscally focused? []

RON SORENSEN: Yeah, that's a different...that doesn't relate to what we have. []

J. ROCK JOHNSON: And MIMS, I don't remember MIMS, M-I-M-S. []

RON SORENSEN: MIMS? []

J. ROCK JOHNSON: The Medicaid... []

MARY STEINER: The MMIS system. []

RON SORENSEN: Oh, that's the Medicaid system. []

J. ROCK JOHNSON: Yeah. []

RON SORENSEN: And I neglected that one. That's one that's also in the Watanabe-Galloway, so. []

J. ROCK JOHNSON: Is that the way that Medicaid is currently...is Medicaid currently using that system? []

RON SORENSEN: Yes. They're in the process of designing a new system, actually. []

J. ROCK JOHNSON: That would be part of the money problems (inaudible)? I believe I read in there something about connections, as a data base. []

RON SORENSEN: I'll have to depend on Mary to answer questions about where they're going with the new grant. []

MARY STEINER: Yeah. On the medical, the person...that's where people who are in nursing facilities or ICFMR, (inaudible) community, and what we have now to track some of our community services is yet another system, CONNECT, that tracks services that people need, authorizations for services under the waiver, personal assistant services, services in that arena. And so I believe that was mentioned in our grant as a way to track assessments and try to align those services for people in that program. []

J. ROCK JOHNSON: So Medicaid had once put out an RFP, and it was satisfied, and there was another RFP with... []

MARY STEINER: That was for the MMIS. []

J. ROCK JOHNSON: Yes. Where are we at with that? []

MARY STEINER: We're working on another RFP to release. It should be out within, hopefully, a few months. But the MMIS system is the system that we pay like a billion dollars' worth of claims in a year out of, and it's from the 70s. So we really need to quickly get that taken care of before it breaks for good. So that's what that process is for, and it's a claims processing system. []

J. ROCK JOHNSON: So that's--I'm sorry--claims processing. But we don't have the capacity to track employment or housing in any of our systems; is that correct? []

MARY STEINER: Probably the only thing I can think of is N-FOCUS might have

employment as part of the TANF program. []

J. ROCK JOHNSON: One last request, and that would be, I understand that there are 118 data fields in MMIS, in Magellan. I'll keep going until I hit the right one. (Laughter) I'd just like to have a list of those, if that would be possible. Thank you. []

SENATOR JENSEN: Okay. Jeff, do you want to... []

JEFF SANTEMA: Thank you, Senator Jensen. I was just going to ask very quickly, and I'm sorry that the commissioners don't have the statute in front of them, but it's 71-810, the section that talks about the transfer of individuals from regional centers to the community. A couple of years ago in 2005, there was a new subsection seven added to that section, which required the department to develop and maintain a data and information system, and there were elements of that data and information system that were included, and it required a quarterly report of that data. In what form is that? []

RON SORENSEN: Well, we've been...we have submitted them to you in the past, and we will... []

JEFF SANTEMA: How have those been submitted? []

RON SORENSEN: Well, we have in the past submitted them, brought them here and passed them out. I don't think we've done that recently, so I'll check on how we're doing that. For the purpose of this group, it was the same stuff that was in what we were doing, so we just stopped bringing it here. But I'll check on how that's going out. []

TOPHER HANSEN: One of the things to kind of follow up--way back, I'll take us, to when Shannon was talking about what Dan had said, which is some of this information, I mean, it's good in very gross aggregate ways. We have more community services being used by people, but we don't know if that's separate people or how much duplication there is in that gross number, and then some of the numbers, we don't know why the drop-off, and there can be multiple reasons by...around that. And I guess that's some of the analysis, I guess, I need to hear and understand a little bit, is why are we flat over that time? What are some of the drop-offs about? And I don't expect that anybody is going to have the crystal ball on the thing, because it is a big system and there's a lot going on, but that's part of why...part of what we need to do to understand. Do we have a trend or a dip, an incident or a trend line that's beginning? And what's affecting this...because all this is so connected from time somebody is on the street in crisis, to somebody being discharged into a psych residential rehab out of the regional center, and...you know, it's all related. It's one string, if you will, and so...and that's important to our money, too, I think, and so any data that can help talk about or understand a little bit of what some of these numbers might mean and where we're going with it, for me would be helpful to have an impression about how are things going.

Because we've increased the number, it tells me a piece of the equation, but I don't have a sense of the entire equation, and that's what I'm trying to get my arms around is, somebody says, well, how's it going? And I can say, well, we've got more people in community services, and you know, we can all see that. But what does that translate to, into behavioral health reform success, I guess? And that's what I keep trying to gather. Some of the data that's been requested here I think would be helpful, and even some, to the extent you all have any analysis of that, that would also be, besides just showing me the number, if you have any impression or analysis, or here's what we're looking at, or here's what we're concerned about, that is really useful information to me, to help understand where we are in. Are we continuing to move forward? Are we stalled? Are we moving backward? I think we have to know that. []

RON SORENSEN: Well, and I think we'll get to some of that as we move on here. []

TOPHER HANSEN: Okay. Sorry to jump the gun, then. []

RON SORENSEN: I think that basically, though, on the information we just went through, we have been working with the regions to try to identify why there's dips in some of those services. We don't have anything but anecdotal stuff at this point in time. []

TOPHER HANSEN: Right. []

RON SORENSEN: I think there is a reason to believe that in the services that are easier to bring up, like community support, we have probably reached the capacity for what we brought up. On the services that are more difficult and require capital investment and more staff investment, they take longer to bring up. So those will take awhile. I mean, for instance, ACT programs that you're familiar with take a while to bring up. So I think we'll continue to see growth in programs like that, because you can't just take ten people and put them in ACT one day and fill the place up. It takes time to work those through. So I think you do see some of that going on. We still have some services that have yet to come up, and Beth, later in the program she can talk about her services that are yet to come up in Region III there. We've got beds that haven't come up in Region IV, that are on the table, and in Region VI they can talk about how, as they've seen services maybe be underutilized, they'd move them to a different place to get more people into those. So it does occur on a continual basis, Topher, and we do continue to look at why this is happening, and as I said, some of it is because of those reasons we just talked about. Some of it is a data issue, getting stuff in, getting it recorded. And we'll continue to try to sort through that as we go ahead, and try to answer some of your questions. []

TOPHER HANSEN: Yeah, absolutely. And I full well understand that, operating a number of the programs myself. And that's how my brain process is, and if that's not

what everybody else wants to know, I can ask privately. But I think some of that analysis some people might not understand. Why the heck, you know. I have been given questions time and again about, how come the ACT is not full? []

RON SORENSEN: Yeah. []

TOPHER HANSEN: What's going on around that? And then I have to explain the whole piece of why it is, and then people understand. But I think that helps people to gain some confidence in where...in which direction we're going, so. []

RON SORENSEN: We'll continue to work on that point. []

_____: Mary, you had a point? []

MARY ANGUS: Yeah. Well, actually I want to clarify something that Mary said. I think, if I understood you right, you were talking about tracking...was it housing through TANF? Transitional Aid to Needy Families? Is that what I heard? []

MARY STEINER: I was thinking of employment. []

MARY ANGUS: Employment? Okay. How many of the folks that are coming out of the regional center are under that program? Or what percentage would you say? []

MARY STEINER: Oh, we had that percentage at one time. []

RON SORENSEN: We'd have to go back into the Watanabe stuff. []

MARY ANGUS: Was it higher than 50 or lower than 50 percent? []

RON SORENSEN: I wouldn't want to even guess, off the top of my head. We'd have to go into that. []

MARY ANGUS: Okay. []

MARY STEINER: And there was a percent that we had that were Medicaid. Some of those were in the disability category, and others were in the ADC or TANF category. []

MARY ANGUS: Yeah, because I... []

MARY STEINER: But it doesn't relate real well. []

MARY ANGUS: Right. []

MARY STEINER: But that is one of the reasons why I think that they included the N-FOCUS in the pool, in the whole group. []

RON SORENSEN: Yes, yes. []

MARY STEINER: Because there is an indicator that people are employed when they have earned income, which is also tracked in N-FOCUS, and that would cross more than the TANF population. []

MARY ANGUS: Right. Yeah, because the TANF population isn't really going to give us much information. []

MARY STEINER: Pretty small, yeah. It is. []

MARY ANGUS: Thank you. []

RON SORENSEN: Okay. Well, let's take a look at EPCs and we'll move on here. This chart really is just one we repeat every time. It compares the years. I think the next...if you go to the next one, which is Slide 14, and really, the important part of this slide is the text up in the left-hand corner of the chart, because what that...if you look just at the bar charts, it only represents half a year. But if you look at fiscal year '07 compared to fiscal year '06 in the second quarter, we are down, I think, if my math is right, it's a hundred and...what does it work out to? I thought I had 164, right? I think it's down 164 for the first quarter, which is a drop of 12 percent over the first quarter last year. So at least on the surface it appears as if we're doing a better job in diverting people from EPCs with things like local crisis response and that sort of activity. Yes, Bill. []

BILL MIZNER: As I look at that, I see over the last two years, from fiscal year '04, statewide we seem to have (inaudible) increases in EPCs. In '05 and '06, in the first quarter we seem to have a decrease. I agree that there may be some impact on the local response teams dealing with that, but it also could be just an anomaly. []

RON SORENSEN: Sure. []

BILL MIZNER: Could you maybe discuss a little bit about why we seem to, over the last couple of years, seen increases, when there's been so much work being done, trying to divert to locals in establishing those teams and that, and why maybe we're just seeing it now, in this last quarter? []

RON SORENSEN: Well, first of all, generally from the first year of reform, we have decreased from the total of 2,030, to last year...2,930 from 2,670. So over that four-year period, we did decrease. Last year we went up a slight amount, and I think that's a good point, to caution you on halfway numbers. I think last year at halfway, we were slightly

under, not as significantly as we are this time, but we were slightly in the number, and then came back up. So like many of these things, it's a point in time (inaudible) have to be careful to measure...be careful how you look at it and not make over-generalizations from it. I think that's an excellent thought. So I'm not sure I answered your question. What else... []

BILL MIZNER: I was just curious. We had seen such a decrease from '02 to '04, and yet over the last couple of years, we've seen, you know, slight increases above that. It's like we plateaued off and we had a little bit more. []

RON SORENSEN: Yeah, yeah. Well, anecdotally, and this is...we talked about this, and it's hard to say why, exactly. Lee can help me out here on this, because she deals with the emergency system day to day. Part of what I hear is, and I see happening is, as a result of LB1083, more attention was paid on...by people who need services, who thought now they could access services. For instance, one example given to me was a patient who came to a hospital in western Nebraska and said, I feel comfortable coming to a hospital now, because I can come here and be EPC but not have to worry about going to a regional center. I know I can be treated in the community. So I think some of that happens, and so I think we see people, particularly right after LB1083 and today, access the system who might not have accessed it before. I think that's part of it, but Lee can help out. []

LEE TYSON: I just wanted to add one comment. In the last couple of years there's been a little bit less of an emphasis by the regions on preventing EPCs, and more of an emphasis on diverting from Mental Health Board commitments. So when you see the next couple of slides, which have to do with Mental Health Board commitments, you'll see that they're way down. And I think people, you know, while they're continuing to do great work with the local crisis response teams--and they do provide a lot of services, they do divert a lot of people--they're kind of focusing more on the earlier points of intervention, and just not so much on EPCs themselves, knowing that there's only so much control that they can have over EPCs. And so the emphasis has been more on, let's get them once they've been EPCed, and then work on keeping them from being committed by the Mental Health Board. So you'll really see big differences in the next few slides that come up. []

SENATOR JENSEN: Susan, then Topher. []

SUSAN BOUST: I'm going to echo, I think, what has become the hallmark of today's session so far, which is clarifying and getting data. I would like to know where the data on the EPCs and then, in the following slides, the Board of Mental Health comes from. I don't know if that's a quick answer or a long answer, but what I'm really looking for is, if you don't pay for the service, do you get the data? Are there people out there being EPCed because that's really a thing that would show up at the county level, and

wouldn't come to you unless you have a contract with them. How many EPCs are happening we don't know about? And the same thing with the Board of Mental Health. So it's a question on where does the data come from. []

RON SORENSEN: Well, in terms of EPCs, it's...the one exception to the collection of data is Region VI, where the only place we collect EPC data in Region VI is from the...from Emmanuel Hospital where Region VI has a contract. So Region VI... []

SUSAN BOUST: And perhaps you ought to recognize that Douglas County Hospital is also there. (Laugh) []

RON SORENSEN: Yeah, (inaudible). Yes, so that's...but that's the issue in Region VI, and that's not an issue in the other regions, that... []

SUSAN BOUST: Now wait a minute. Do you have contracts with Mary Lanning right now? []

RON SORENSEN: Yes, yes. Faith Regional has a... []

SUSAN BOUST: So all people who are EPCed there you get data on? []

RON SORENSEN: We get data, yes, through the Magellan system. []

SUSAN BOUST: Right. Thanks. []

RON SORENSEN: So Regional West...well, all the other regions go through the hospitals. []

SUSAN BOUST: And could people possibly be EPCed to a hospital that doesn't have a mental health facility? []

LEE TYSON: That would happen very rarely. []

RON SORENSEN: You're talking about all the county hospitals out there? It's hard to say. I don't know. Maybe Chief Mizner would have a better handle on that. Do people get EPCed to some of the smaller county hospitals out across the state, that you know of? []

BILL MIZNER: I think from my experience we have a lot that come into Faith Regional. []

RON SORENSEN: Right. []

BILL MIZNER: They will come there, and many times they will either be brought by family members, or they may be brought by law enforcement, and then brought to the hospital. Ingrid might have a better handle on whether they show up at other hospitals, but... []

INGRID GANSEBOM: Well, they don't get EPC services there. They make take them to the other hospital for medical stability before they take them to Faith Regional. But otherwise, they don't get EPC services there. They would go to Faith Regional or to Richard Young, or one of the other hospitals that have a... []

DANIEL WILSON: I think it's a little different in at least the metropolitan Omaha area, where there are persons in general hospitals, looking for psychiatric beds that are not consistently found, and that can go on for some days. Some of those people never end up in a psychiatric facility. They may be discharged after several days in an emergency room, or in an intensive care, ICU general hospital bed. []

TOPHER HANSEN: Which I think begs the question I was going to get to, and I promised Susan I'd coordinate this ahead of time, but thanks for (inaudible)(laughter), which is how many aren't we hearing about. And we talk about this at Region V, and one of the things I just heard yesterday that I haven't talked with C.J. about is, several of my program directors said, well, there are lots of people who aren't EPCed, because the police aren't EPCing them--clearly, psychotic individuals who need the help--and we have literally been told on an occasion, leave them alone, they'll be fine in awhile. And so what they're seeing is resistance by the police department to take the step to EPC. I don't know the reason. All we know is what we're seeing, and that we push and push and push, and have them driving that decision and rejecting the notion of EPCing. So in our conversations yesterday at a program director level, what I'm hearing from numerous program directors is, in Region V, in our experience we're finding a number of times that people are not EPCed, or the alternative is, go into a medical setting for those that have resource or whatever, and wouldn't go through the EPC route. And I'd be interested in Bill's experience. Are officers running into that, where it's...there's no room at the inn; let's figure out the alternative? []

BILL MIZNER: Well I think, Topher, our experience, in talking to other law enforcement officers around the state...our experience is the more that things change, the more that things stay the same. And what you're probably seeing is law enforcement officers who are getting very frustrated taking people into emergency protective custody, having no place to take them, and they're tied up for an entire shift, or they have to travel halfway across the state to try to find some place to go there. []

TOPHER HANSEN: Right. []

BILL MIZNER: I would hate to see that happen, but I think it's a...probably a very

understandable thing that officers are saying, I'm not going to put myself out if it doesn't appear like the system is concerned about trying to deal with these people if I bring them in. I've talked to sheriffs and chiefs who have said that they're ready to just start handcuffing people to doors and leaving when people say, we're not going to deal with this, just because they're saying, look, if you're not going to deal with it, what am I supposed to do sitting here, when the system has nothing to offer me when I take them in. So if there's somebody there, if there's a friend, if there's a family member who is able to at least stay with them, and they don't seem to be overly violent, or at least have calmed down a little bit, I can see where officers will start saying, okay, I'm out of here. And call us if something really blows up again. But there's a level of frustration out there about trying to do what they think they're supposed to do, and then finding that there's no place to take these people, and they're stuck having to hold these people. []

TOPHER HANSEN: And there's added factors, of course, in rural and frontier areas that urban areas don't face, so I think the thing that that points out to me, and there are probably a number of reasons that's going on, but the thing that points out to me is the importance that the flow be opened up, that we be able to fine-tune and adjust this system, or the particular systems, because we don't have a system, we have multiple systems throughout the state. But we'd be able to fine-tune from front to back, and if you have one part of that that's clogged up, then you have problems throughout the whole system, that we have to continue being aggressive and innovative in how we open the systems up to allow that flow to continue happening, because I was familiar with the numbers in Region V about, we're reducing...and the numbers of repeats into the crisis center have been reducing, and I think that can be attributed to some of the work that's going on in community-based services. However, you've got to look deeper at that data and say, how many people aren't being EPCed and why? And then we've got to get that system opened up to do that, because people are being hurt by that. []

LEE TYSON: I think that...and I agree with you, the more data we have about those kinds of things, the better off we are. []

TOPHER HANSEN: Yeah. []

LEE TYSON: The problem with people who aren't EPCed is that we have no way of collecting that data. []

TOPHER HANSEN: Oh, absolutely. []

LEE TYSON: Yeah, and we hear a lot of anecdotal stories about this, but absolutely no data to show where this is happening, the extent to where it's happening, the quantity, the frequency. We just have anecdotal stories, and we need to collect data that shows, here's what's happening and when. []

TOPHER HANSEN: That's going to be hard data to collect, but what we need to do is, we still need to go for understanding the issue, whether we can put hard numbers on it or not, to understand if it's happening, and how to begin in a system...how to adjust so we're not hearing about it. []

RON SORENSEN: Well, actually, later in the agenda we get more into the hospital issues and the availability of beds, and I'm sure we'll have an interesting discussion at that point. J. Rock. []

J. ROCK JOHNSON: So what I'm hearing is, we're unable to measure our successes. []

_____: Um-hum. Or to understand if that's a failure. []

RON SORENSEN: I guess I'd disagree with that. I mean, I think we are measuring our successes. One of those...I know we hear the anecdotal stuff, but I think there are another bunch of variables we haven't talked about. We have system-wide, nationwide issues in the health system, in terms of accessing hospitals. And part of that is what's contributing to this problem, is that the beds of hospitals aren't just filled up with people under behavioral health reform. We'll get more into that as we get down the road here. I'd rather save that whole discussion for that time. []

J. ROCK JOHNSON: If I may, I didn't say what I intended, which was apparently we don't have a way to measure--which I should think might come through our emergency service people--of how many people we keep from being EPCed. That's what I meant; our success relative to law enforcement. []

LEE TYSON: Now that we can do. []

J. ROCK JOHNSON: Okay. []

LEE TYSON: The areas that have local crisis response teams keep excellent data in terms of the number of encounters they have, and the numbers that are EPCed, and the numbers that aren't. []

J. ROCK JOHNSON: Okay, that's great. []

LINDA JENSEN: But we don't have that data. We don't have that data here. (Laugh) []

LEE TYSON: Okay, we'll see if we can't them all to report it. Yeah. []

J. ROCK JOHNSON: The other point that I wanted to make is that police, law enforcement at all levels, actually become first responders in this situation, and at the academy in Grand Island, there are now 16 weeks of training. Forty hours of that are

domestic violence; eight hours of that have to do with people with mental illnesses, and you know, there's a long history of training around the country, which will enable some of the law enforcement people to de-escalate a situation and work with the people, but many of our folks haven't had the opportunity to develop that skill. I'm just suggesting this may be an area that there could be continued collaboration on, as well as continuing the trend of consumers being hired as facilitators and being paid to do lectures and help develop those manuals in those settings. []

RON SORENSEN: Actually, great minds think alike, because the last couple weeks we've been talking about how we could be a bigger part of law enforcement training, State Patrol training, cities of Lincoln and Omaha training. And we think there's a real need for that, something like what Alegent has done with the CRT training, crisis response team training. []

LEE TYSON: I know that Regions I, III, and V...I mean, and I can just think of them off the top of my head, have done some outstanding training with law enforcement. I know Region V has...I bet there's not too many law enforcement officers in Region V who haven't had exposure to that local crisis response team and their training. I myself have done training in Region III and Region I, and I (inaudible). So efforts are being made along those lines. It's just we need to do a lot more of it, and you're right. []

J. ROCK JOHNSON: Let me throw something into left field, which is, I don't know where I read it, (inaudible), but they're using emergency medical service personnel to be trained and to become part of this wider community that understands and cares and works with people. []

LEE TYSON: Absolutely. I'm thinking Sidney, Nebraska, right off the top of my head. There are very few licensed mental health practitioners in Sidney, Nebraska, yet they need local crisis response team services. So we have to take a look at, well, who else would be provide training to, to help us in this effort? And EMTs were one of them; clergy is another group, and then they have the ability to refer up to other professional people, as needed, so yeah. Oh, I'm sorry. I can't call on you. Senator Jensen. []

SENATOR JENSEN: Mary. []

MARY ANGUS: Bill, I am hoping that that is a description of the frustration that the police have. My really big concern is that if a parent, if a caregiver, if anybody handcuffed somebody anywhere and walked away, we could prosecute them to the top. And as a joke, or as a description of the frustration of the police, we will be talking about abuses, both to the consumers and the police. And I am extremely concerned that that would even be a statement someone would make, and this isn't directed at you, but it's...you know, I'm kind of looking at you, because I mean, I...I cannot register my disdain for that. []

BILL MIZNER: I'm not aware that that has happened. I heard that comment made two weeks ago in a meeting,... []

MARY ANGUS: And I'm saying... []

BILL MIZNER: ...expressing frustration, that when they went to get help and they were told that there was no place to put this person...and that's what this individual allegedly told a mental healthcare worker, saying look, if you don't help me, I'm just going to do this. And... []

MARY ANGUS: And like I say, even that level of frustration, I am livid. If I did that to my kid, I could have that child removed permanently. And if that police officer ever does that, I hope that he gets prosecuted or she gets prosecuted to the full extent of the law, without any sympathy given to that person. We cannot... []

BILL MIZNER: Well, I absolutely agree with you. []

MARY ANGUS: We cannot tolerate even statements like that. []

BILL MIZNER: Well, I absolutely agree, and that's why I said, since I've sat on this board, as long as you leave law enforcement holding these people with no place to take them,... []

MARY ANGUS: Exactly. []

BILL MIZNER: ...they are being treated as criminals. They're in the backseat of a squad car, they're handcuffed, and that is where law enforcement is getting frustrated, is the fact that no one seems to want to do something that will eliminate that dead time, where an officer has to keep this person in custody and treat them as a prisoner, not as someone who needs mental health care by those people who are trained and are to be doing that type of thing. So if something like that happened, I'd be the first one to jump up and say, this is wrong and something needs to be done with that incident (inaudible), but in the general terms, that is only a symptom of some of the feelings out there, of frustration, that have been going on,... []

MARY ANGUS: I understand that. []

BILL MIZNER: ...not just since this actually started,... []

MARY ANGUS: Oh, no, no, no, no, no, no. []

BILL MIZNER: ...but for years and years and years. Law enforcement is on 24/7.

They're the ones who get called, and they're the ones who are stuck holding these people until something is found. That's the level of frustration that's out there, and I just think it's time it has to be addressed. []

MARY ANGUS: And the fact that it has continued--and I am fully aware of the length of time with which that has continued--indicates to me a failure of the system to address alternatives to hospitalization, and to address creative and innovative ways of dealing with that, to never use a hospital, that have been used in other communities. I couldn't tell you what those are, but they are out there, and if we aren't using those, we are continuing, not only to treat people with mental illness as criminals, but to treat them as somebody that we have to tell them, or the community or the police, tell them what they're supposed to be doing. And it's not in my best interest for somebody else to tell me what I have to do. And the fact that we can go...that we have to go...I mean, this has been one of my pet peeves, we have to go in under an EPC or under a Mental Health Board of commitment to get any treatment that we volunteer for, that is criminal, too. []

LEE TYSON: And that should never happen. []

MARY ANGUS: It should never happen, and that is the policy at this point. []

_____: The policy of who? []

RON SORENSEN: That's (inaudible) policy. I mean, the simply reality is, the state of Nebraska has the responsibility for people committed to HHSS. And that means, right now, some of the beds at the regional centers are devoted to that purpose. The state does not have the responsibility under the law for people who come into hospitals voluntarily, and that's the reality of it. If you want to go that direction, you've got other issues you're going to have to deal with. []

DANIEL WILSON: You know, Ron, I think this is a very productive and highly charged discussion that suggests to me that there's a serious problem here--we've talked about it before--the whole interface with emergency response has not been a focus of reform effort, so far. And it needs to become more and more a focus. In other states where I've been, the police were called when there were dangerous situations, and they took people to some place for proper evaluation, and that was their...the sum total of their responsibility. And for some peculiar reason, Nebraska has, as J. Rock say, police being the first responders, and we're still relying on that, and now adding to it an ongoing...hours of actual caregiving of some sort, transportation here and yon. It's...this needs attention. We've talked about it before. Some of the resources that are leaving the regional centers, going to the regional authorities, needs to be focused on this. []

LEE TYSON: You're absolutely right, and I completely agree with that, and I completely agree with the point that you made, Mary. You are right on. That is spot-on where we

need to be, finding alternatives to emergency care, because EPCs are traumatic to the consumers who are EPCed. They're terribly traumatic, and for that reason and that reason alone, we need to do everything we can to prevent them. So in most cases, every time somebody is not EPCed, that's a good thing. There may be some instances where it happens the other way around. I'm sure that that does happen, but what we want to see is that downhill slope away from folks getting EPCed. And the way to do that is to find alternatives in emergency treatment. You're absolutely right. []

LINDA JENSEN: So you're talking more about successes again. You know, I mean, we're talking about a success for someone who isn't EPCed, and that's what's hard to get data on. You know, like, are there...how many people are involved in RAP programs, NAMI care programs, whatever else that, you know... []

DANIEL WILSON: You know, but Linda, it's not a success if people are not EPCed because there's a belief that there's no treatment that's available for them. That's not a success. []

LINDA JENSEN: Well, but I'm talking about, we have information about all the different services, such as,...you know, that HHS is paying for. But there's the other services out there, like...that some payment may be made, maybe not--the consumer empowerment programs, I'm talking about. You know, that's where the real difference is going to be made, is the consumer empowerment programs. []

LEE TYSON: Region VI is doing some very exciting things along those lines, and maybe they'll get a chance to talk about it a little bit. There are things happening, and yeah... []

LINDA JENSEN: Yeah, I know there are, but we're not...you know, again, we need to bring that forward. []

LEE TYSON: We've got to collect data on them and report to you, yeah. They are working on the RAP data. There's a plan afoot to gather information about who's benefiting from RAP, and we do get some of that other information reported by the regions, and so next time, we'll report it to you in this meeting. []

LINDA JENSEN: Okay. []

TOPHER HANSEN: And if you're ever interested,...it's hard to...you know, there are so many programs, and some of them connect where you can get data across the programs. But sometimes they're different enough that it's hard to gather success data in the way you're talking about. But we are asked that all the time, about what's your success? How are you doing? So we publish it on our web site. So every...we reduced it down to readable information and put it on our web site. So go to our web site; you'll see

what we're doing and we think that's part of what we do in the world. You've got to publish how you're doing, because if you're not doing good, you need to improve or get out of the business. []

JIM JENSEN: Well, and along with that, on EPCs, do we have any data that says, well, was this done in connection with some substance abuse, also? Does that show up? In other words, is it strictly psychotic, or is it something that happened with drugs that were being taken? We had an individual in Omaha that was killed just day before yesterday, and you know, he was on this drug called "wet," which I didn't...hadn't realized. They keep coming up with newer and better ones all the time, evidently. But, I mean, that was unfortunate, and his family said, well, he was crying out for help before that. Well, that usually happens, but how many of them can get that help, and how many will go for that help? That is a problem, too. []

LEE TYSON: I know just from experience in...being an emergency system worker person that quite a large number of EPCs involve intoxication on a substance, and the largest number is alcohol intoxication. []

SENATOR JENSEN: Sure. []

LEE TYSON: Much higher than anything else. But you know, we need to work on a way to collect the data and report it to you. We can do that (inaudible). []

SENATOR JENSEN: Now we've got a lot on our agenda, and I don't want to delay anything that should be said. But we have an issue coming up, I think, that will take a lot of time. []

RON SORENSEN: I think we're already talking about it, and maybe we can put a little structure to it. You've seen those charts. This is the mental health commitment admission to behavioral health units at the regional center. And you've seen the decline over the period of time, since starting reform. What you'll see in this chart, then, the real issue...there's the text on the top there of the table, which says in the first and second quarter, compared to last year, we are down 143 people. That's like a 47 percent decrease in the number of people being admitted to regional centers. Okay, I'm going to keep you a little long here. This chart shows the admissions and by region, into the regional centers. This is sort of relevant to our discussion later, but what you see there is a general, overall trend down, and this is by quarter. And I think you'll see one region that goes up in the last quarter, and that's Region 6, and our belief is that it could be because of the beds that went down at Douglas County. Is that 10 or 11, John? []

_____: Eleven. []

RON SORENSEN: Eleven beds. It went down there, and so there's been more demand

out of Region VI at that point. Now we'll get into this later, when we talk about what they've done in response to that, things that are going on. Okay? Okay, this is the trends and the referral list. This is a list of individuals that are put on the list by hospitals who have people in their facility who have been committed. As you can see, there was an immediate downturn in the size of this list early on, then it climbed back to its high points there, which is about the same number of people we had on the referral list five and six years ago, and now we've had a little bit of a downturn again. The caution with the referral list is, these are people put on a list at a point in time the hospitals--the doctors at the hospital--feel like they should go to the regional center. But each hospital has a little different way of doing this. Many of these individuals are diverted before they ever get to the regional center. They are actually diverted off this list into community-based services. The regions work very hard at, when somebody gets on that list, finding an alternative placement for them that's appropriate. So...but not everybody that's on the list will make it in the regional center, but it gives us a sort of general way of tracking how many people we might need to admit, as we go forward. []

MARIO SCALORA: Ron, a rough idea, and maybe Lee--I know Lee works with this--how long, if people aren't diverted are sitting on that list, and how many people are diverted versus ending up in a state hospital bed? If you...a rough idea, numbers wise. []

RON SORENSEN: Well, we know...and maybe (inaudible) as well, but we do know that the length of stay on the referral list has increased from about 14 days to 25 or 26 days. Now we need to understand, though, that the original part of the strategy when we went forward was, that we would average 30 days in a hospital. []

MARIO SCALORA: Right. []

RON SORENSEN: We contracted with hospitals for 4 days of acute and 26 days of subacute to replace regional centers. So that number still is within that framework, although, as we'll get into the discussion later, that's not particularly where hospitals would like the number to be. []

MARIO SCALORA: Right. []

RON SORENSEN: So...and that's something we'll work on as we go forward. []

LEE TYSON: And we're diverting approximately 70 percent of people off that list, so the entire month of January, out of all the people that were on the referral people, only 11 got admitted to regional centers, so. []

MARIO SCALORA: Thank you. []

LEE TYSON: Um-hum. []

TOPHER HANSEN: And Region II and I are doing what? They're not here. []

RON SORENSEN: Well, they typically don't have anybody on the list. Is that what you mean? []

TOPHER HANSEN: Yeah. I mean, they just don't have anybody? Because life is better out there, or...(Laughter) []

_____: Some will say yes and some will say no. (Laugh) []

TOPHER HANSEN: Some would say yes. I mean, many of us could agree with that. (Laugh) []

RON SORENSEN: I agree with that, but I think there are other issues, as well. Region I, in particular, has a very unique relationship with a hospital where a few years ago, that hospital had a psych unit that they didn't know if they wanted to continue, and we sort of went into partnership with Region I and the hospital, to keep that unit open. And what resulted was I think a very effective system of moving people in and out of the hospital. Now they've also converted some of their beds to dual. So they've been pretty flexible in how they provides services, and what kind of services they provide, and so I think they have a unique situation. Maybe that's not something you can duplicate in a more populated area. I don't know. I think there are some advantages sometimes, to having limited resources and being smaller. And so I think in those areas they have historically maybe, paid more attention to managing the population, because, you know, when you drive from Scottsbluff to Hastings to take somebody to the regional center, that's a long way. And maybe that's had an effect on that. []

TOPHER HANSEN: And is Region II working with Region I, then? Is that... []

LEE TYSON: They do work together a lot of times. They have a real hands-on way of doing things, too. There's a lot of feet- on-the-ground, personal involvement, hands-on kind of intervention with folks that you don't see in larger metropolitan areas, and that makes a huge difference. At Regional West, people are committee there, the same way they are committed to a regional center, but the length of stay is under 30 days, instead of, you know, what we see in the regional centers. And the recidivism rate is 11 percent or less, which is really good. So you know, it makes a difference. Yeah? []

MARY ANGUS: Could we not use the word "recidivism"? That's actually a criminal term, to begin with. []

LEE TYSON: Okay, never again! []

MARY ANGUS: You know, that means I went back to jail again, and that criminalizes folks. Thank you, Lee. []

LEE TYSON: Okay. I will watch my language. No more recidivism. Strike that from my vocabulary. []

MARY ANGUS: I've been really recidivist, so I don't want to be using that term. (Laugh) []

RON SORENSEN: All right. Well, let's move along to the...look at the census. What you see in there is a declining census over time for the total. What you'll see in Lincoln is a slight growth--that's the bottom color there, whatever color that happens to be--sort of a brown. And what you've seen is the addition of a few beds at Lincoln, and as we've told you before, we will eventually be at 100 beds in Lincoln, and that will progress over time. But you see a small growth there. And then you see the other numbers, at Norfolk, in particular, looks like it's growing, but the next slide will explain that. And then Hastings you see substantially reducing. I think I'll just go to the next slide and talk about what's going on at Norfolk. And what you can see here is that the behavioral health population continues to decline, and the sex offender population is increasing there. And actually, if you look there, their census as of yesterday, we had only 50 people at Norfolk. The regions, the Norfolk staff, and our staff have been working very hard at Norfolk to help people find appropriate community placements. It's interesting to track people's attitudes as we went forward with this. You know, there was a time when we said, well, there's probably 80 people there we can't get out. And then it was down to 70, and then it's down to 60, and now we've got 50. And so those sort of estimations don't seem to hold much water. It's an individual case of working with a person on a one-by-one basis, finding appropriate services, and helping them move back to where they should be. []

DANIEL WILSON: Ron, is the sexual offender population, the services, is that funded by the same revenue stream (inaudible)? []

RON SORENSEN: Well, that's kind of hard to explain. (Laughter) You had to bring that up, didn't you? []

DANIEL WILSON: Yeah, I'm sorry. []

RON SORENSEN: There are two funding sources for sex offenders right now. Okay, technically there are three, but we'll deal with two. When LB1199 last year, they created funding for individuals who were committed by the Mental Health Boards under the Sex Offender Commitment Act. So anybody committed under that act is paid for out of that system, okay? And I don't if I have any of those exact numbers with me, how that splits out,...I think they have 43 people there today, so I think 15 of them are LB1199. We had 17, and had to send two of them to jail, and then we have about 28 people who were

committed under the Mental Health Act, and so those people technically would be the responsibility of funding under Program 38 or LB1083. Does that make sense? []

DANIEL WILSON: And that number won't increase because of the change in the law, or it could? []

RON SORENSEN: Well, actually it is. It is increasing. Mental Health Boards can commit under either statute, and as you know, in LB1199, there are specific kinds of crimes or repeat crimes that are identified, and those people we try to make sure, with those qualifications, are committed under that statute. There are occasions, though, where people might have lesser sex offenses, who can be committed under LB1083, or the mental health act. In fact, I think we had four or five on July 1 of 2005, and we've got 28 now. Some of those, four or five of them have been, since LB1199 became effective. []

MARIO SCALORA: It could shed a little light, since this is a population I see a great deal of. Most of the folks who are committed under the previously existing statute and now a part of LB1083, mainly child molesters and folks who get...were committed as they have been, and through the distant past, under a traditional mental health commitment act. Most of the folks who are coming in at LB1199, and we're getting a growing number, are generally more folks who wouldn't have fit under that umbrella anyway--more rapists. And so you're seeing a slightly different population, a group of folks who look substantially more antisocial, different sex assault histories. So what we're seeing is an increase in sex offender commitments under both rubrics. And I know the state works very hard to try to project this, based on prior commitment rates, and I think those rates are just increasing for a variety of reasons. So we're seeing more and more sex offenders coming into the system and raising challenges, because some are taking up mental health beds, are coming in, could potentially still fit in the services under LB1083, but raising questions or challenges for providers in the community, in terms of what types of individuals they can manage, and manage with their other population. []

DANIEL WILSON: Is there any sense of what the financial impact of this is going to be in two to three years, in terms of cannibalizing dollars? []

RON SORENSEN: Well, we projected 33 people a year under LB1199, based on some correctional data that was given us. That seems to be holding true. We had 17 this year so far. And we had been getting something like 17 or 18, I think, showing up on the other side, and right now, that seems to be holding. So right now, we're probably in the 40, 50 range a year, and so the real variable there, then, is how can you get them out, and how fast can you get them out? []

MARIO SCALORA: And the reason it becomes a challenge is, these are folks who do not leave the system as quickly, and as a result,...so even if we're at pace, it's still

accumulates at a significant amount. So this becomes quite a challenge in many respects. I think the state personnel work very well to try to anticipate these issues, and I don't see this as a problem of planning--this is just the nature of a problem of the (inaudible) population. []

DANIEL WILSON: But demographically, this group could substantially erode the financial basis for care for indigent mentally ill people. []

SENATOR JENSEN: Those that are committed under LB1083, or behavioral health, who have a sexual offense, how are they treated? Are they treated as sexual offenders? Is the treatment in the regional center for sexual offense, or is it mental health? []

RON SORENSEN: It depends on the individual. []

SENATOR JENSEN: It would seem to me that that's where the real criteria should be. If they're treated as sexual offenders, to try to alleviate that desire, whatever you want to call it. Then they should not be behaviorial health individuals, and drawing from behavioral health dollars. []

RON SORENSEN: That is the way the funding was set up when the bill was passed, that LB1189 or what we call program 870 would fund the sex offenders committed under LB1189, and so that's an issue. Go back a little farther. We have sex offenders who are committed for sex offender treatment, but we also have some individuals who are sex offenders who are committed for mental health treatment; they're not there because they are sex offenders. And they also present problems getting out because it's difficult for providers to want to take them into their population even though they weren't committed for sex offender treatment, so. []

MARIO SCALORA: I was speaking strictly of those committed for sex offender treatment. Ron raised a good point. []

RON SORENSEN: So...and LB1199 presents some real bigger challenges in getting people out because there are some elements of that statute that make it...set up some pretty high standards on letting people out into the community, so. []

SENATOR JENSEN: Like almost a guarantee that they'll never reoffend. []

RON SORENSEN: That's pretty much the way you read it, yeah. It's basically very, very low risk. []

SENATOR JENSEN: I mean, far greater than a normal person who was sentenced for criminal activity. []

RON SORENSEN: Yeah. And it presents a...sex offenders coming into our system now, in greater numbers, presents some unique challenges for our staff, particularly at Norfolk, because some of these people have been in the corrections systems 25 years, 30 years, and there is a whole culture about that, as you know, and they present some problems. We've had a couple cases where sex offenders have been assaultive and are in jail now because of that. So they'll probably end up back somewhere in the correctional system. Okay, yes. []

MARY ANGUS: Excuse me. My question is twofold. One is how are we protecting the folks with mental illness from the people that are committed under LB1199, and the other question is, when they've been committed under LB1083? It's a whole different group because they're in the population. They are in the rooms and they are in the floor, in the units with folks who have been committed...or, yeah, under the mental health step under LB1083. []

RON SORENSEN: No, they're not. All sex offenders are put on...in Norfolk they're all on the third floor. []

MARY ANGUS: Even if they've been committed under LB1083? []

RON SORENSEN: If they have been committed for sex offender treatment they are on the third floor. Now, if they are committed for mental health purposes but not for sex offender treatment, that's not part of the issue that was part of the commitment, they would be in the general population. []

MARY ANGUS: And how are we protecting other people in the regional centers? []

RON SORENSEN: By separating. We have locked doors. People on the third floor can't access the other units. We separate the population so that they can't get to each other. []

MARY ANGUS: Yeah, I've been in the building. []

RON SORENSEN I mean, it's not unique. It's not unique. []

MARY ANGUS: No. []

RON SORENSEN: We have the same issue with Lincoln where Building 14, they are separated by locked doors and so on. []

MARY ANGUS: But the people who are in...they've been committed under LB1083, prior to or afterwards, 1199. They are there for mental health treatment, not for sex offender treatment. How do we protect the other folks in those units from those people

who are not locked in another unit, those people who are not... []

RON SORENSEN: We have separate populations. We have two units in the behavioral health side and two units on the sex offender side, so we separate them by units. []

MARY ANGUS: Even if they're not committed for sexual offenses? []

RON SORENSEN: The behavioral-health committed people... []

TOPHER HANSEN: But one of the issues is that not all sex offenders are a risk to all other people. []

RON SORENSEN: Right. []

TOPHER HANSEN: The sex offenders are as varied in their makeup as are mental health people or any other groups, that there's a continuum. Certain people are, certainly, but our experience is most people that come to us that have sex offense issues are not a risk to the population they're with because either they've been treated, in which case there's about an 85 percent rate that they stay away from that behavior, again if certain groups of people, and they don't reoffend. They're at low risk for reoffense in that way but there are some who are...we just had, the other day, a person referred to us; two rapes. And we said, no way. There are huge issues there that will victimize the population. []

RON SORENSEN: And that's what the staff at Norfolk does. They make a determination of risk when somebody comes in. Is this a person who would put the general population at risk? And if so, they wouldn't be with the general population. I mean, that's what the staff does there when they...we do a risk assessment on everybody that comes in, independent of the risk assessment done in the mental health board process, and so they make that determination. As Topher says, some individuals don't represent a risk in the general population, that's not where the concerns with them are, and so they make that determination. []

MARY ANGUS: But there have been reports of rapes in the regional centers, which means that no matter whether we think they're going to be a risk. There are people on the units that are not being protected, and that's my question. How... []

J. ROCK JOHNSON: But those are staff, Mary. Some of those are staff. []

MARY ANGUS: Okay, that makes it even worse. (Inaudible.) []

MARIO SCALORA: Right. These were not people designated as sex offenders previously. You raise an important issue for safety, but it's not necessarily this

population causing that behavior. []

RON SORENSEN: I think the instances you're referring to weren't caused by a convicted sex offender. []

MARY ANGUS: Okay. Still, how are we protecting people from abuse by staff or by other people that are on the unit? []

RON SORENSEN: We've been doing a lot of training at Norfolk with staff on everything from seclusion and restraint...(inaudible), you can help me better since you do some of that. But being involved heavily in training. We have done a lot of security. We have added 64 cameras, I think, to monitor what goes on at Norfolk. The staff there has been working with our staff at the Lincoln Regional Center for how to manage sex offender treatment and making a consistent program across both regional centers. So there's been a lot of work going into security there, a lot of work continuing on that. So we've done what we've had to do, I think. []

LEE TYSON: There is a corrective action plan that has to do with these issues at Norfolk, which is very detailed in terms of what is being done there to correct some of those situations, which I'd be happy to share that with you. It really addresses things on a very detailed staff person by staff person level. []

SENATOR JENSEN: J. Rock. []

J. ROCK JOHNSON: Well, it would be the equivalent, I think, of turning the Queen Mary around in the Platte River, but some people (inaudible) is a terrific grasp of the obvious are suggesting that perhaps people who are adjudicated sex offenders should have treatment first. And then if that doesn't work, then utilizing the criminal justice system (inaudible) they need to be in order to protect the public. It seems rather an oxymoron and counterproductive to put individuals into a jail population where they learn more and more and more about crime and various ways to behave and bulk up and so forth. So I simply throw that out as something that I think that needs to be...that that conversation needs to start. We need to think about how we can do that. The other is, how much more than the $1 million that's spent so far, it's my understanding, for the life safety code update at the Norfolk Regional Center? Do you have any idea how much more will be invested in those facilities? []

RON SORENSEN: Not all of that is up to us. I don't know, Chris, can you answer that? []

CHRIS PETERSON: Yes, there was, I believe, (inaudible) or $1.4 appropriated for the fire safety issues that included testing, the new security cameras, new doors, closing off some of the doors and putting in swipe cards. In addition, in the original proposal we

looked at 309 projects and I believe that was an additional $6 million or $7 million. []

J. ROCK JOHNSON: Will you know, if you know, will that enable that facility to, with little or no additional work to qualify as a hospital under the joint commission standards? (Inaudible.) So that's the expectation is that the Norfolk Regional Center will qualify... []

RON SORENSEN: Yes. []

_____: Under the (inaudible). []

J. ROCK JOHNSON: And that would be the entire facility or...? []

CHRIS PETERSON: That (inaudible) for you, and we can find that answer out, but that's the (inaudible). []

J. ROCK JOHNSON: Thank you. []

RON SORENSEN: We've been working for some time now on the policy and staffing issues associated with...also associated with J-Co or JC as I guess we now call it. []

MARY ANGUS: Joint Commission. []

RON SORENSEN: I keep flashing back to Jesus Christ, Superstar. []

J. ROCK JOHNSON: Yeah, they answer to J-Co, so. (Laughter) []

RON SORENSEN: I don't know. I guess I'm old enough that that means something else to me. Okay, I'm going to move to the next slide here, and this is our patriotic slide of red, white, and blue. And what this is in here for, it is the census at Hastings. And what you see back early on where you see the blue and red bars is when we closed the acute unit at Hastings back in 2004, and you see the population today. And actually I can give you an update on; the population as it was yesterday. We now have four people at Hastings. And this is here to alert you to the fact that we will be moving ahead with, as we're required under LB1083, of notifying the appropriate parties of the Legislature and oversight commission as to reducing the size at Hastings. So we don't have the official notification yet because we still have some plans to work out with those four individuals and so on, but you can expect that as we go down the road here. []

SUSAN BOUST: Ron, could you clarify that notification? Are you notifying that this will be the termination of behavioral health services at the Hastings Regional Center? []

RON SORENSEN: It'll be the termination of adult behavioral services. []

SUSAN BOUST: Adult behavioral health services. []

MARIO SCALORA: Adult...for part of the services. Everything but the remaining juvenile services. []

RON SORENSEN: Yes. It does not include juvenile services... []

SUSAN BOUST: Okay, thank you. []

RON SORENSEN: ...or the Bridges program. []

MARY ANGUS: Are all of the units at Hastings that are housing juveniles up to life safety codes at this time? []

RON SORENSEN: Are they what? []

MARY ANGUS: Up to life safety codes at this time? []

RON SORENSEN: I believe so. (Inaudible) bill (inaudible). []

MARY ANGUS: Okay, thank you. []

RON SORENSEN: Okay. I'm going to let Joel do this next one here, an update on the (inaudible). []

JOEL McCLEARY: I'm going to jump up here and just speak from this...I like being flanked with doctors on all sides. It's great. This slide is the only slide I'm going to offer from consumer affairs because I know you have other fish to fry, but what I want to tell you is the good news is that one of the consumer specialists at the region, Region III, has been hired. She's been on duty for three and a half weeks and is getting to know the consumers in her area better than she even did before. We have Region I is readvertising, and if you know anybody who might be interested in that position with a consumer background, they would be interested in knowing about that. They did run one set of advertising and a series of interviews but are readvertising for that one. So Region II, Region III, Region V, appear to have hired, and Region IV and VI are interviewing, and I don't even have the names for those folks yet. So the most up-to-date information will come from the region on those. You had a couple of other notes here. We have an administrative assistant in the office of consumer affairs now effective last month, and we are excited that one of the skill sets that she brings is a fluency in Spanish, so she's the only one in our little corner of the office that speaks fluent Spanish and we think that's going to be (inaudible) besides she can help keep me organized. We expect that all these positions here will be filled within the next month to six weeks. I think earlier than that but that's a good margin. One of the things that I want

you to look forward to is an opportunity for us to talk about what these positions will have to do with emergency services, because I expect that we will build a statewide team among these people with my office in the way that Lee has constructed a team of emergency services folks there. And once we get those two sets together there's going to be some interesting dialogue going on because we're going to have people who know each other in the consumer world and their community and they're going to know the services and the people who are providing those services. I think it's going to open up some new things that we can talk about in the next commission meeting. I want to congratulate Region VI, just offered a training at the expense of the region. Eighteen new RAP facilitators are in their space now, so that brings our state total to about 28 RAP facilitators. We are not as limited as we were but now most of the facilitators are in the Omaha area, and I am expecting some fun things coming out of that. As we connect in the regional centers with RAP training there and help people prepare for the movement into the community, we're finding the communities of RAP-informed and RAP-facilitated groups be of real service. So those that are going to Lincoln have a good team there to visit with, and now we have lots of nice folks in Omaha ready to receive them. And your word, recidivism. Lee and I talked about that. She doesn't like that word either. []

MARY ANGUS: Thank you, thank you. []

JOEL McCLEARY: But I'm not sure what the better one is. Frequent flyers comes to my mind and to my lips sometimes but I realize...you can use it on me but I don't know what others prefer. []

LINDA JENSEN: How about readmission? []

JOEL McCLEARY: Readmission. That's so simple. Great. []

_____: It's a little more neutral. []

JOEL McCLEARY: It's much easier to say and spell. Were there questions? J. Rock, yes. []

J. ROCK JOHNSON: Yes. It's my understanding that these positions in question will...that their scope of practice, if you will, knowing that these are not a professional position, will involve all the behavioral health populations and all ages. Is that correct? []

JOEL McCLEARY: Each region has defined its role based on consumer input, and each region should probably be consulted on that individually. My understanding, my belief, my wish, is that we be there for everybody but I know that's impossible. We'll do the best we can. I do think of them as professional positions. I don't know exactly what words we're using... []

J. ROCK JOHNSON: Licensed, perhaps, is what the word (inaudible). []

RON SORENSEN: What we do know is that these folks have been embraced. The positions have been looked up from the very beginning as a real team member of the administrative decision-making group. That is huge progress for our state. So I'm excited about the potential, as much about the reality. It's going to be some good times coming down the road, but we have to give it some time and think what we're going to do with it all. Yes. []

J. ROCK JOHNSON: Well, I was quoting a comment that you had made that that would be the scope of what people were involved in, and I see now that's referred back to the region. You did however, in presentations that we've had in the past, one of the things was that (inaudible) and I remember I know there were others, consumers would be strongly involved in the interviewing. Now, is that something that you could perhaps write us a short report about how that worked in the regions? []

JOEL McCLEARY: Well, my perception is that that's true. It was our intent going into it that consumers would be involved at every level. That's where all of the information which described the positions came from. And it was...I'm glad it was consistent with what we thought it might look like. But each region had its own mechanism, but my belief is that consumers were involved at every level of it. []

J. ROCK JOHNSON: Well, if that's not, to quote my colleague Topher Hansen, if that's not what everyone else wants to know, I assume I can ask privately because my understanding is that that isn't how it always worked. And I think, given the lead role that you have taken here and the standards that you set and your relationship to the regions, that it would be appropriate for you to provide us with a report of how that did work, not to, as some might think possibly, to say gotcha, but this has never been done before. We can all learn from each other. And it seems to me that your office is the appropriate place to gather that information to share that report. []

JOEL McCLEARY: I'm certainly interested in hearing from the regions about how they work through the process, but up to now all of it has been consumer engaged as far as I can tell. I have no reason to doubt that consumers have been involved at every turn. []

J. ROCK JOHNSON: So you'll be willing to write us a report? []

JOEL McCLEARY: Sure. I'll write you a letter. Is it...? []

_____: Okay. We'll look forward to that. []

JOEL McCLEARY: Yeah. We can be more detailed about. I'm into data. I'm sorry this

one doesn't provide very much data, but I love it, so the more you can send me, the better. []

J. ROCK JOHNSON: Another thing along that same line is a couple months ago there was discussion in this group about the fact that there doesn't appear to be, at least we haven't seen or heard any formal mechanisms or policies about how the office operates, reporting structure, the advisory groups. I mean, there are lots (inaudible) all different ways to do that. []

JOEL McCLEARY: Actually all of that was...actually I have a very defined job description and a description of the office of consumer affairs which was written in April 2004 in preparation for filling the position. It was during the behavioral health reform writing and it's quite detailed. I went through it, knowing (inaudible) anticipating your question, I went through it, and it seems like what we're doing is consistent with most of the areas that were expected for us to be doing so I can speak to that. []

J. ROCK JOHNSON: Well, it's always good to feel confident in the work that you're doing. I mean, that's really important. But what I'm thinking about is the fact that this position has been occupied, the program administrator and the office of consumer affairs, just over a year now, and there has been no written reports that have come out. For example, I know that the office maintains a database of consumers. It's in the block grant. It says that it develops and maintains but doesn't it say anything about using it, so that's one question, and there's a log, there's an 800-number, a log is kept of calls that come into the office of consumer affairs, and I don't know that I've ever heard discussion about an analysis of that. And those are just examples that I've come up with. []

JOEL McCLEARY: Well, it's entirely possible that you haven't heard that. It's taking place, but I may not have communicated it to you. []

J. ROCK JOHNSON: Well, perhaps there needs to be some more discussion (inaudible). I'm a bit frustrated myself. I'm not sure how I can more plainly say that I believe there needs to be accountability. Accountability is usually done in the form of a written report. And the accountability of this particular commission and (inaudible), and the creation of the role of the office of consumer affairs to help with (inaudible) was changed. I should think that it would be something that you would have done and be really proud to do, and I hope that you will be proud to do that and that you can generate (inaudible). []

DANIEL WILSON: It sounds as if we're ready for your first annual report. []

JOEL McCLEARY: I can do that. I'll use the State of the Union as the model, right? []

RON SORENSEN: Okay. We're going to plug ahead here. Okay, some of the issues that we've talked about this morning come back to what I will call, for lack of a better term, hospital issues. We had, as in previous meetings, we talked at some length about this. But we were presented by representatives of another hospital--Shannon is one of the members of that group--with concerns with about what's going on in the system. And I hope I've characterized Shannon with the group that suggested it, and if not please feel free to add anything to the list. The first was that the length of stay at a hospital for behavioral health consumers committed to HHS was basically too long. I don't know how to say that any differently. And that the length of stay for behavioral health consumers in emergency protective custody were also excessive because of things like continuances and so on. And then finally that the hospital emergency departments in behavioral health were full, resulting in transportation of consumers in EPC from one hospital to another, so. That...I'll look to Shannon of things we should add to that or does that cover it? []

SHANNON ENGLER: Those were some of the primary issues, yes. []

RON SORENSEN: Okay. So what we did then was...I should say that first a number of hospital administrators have been meeting with myself and Dr. Shaffer and John McVay at the time and Joel McCleary, about once a month to talk about some of these issues and deal with them to the best we could. And then as we proceeded in the last part of the year, we would agree we've spanned these meetings and work on the problems more formally. So on November 29 and January 23 we met with hospital administrators, hospital clinical teams were involved early in that, regional administrators and their staff, our staff, Medicaid representatives, particularly Dr. Easterday, and the administration of HHSS. Our goal was to identify what those problems were, possible solutions have come up with a series of steps and plans of action that we could...so we could address those issues as we saw them. So just some of the...and help me out here again if you've got additions to this, Shannon, but what we saw as potential causes to this issue was increased number of consumers, but medical services accessing hospitals. And I'm not talking about behavioral health consumers; I'm talking about people seeking medical care, and that seems to be sort of a nationwide issue is people without insurance having access to hospitals rather than doctors. Increased number of voluntary consumers of behavioral health consumers accessing hospitals for services. And I should add here that this isn't true in all cases. It seems to be almost a hospital-by-hospital issue as to how they would represent the growth and the number of people showing up, whether it's voluntary or commitments or whatever. And then the other thing, the potential cause we talked a little bit about already today, was appropriate services in the community necessary to either divert consumers from hospitals or the discharge of consumers back to the community were not available or accessible in a timely manner. So those are the issues we identified as we went forward. And I should tell you, I don't consider what we're doing at this point to be final or complete at any means, but we basically started with a few things, and I'm sure not all of the parties there are quite happy with

everything we're doing but we'll continue to work on that. So what we did was focus on four areas of strategy areas to deal with. One was to reduce the length of stay at community hospitals by improving the access to the Lincoln Regional Center, and that means basically reducing how long people have to stay at regional centers. What we discovered when we looked at Lincoln Regional Center, for instance, is that sometimes there were as many as 20 or 25 people there that the regional center considered to be discharge ready, who were still at the hospital and were taking too long to get out. So that's why that was (inaudible). We talked about expanding capacity of community-based acute and subacute hospital beds. And this we don't look at a long-term solution but hopefully as the system adjusts and we get new programs and services in place, they would not be permanent necessarily. And expand the acute and long-term capacity at the Lincoln Regional Center which we talked about before. And within the existing appropriations, and that's an important point, we already have the money out there we have available for services, but we would look at those services to improve access and the quality of community-based services. So those were basically the four areas we came down to. And so the next slide really talks about the specific side of this. And early on, and this is last summer, we added 16 subacute beds at Richard Young to take some of the load off the hospitals. We are in the process of ten additional acute beds at Kearney to continue help alleviate some of the bed filling, for lack of a better term, and the waiting list or referral list. We also will be adding ten additional acute beds at LRC. That's been in the plans for a few months now. It looks like March 2007. It would have been sooner except we discovered asbestos in a basement floor I think it was (inaudible). And so that's being resolved and worked through to remove the asbestos before we can add those beds. The fourth idea was a bed allocation plan which we're going to discuss in more depth. Fifth, we're going to increase the utilization of telecare in Region VI. I think some of you may be aware that telecare hasn't been utilized fully and has been, in some times, over 32 beds half full. So our goal was to increase that access to that facility. Number six was to revamp some community-based services, enhance community-based services, including things like crisis respite, some people call blended, some people call intensive case management. Local crisis response teams, emergency community support, enhanced psych res-rehab, and dialectical behavioral therapy and med management services. So all those things are being as identified as what the regions can do in their current service mix. We also agreed that we would continue to try to identify services to reduce admissions to an expedite discharges from hospitals, and it says including monitoring utilization of community-based service. I think just as important as looking at getting discharged people out of the Lincoln Regional Center when they're ready to go, it's getting people out of community-based services, whether it's psych res-rehab or whatever it is. When we have looked at lengths of stay at some things like psych res-rehab, we've seen very extended lengths of stay that we're not sure justify it. So part of the quality approach is to look at those just as we do the regional center. And we hope to continue to work with the partnership with the hospitals, providers, the regions, and ourselves, to address these issues and I think we've talked about expanding that,

and I'll have to consider...we'll talk a little bit more about what we're doing as we continue with, particularly number four on your list, to involve doctors and psychiatrists. Number nine was just to keep in everybody's mind, we still have seven subacute beds at Faith Regional Hospital that we're planning on having up, it looks like June or July now. I do have pictures showing that the construction is under way. (Laughter) []

_____: (Laugh) So you have a report. []

RON SORENSEN: Yes, I have four pictures of construction--people actually working with the walls and what they do when they do that stuff. So we are confident that's happening, so. []

GORDON ADAMS: I might interject that asbestos was a big problem and it took a long time to do the asbestos mitigation. I'm assured that the walls are all gone and that it's being drywalled as we speak. []

RON SORENSEN: The pictures I saw would attest to the fact that all of the original walls were gone and everything off the brick exterior walls was taken off and the only think in there now was the steel frame wall studs and so on. []

RONALD KLUTMAN: Could I ask a question? []

RON SORENSEN: Yes. []

RONALD KLUTMAN: Part of the reason for reducing the regional centers is that they did not qualify for Medicaid matching funds because, quote, they were a mental hospital? Am I correct in that? []

_____: Yeah. []

RONALD KLUTMAN: Is there a bed number for that or is it just how you designate it? What I... []

SENATOR JENSEN: Sixteen. []

RONALD KLUTMAN: Sixteen. []

RON SORENSEN: Yeah. Okay, anything... []

RONALD KLUTMAN: And I may be talking about oranges and apples, but I... []

RON SORENSEN: Well, it's never quite that easy. If you're at a state institution, you're automatically an IMD, okay? If you are in a hospital, basically the rule is...help me out,

Mary...if half the beds or more are nonbehavioral health, that is they're med-surg beds, then you're not an IMD. []

RONALD KLUTMAN: Okay. []

RON SORENSEN: If you are a community-based provider and you're providing things like something that involves residential care like psych res-rehab or whatever, short-term res, 16 beds is the limit, assuming that you're also not part of a bigger facility. And the issues are basically (inaudible). []

RONALD KLUTMAN: But your watch...I guess...make it simple. It sounds like the Richard Young, you're going to throw it into a category that it will be Medicaid. []

RON SORENSEN: Yes; it fits. All the local hospitals we contracted with fit into the Medicaid-eligible. []

RONALD KLUTMAN: Now, what about the Lincoln Regional Center? []

RON SORENSEN: No, it does not. []

RONALD KLUTMAN: Okay, so then we don't get Medicaid matching funds for the Lincoln Regional Center? []

RON SORENSEN: No, we do not. []

RONALD KLUTMAN: Ah, okay. []

_____: For adults. []

RON SORENSEN: For adults. We do for kids; not for adults. []

_____: And over 65. []

SENATOR JENSEN: C.J. []

RON SORENSEN: At some point you've got to look at that. And I think it's...we, as part of this plan, have brought up some hospital beds, and that's not really what we wanted to do. It's ideally a short-term solution. But I think it's not like a regional center bed is equal to a hospital bed. They aren't. I mean, at the regional centers we were averaging, at Norfolk the average length of stay for people who were discharged, at more than 120 days. When we looked into the hospitals now, we are, depending on the hospitals, I don't know what Shannon's is. I know Mary Lanning is about 16 days I think, is the last, so... []

RONALD KLUTMAN: So, we're (inaudible). []

RON SORENSEN: Yeah, so it's different. You have much greater utilization in a hospital in the community than you do, in terms of the number of people, than you do in a regional center. []

RONALD KLUTMAN: And could I ask one last thing for the hospital association here? I was excited about trying to get this into the community and everything else until I started having our hospital look at the financial aspect. And it looks like you need at least 8-10 beds to make it financially viable, is that correct? If you get below that, the staffing problems and the other things are so overwhelming financially that you can of do lose your (inaudible) line? []

RON SORENSEN: Correct. []

SHANNON ENGLER: There are several factors. []

RONALD KLUTMAN: There always is in hospitals. []

SHANNON ENGLER: There always are. The units that I run, I wouldn't want to have a 10-bed unit but I have heard from other areas, 10-12 beds would be a minimum. And then a lot of it depends, of course, on reimbursement of which Medicaid and other reimbursements are inadequate. They do not cover costs for inpatient acute hospitalization, because when you were talking about lengths of stay up in the teens, at BryanLGH our length of stay has crept up to five days now--our average length of stay. So apples and oranges doesn't even (inaudible). []

RONALD KLUTMAN: Are they DRGs then? Your psych beds? []

SHANNON ENGLER: They are basically all reimbursed on a per diem. []

MARY ANGUS: Could I ask what DRG stands for? []

SHANNON ENGLER: Diagnostic related group. Put several diagnoses in... []

MARY ANGUS: Okay, thank you. []

RONALD KLUTMAN: So if you go into the hospital with pneumonia, your Medicare says they'll pay you four days, so if you get out in two days you make money and if you get them out in ten days you lose money. So that's what a DRG is. []

MARY ANGUS: Thank you. []

RONALD KLUTMAN: That's not what this is. []

C.J. MARR: Ron, excuse me if I can go back to my old health planning days, but we used to have bed formulas for the entire state in terms of types of beds, categories of beds, payer mix. Is there any bed study in terms of behavioral health beds of all types statewide that's been done? []

RON SORENSEN: Not that I know of. I don't know unless Medicaid has done one. []

C.J. MARR: Could we look at doing that? Because a lot of the issues we talk about, we get into all these types of categories of beds and seven here and ten there and subacute and acute. There is a lot of change going on and we're all trying to drive patients from those beds into other more appropriate levels of care, but we still need beds. And if we could do a survey of what we have right now statewide, both public sector and private, and then look at the locations and types of beds, at least it would give us something to compare against as we keep moving ahead and as we try to track change. But right now what I'm concerned about is that if we add a few beds here, we add a few beds there, we may be meeting a local need but it may not be meeting a systemic need. So is it possible to even look at a study like that? []

RON SORENSEN: Mary and I can talk about how we might do this and how we find the resources to do that, but we'll be happy to talk about how we can do that. []

SUSAN BOUST: I want to speak in favor of that as kind of one of my biggest points for today. We see this leveling out of our community behavioral health services and we see this crisis happening in our local hospitals. We have a lot of plans about how to deal with that. But I do think it's the state's responsibility and this group's responsibility to say what is the right number of beds--at what point do you get out of the crisis. And counting beds, I think is very difficult. Is a res-rehab bed, a bed? If you have a respite bed, is that a bed? It's crisis bed. I don't know the answer to those things but I know that we are at a point, when I look at this data, we should be at a point that we could make much better than a dart board kind of guess about what's the right number of beds at various levels for Nebraska, and we ought to have that number in front of us. []

RON SORENSEN: I would throw out those, Dr. Boust, that I'm not sure there is a right number. I think ideally if we were...if we had all the resources in the world we could, and we could do this right, we would start at the low-end service. We would build the low-end services first. We would build housing, we would build community support, we would build intensive case management, we would build ACT, and that's the way we would build the system. Because the number of beds is going to depend on what you do at the lower levels. It's not...and I'm always reluctant to say, oh, we need 100 beds because I don't know if we need 100 beds. Because until we have everything else

balanced and moving, I don't think you'll know what the front door demand is in a hospital, and so that's why I'm reluctant to say, okay, let's say we're going to have 100 beds and then that's the plan. That's my concern. []

SUSAN BOUST: And I'm not disagreeing that that is a very hard number to l and on, but what I heard in this plan is given our current allocation. So I think none of us, none of the leadership here from the state is planning on going to the Legislature and saying we need extra money. So I'm saying we've got what we got. And at some point you do have to deal with the issue of folks who are in crisis. You can't just continue to ignore what's happening at law enforcement, with the folks in emergency rooms. I'm fine with saying this is a temporary plan, but I think we've reached a plateau where we ought to at least take a stab at saying, given what we have in Nebraska, how much community inpatient assistance do we need? []

RON SORENSEN: Well, I'll work with Mary and see if we can somehow do a bed study, and you're talking about behavioral health beds specifically, right, in the hospitals, for start? Okay. I think we can get everything else we need. []

MARY ANGUS: If I could I would commend you, Ron, for expressing that particular...I agree, I think that when we feel like we have to have...and I don't argue, I've been overnight in an emergency room. I don't argue with that possibility. But when we look at how many beds do we need across the state, we're looking at...we could even be inflating the number that we actually need because until those community-based services are up and running, when they are up and running we don't need that many beds. We are absolutely going in the wrong direction. So I have to applaud your saying that. We don't want to look at a maximum number. It goes back to my statement about avoiding being hospitalized in the first place and the community services, which we can be very creative for and cost less. []

RON SORENSEN: Okay. []

SHANNON ENGLER: Ron, excuse me. []

RON SORENSEN: Yes. []

SHANNON ENGLER: One thing I do want to say is those of us that run acute units have been waiting for two years for these plans to materialize to take the pressure off of what we're experiencing, and it's not happened to date. So while I don't believe anyone would disagree with what you just said, I don't want the fact to be mitigated that there is a serious problem and there continues to be and we need to do something now rather than wait for a bunch of plans that may happen in six months or nine months or 12 months when we're at least two years into this at this point. []

MARY ANGUS: Okay, Shannon do you see...can you give me any sense of why they haven't come up? I mean, I am certain as being in your position you can see where they could have come up and haven't. Do you have any sense of why that hasn't happened? []

SHANNON ENGLER: I believe that there's different reasons in different regions, and Topher made a great comment earlier that while each of the subsystems kind of has different situations, each of those different situations then affects the entire system and we end up with what we have at this point in time. So we've been trying to get together to figure out how each of the regions can maybe do some adjusting that then ultimately it will impact the entire system, because again the acute levels of care and the emergency departments have been dramatically impacted by this. And I want to share with the room, a statement of a consumer that way back when we were having the planning in the regions, the Phase 1 planning. You know, that's been some time ago. But there seems to be a general sense that people think hospitals--bad; other services--good. And I can tell you what, during one of the meetings, and I'll remember this for the rest of my life, a lady said, when I'm sick I want to be able to go to the emergency room and I want to be able to be treated at a hospital; I don't want to sit somewhere out in the community and have someone watch me or whatever. And that really strikes home because when I'm sick with whatever it may be, I want to go to my emergency room and I want to get all the appropriate treatment, and if I need to be in a hospital, I want to be there. I don't want to be in some...I don't want to...I don't want to say cut-rate but that's what I'm thinking of. It's like, okay, we've got a whole population of individuals that deserve appropriate treatment. Let's not give them cut-rate treatment. Let's give them the treatment that they need. Okay. And I'm not suggesting that what we're doing is offering a whole bunch of cut-rate treatment, but, again, at the appropriate levels of care be that an inpatient acute hospital care is not inappropriate. It is appropriate for many people. []

MARY ANGUS: Yeah. And I think my comment was intended to commend Ron on looking at that in terms of reducing rather than, you know. But...and in response to what you are saying, there have been many times where I felt I needed to be in a hospital. However, some of the things that could have happened before it got to that point, aren't there. []

SHANNON ENGLER: Certainly. []

MARY ANGUS: And so at that point I would not have needed, even in my own appraisal, to be in the hospital. And so some of those things...I mean, it can...I don't know if you're familiar with dialectical behavior therapy, you're looking at what came before and what came before and what came before, and how can you use your tools. And that we can look at as a community too. We look at before, we look at before. We see what has happened in EPCs; we look at that. It would similar to a critical incident

report where then you have discussion as to why that got to that point. And that's where we have to...we find out what happened in that particular situation, see what systemically we can do to keep it from getting to that crisis level. When we are dealing with things on a crisis level at all times, that's tyranny of the moment--the tyranny of the moment. And if we can do some things to get it behind that so that I'm addressing the needs that I have before I feel a need to be in the hospital, it would be similar to getting an antibiotic when I first get sick instead of getting sicker and sicker and needing to be hospitalized for pneumonia. []

SHANNON ENGLER: You bet. []

MARY ANGUS: That's where I am kind of coming from. And that would address what Ron is talking about. That would address not having to look at...it's kind of the soft bias of low expectations. If we expect that people are always going to, and I'm not saying that they will ever not need it, but if we expect that people will always need hospital level of care then we're expressing that soft bias of low expectations. And, again, I do not say we would never need those. []

DANIEL WILSON: I believe...I've got to say, Mary...with all complete enthusiasm about prevention, we are decades away from not having a need for emergency evaluation and some sort of lifesaving care in behavioral health. We're talking about the scope of it. Right now, the footprint is too big. []

MARY ANGUS: Right. []

DANIEL WILSON: But we're nowhere near. []

MARY ANGUS: And I probably am not expressing it clearly enough. I don't think that there's a time in my lifetime that it will be totally gone, and I know that for myself sometimes that has happened so quickly that there hasn't been a lot that might have been able to prevent that. But...and I don't want to be saying we don't need all kinds of level of care, but again I'm commending Ron on his looking at that in terms of raising expectations for the community. []

C.J. MARR: Ron, and if I could just, on my point, I believe that we need, one, an inventory of all types of behavioral health beds in this state. How many do we have right now? And then if there's some way we could look at current need ratios to at least determine whether we have, at this point, given everything that's in place, what we might need or might not need. And then once you have that set, you've got something to compare against as each region talks about adding beds or looking at this need or looking at that need for further planing with the hope that you can start to reduce the overall number of beds. But I think what's interesting that we need to note, this are of subacute beds, there weren't any a few years ago, right? []

RON SORENSEN: Right. []

C.J. MARR: So now we have a new type of bed that's sort of come up that's being used and needed, but we need to track that and how long will that be needed and how many, as well as the acute beds, as well as all the other types of beds that are part of the overall continuum of care. I think that's our oversight responsibility. []

RON SORENSEN: And we have, in the past, provided you a map which shows the services, and we can provide the table that shows exactly what beds and what services are brought up as a part of the system. []

LINDA JENSEN: I was going to say, what you're asking is not just beds that the state has contracted for but beds... []

C.J. MARR: All beds, private and public. []

LINDA JENSEN: All beds that are available in the state. []

C.J. MARR: How many do we have in place and where are they right now. []

LINDA JENSEN: Not just the ones the state contracts for. []

C.J. MARR: And then you look at each region, and as I said, we're going to add seven beds at Kearney and 20 here. Well, that's fine, but against what type of need and plan? Or else we'll end up with perhaps more in some place than we need versus others. And again I'm not trying to get back to statewide planning but there needs to be at least some statewide oversight of the types of beds and the growth of them and how they're appropriately being used, and then you add to that the whole thing of payer mix. So it's a worthwhile exercise to help define where we're going, and measure it. []

TOPHER HANSEN: And if I understand, then once you see that picture, because we have a crisis in, say, Region V where we can't get people into the crisis center, doesn't mean we need more crisis center beds. It may mean that we need a better fine tuning of the entire system to do that. And so that...and of course then that is as of today. But when the state reaches $1.8 million in whatever distribution, we have to recognize the fact that we're growing and that we're in that tipping point in some areas where we're going to see more of this in different areas, and so on, and we have to be thinking about tomorrow. We can't put this together today and think we're done. And that...I think that measurement of how everything is going would be about as comprehensive a look at the system and fine tuning it as we could ask for. []

RON SORENSEN: Okay. Well, speaking of the system... []

SENATOR JENSEN: Why don't we...Ron. It's 20 after 12. Well, first of all, J. Rock, I think, had one question, but what I'd like to do is take a 30 minute break for lunch, and while we're taking that break for lunch, if you...I'm not asking that we do business but that you would look through the last several pages that Ron has so that we can begin discussion of those at that time. And so, J. Rock, your... []

J. ROCK JOHNSON: I don't want to stand between you and lunch, believe me. Einstein said that problems cannot be solved at the level that it was created. I believe that the office of rural health has most if not all of the information that's needed around where hospitals are and what they're doing. At least that's certainly the first place to go after. As a corollary, I'd like see a consumer-based needs assessment. There has never been a needs assessment of consumers. And I think...it's kind of ironic here that we have with us our behavioral health administrator who can stand up and tell us exactly what it is that we need to do, which is develop those low level, quote, unquote, services, but we have had embarked upon a course of rehabbing hospitals. And part of that rehabbing is, we're going to have so many hospitals down that people will continue in that (inaudible) hue and cry of, hospitals, we need acute beds. Just in part from the rehab (inaudible). And I would say, one comment, the strategy to address the hospital issues. Why are these hospital issues? These aren't hospital issues. These are the needs of people that need to be addressed, some of them need to be into the hospital. That's part of changing our way of thinking. And I see that what's stated here within the existing appropriation, improve access to and quality of community-based services. Well, I've come to the conclusion that this system is so underfunded it couldn't make change. Something (inaudible) could be done about that. []

SUSAN BOUST: Senator, I will be talking about some handouts which I would...if people are going to peruse something while they eat they might as well peruse this as the same time, as well. Pass them around the table, I guess. []

SENATOR JENSEN: Okay. We'll break for 30 minutes. []

BREAK []

RON SORENSEN: We mentioned the system just a little bit ago, and I know this is a very linear type chart and I know it's from about 50,000 feet or wherever, but it attempts to put some sort of a definition on how people move through the system. And we've been through this before but I wanted to talk about the bed allocation plan. We've developed...one of the strategies we've talked about and as I went through that plan slide earlier was that we were going to set aside a number of beds at the regional center by region, and that's the bed allocation plan. And the reason for that is, as we looked at the system and we looked at the issues of the beds being full at the hospitals, we spent some time thinking about, well, we've got people sitting at the Lincoln Regional Center

who are discharge ready and we can't get them out. And if we could get them out, that would facilitate moving people through hospitals quicker. And so that's what started this. As you may recall, we focused initially on two parts of the system. One was how do we keep people from ever having to get into this situation and we have the services down in the community to prevent that, and then when they are in the regional center they've been put there after commitment, how do we get them out? And when I came into the behavioral health division a few years ago, one of the problems, we had it recognized for some time was the problem of moving people from regional centers to the community. Regions would complain that somebody just showed up at their door. They didn't know they were coming. The regional center didn't call them; whatever the case may have been. On the other side, the regional center staff would complain that they couldn't find anybody to help them discharge people. And what we had was really, in the critical pass here, and that's right here in terms of getting people out of the regional center, it just wasn't working. And we spent, I know of three separate projects we identified in ten years to help specifically with the Norfolk Regional Center to move people back into Region VI. And I have to say none of them worked for various reasons. Some of them totally outside of the control of the system, thinking of political issues of are we going to close Norfolk or not close Norfolk, and all of that. But that's been a challenge. And as we looked at that, we wanted to focus on it. We wanted to say, how do we incentivize people to look at this? How do we get people to become more involved in the regional center discharge process? And the plan we came up with was what we called the bed allocation plan. So the bed allocation plan was a pretty simple one on it's appearance. It's a simple table where what we've done is, by region, list the population and we used the 2005 estimated census. And as you can see, the regional populations are in the second column there. And then the third column which says dedicated beds at LRC, I have to explain a little bit. When we did the original plan back in 2004, we gave money to regions based on the number of commitments they had in previous years. And so each region was given, based on commitments, a number of dollars. The number of commitments was computed using the number of days estimated in the hospital. We then determined the number of dollars that would go to each region for acute and subacute services. There was one exception and that was Region V. The decision was made in that process that rather than contracting with a hospital in Region V, because there was a regional center in Region V the regional center would become the hospital for Region V for all services, acute and subacute. So what we did when we did the bed allocation plan was go back and say, look at the original commitment numbers and say if we used those today how many beds would Region V have been given if they had been given money to do that in their community, and it's 18 beds. So right now we have 90 beds at the Lincoln Regional Center that are open for use. So we decided we would take those 18 beds right off the top and say those belong to Region V because they didn't get money to do that. So what that left is 72 beds. And so then we split up the rest of the beds based solely on the population. And obviously they're rounded off, so you can see Regions I and II, you get four beds; Regions III and IV get nine beds; Region V, with 17 beds plus the 18 ends up with 35;

and Region VI gets 29. And so that was the bed allocation plan. And the intent was that this plan would allow the regions to manage their own resources. When we distributed money on the reform, the excess of $20 million that went out to the regions, we were basically saying this is your resources to manage the people that are not or are no longer going to go to the regional center. We are going to close, for behavioral health purposes, Hastings and Norfolk, and we expect the people that would have been served there either to be served in what's in Lincoln or in your community. And so this was a logical step for us to say, okay, we're going to split up the resources at the regional center and this is what you get. You can manage that. You can manage who gets in and you also have, of course, the responsibility of working closer. You know, who gets in is a function of who gets out. If you don't get anybody out, nobody can get in. And that would give us, we hope, the focus on the discharge process and the movement of patients out so that regions could manage those resources. And that's basically the theory. I hope I've been clear about that. But that's the plan as we have proposed it. I'm going to go along here, as I...a couple things to keep mind are some operational issues you have to deal with in this process. Things like, we have at last count, I think...Bill, you can correct me...I think we have seven people now in Lincoln that really take up a whole room which means that reduces the number of beds by seven basically that are available. []

BILL GIBSON: In the general hospital, all of the accommodations are semiprivate, and for males, if we have somebody that can't have a roommate for clinical reasons, we have the ability to move them over to the security building where all the accommodations are private. Females, we don't have that luxury, so we have four (inaudible)... []

RON SORENSEN: Four? (Inaudible) four? Okay. []

BILL GIBSON: ...who are requiring private rooms. []

RON SORENSEN: Okay. So those are the kind of operational (inaudible) you have to work through this. Basically what happens in that case is if a person requires a private room, a female requires a private room, in this case, say they're from Region V, then that would count as two beds basically that were full. So longer term, when the beds become available, the additional ten beds become available at Lincoln, the numbers change a little bit, particularly for Region VI and Region V. I think everybody added at least one but Region I. So that's basically the plan. Questions about any of that? []

TOPHER HANSEN: The premise of the number that you arrived at is the 2005 census? []

RON SORENSEN: Yes. []

TOPHER HANSEN: Okay, my thinking is that if we didn't...if we weren't really engaged and didn't have our systems up and we established this number, but then as systems get up, theoretically we're going to fine-tune how all this happens. So what's the adjustment factor here? That is, if...let's take Region I, for example. If they didn't have any of their stuff going but then they got it going where we see they're using so much internally now that they have very little need for that, then you might reserve a couple because they might need a couple occasionally, but generally speaking, not. So maybe they would reduce down to two. I'm not suggesting they go to two. I'm just saying not having a system and projecting how many beds versus having an operational system might require a different number of beds. []

RON SORENSEN: Yes. In fact, I think that's demonstrated on the next slide. So what you'll see in this slide is the allocated beds at 90--I used the first chart, the 90 beds and not the 100; the current census, and again those four people there account for two beds, so what we've got is 84 patients when we did this. And what you'll see is, for instance, in Region I, you would...well, I'll point out Regions I, III, IV, and V, right now, you could say that...well, I'm not going to go that far. Let's take Region I. Let's say in Region I their system seems to be operating so that they don't need those extra beds. If you'll look at the referral list on the right, on the...that isn't a good move. Okay. (Inaudible) list on the right you've got on your charts there, what you'll see is what's is on what we call a referral (inaudible). And that...(inaudible). Okay, so in Region I you could say that they seemed to have managed their system. They've got, for whatever reason, they've got one person in there. We allocated them four beds and they've got nobody waiting to get in. Okay, so in that case we've got three empty beds. Well, we're not going to keep empty beds. We're not going to have somebody sitting on there for 30-40 days and have three empty beds. So that's part of the operationalizing of this, and that's balancing out when we have to balance out. We mighty keep one or two beds open, total, so that if somebody does pop up in Region I needing a bed, we would be able to access it. But we're not going to keep three empty beds for one region, so... []

DANIEL WILSON: Ron? []

RON SORENSEN: Yes. []

DANIEL WILSON: Ron, would Region I, for an example, be able to sell its extra bed? []

RON SORENSEN: Well, that...(laughter)... []

DANIEL WILSON No, this is a very serious question. []

RON SORENSEN: I know, and it's already come up. It's actually Region I has suggested somebody might buy their beds, but we're not going to let people buy bed at this point either. What we want to do is make this work, and it's going to take cost and

adjustment maybe to the numbers, maybe to the process, but we're not going to let people sit on a list for a long time and we're not going to ask regions to buy beds from other people because funds are short enough in the regions already. []

HOWARD OLSEN: Ron. []

RON SORENSEN: Yes. []

HOWARD OLSEN: Ron, why can't we just footnote that? I mean, even though the beds are given up, if the need then continues with a need for another bed within the 30 or 45 days, they'll be a bed available. []

RON SORENSEN: Yeah. []

HOWARD OLSEN: And you'll move the beds around such that... []

RON SORENSEN: Yeah. []

HOWARD OLSEN: ...(inaudible) be like kind of a shell game going on. []

RON SORENSEN: Well, in a sense it is, but we play the shell game now. If you look at what we've done here, and I will say I think right now what we do is just take people off the list, total, regardless of where they're from. It's the length of time on there. It's a level of acuity. You come up to the top of the list. Well, I'm sure...I don't want to speak for C.J. in Region V, but C.J. will tell you is that they've done a lot of work at getting their numbers down. They've spent a lot of time at it. And their concern with the current system is I empty a bed but that doesn't mean I can get somebody off my list. It's going to be somebody from someplace else. And I would much rather manage my own resources and get the people in there I know need to be in there, and then that responsibility would fall to every region, that as long as I keep working on discharging and as long as I keep working in the community to keep people out of the regional center, I've got resource to manage at the regional center and hopefully keep the flow of patients moving through. So that's what we've been in the process of discussing. We agreed that before we implement this we're going to be meeting with Dr. Boust's group, the psychiatrists, and I think also the medical association, right, to discuss this in more detail. But basically that's what the bed allocation plan is; I'm sure you've heard of it. It is fundamentally to identify a way to help us manage the capacity at the regional center and promote people moving through in an effective manner. When you've got 20 or 25 people sitting there for a period of time who are discharge ready, that's not fair to the patient. It's certainly not appropriate. And it doesn't help them recover at all; it might even, in effect, do the opposite. And so that's what we hope to encourage here as we move forward. It creates some problems. Obviously in Region VI in implementation it presents a problem because they wouldn't be able to get people in for awhile, but we've

talked...we've discussed different ways of managing that to start off with. And I do want to add here that Region VI has really worked hard here to make this work. It shows four over, but I think they took...and help me out with the numbers...I think they took six people off the referral list this week. Am I correct? So they've worked hard on the referral list. I don't know how long, a month or two ago they had 16 empty beds at telecare out of the 32 total in the two facilities. There's now 8 beds available at telecare, so they've done a lot of work in getting people to move and use and utilize the capacity that's already available. And I know Patty's got a person on board now that is working...I don't know if she works full-time on this but probably has to work pretty much full-time working with the Lincoln Regional Center to make this work. In fact, I know Dr. Boust is going out there today to look at some people that might be moved out. So that's basically the plan in the simplest terms. Yes. []

TOPHER HANSEN: My understand was it's supposed to be effective February 1, and that as far as anybody knew it was going to start February 1 but hasn't? []

RON SORENSEN: We were asked to delay it until we could talk to the psychiatrists and medical associations. []

SENATOR JENSEN: Susan. []

SUSAN BOUST: Actually, I want to thank the state for their responsiveness to the concern about process and adequate input, but although I think the physician input into this is really important, actually what I had said was, we were told about this as a possibility in November and told at that time it was very much just an on-the-drawing-board, don't worry about this, so we didn't discuss it in here. And then it was going to be implemented before it could be even discussed in here again. And this is one of the few places where physicians do sit at the table in this planning process, so I appreciate that the state was willing to say let's take this step back. I did want to take just a brief opportunity, too, to kind of do my own reaction to the plan, and we will be setting up a conference call with the state people and the Nebraska Psychiatric Society and the Nebraska Medical Association's mental health task force. But I had concern about this on two levels: one, as a physician, and one as a person from Region VI. I think the physician is the more important piece of that, and if you'll give me just a moment I'm going to tell you a story about the veterans' affairs hospital in Omaha. When I started as a resident, there were...which was (inaudible)...there were over 100 beds there, and every night, on call, veterans would show up in the local emergency rooms because the VA hospital psych beds were full. I was on call yesterday and they had one person in the hospital bed of their now 16 beds, and you haven't even heard about this. One of the staff from there gave the grand rounds on Wednesday about how they did this, and they did it with a combination of two things. They brought up appropriate rehab services and they worked with their doctors to change how they do business. Now, I happen to...they put in a thing called advanced clinical access, and I

happened to be around when the VA administration proposed that, and believe me, it was not met with open arms by the doctors. They didn't like it; it wouldn't work; it wasn't possible. And now, three years later, they love it and they're responding to the needs of the patients at the VA. Advanced clinical access. What they did was they started a relationship with their patients so that when the person came in and got a new set of medicines or their meds refilled, instead of giving them their next med check a month from now, they said you call me when you need to come back. And for those people who couldn't maybe make good judgments about when they needed to come back, they made sure that they had a rehab service that was connected with them. Now the doctors, instead of having every minute of their outpatient time blocked out for committed appointments out four months, they've got open time of their schedule and they see up to 4 to 6 walk-ins a day. These are folks that they can then meet their needs right at the time and defer them from going to the emergency room. If my contention to the statement, I think you'll hear this from the other doctors, if you...you're downsizing hospitals. If you do not get doctors involved in your system change, it can't succeed. Now, I don't know how to tell you to do that, but I guess I would start with this conference call. I would start with saying to the regions, and I've said this to Patty in Region VI, she held two forums about two years apart, and had over 50 psychiatrists at each of them. Doctors are eager to join this and talk about how we can work together. There is just no place at the table for us. We are here at this table but you have your providers meeting. How many physicians are at that? How many physicians are contracted? I mean, we just maintain this fragmented system where the hospitals are sticking out here and the doctors are over there and then the rehab services are over there and the state hospital is over here, and we have a crisis in beds and I think that's why. A couple other things. In your document, and I don't know if this the most recent...this is a draft, 1-22-07, and I understand the need to make a policy to try and do something to deal with the regional centers, but there are two pieces of policy in here that I think need to come before this body. One is what is the role of the regional center? And this document says the Lincoln Regional Center is evolving into full force for extended psychiatric treatment at a publicly funded treatment center. I'm saying this body ought to at least weigh in on do you want to have the Lincoln Regional Center be extended for some, acute for others? This document says it is the responsibility of the regional program administrator. Desired outcome number two, consumers who are EPCed or committed will received treatment at a local hospital or crisis center and returned to live in the community and receive community-based services. Only when the individual cannot be safely or effectively stabilized at the local level will persons be treated at the regional center. I do not see that desired outcome reflected in this plan. This is essentially a triage plan. And while it might be a really nice idea to have people at Region V or Region I to have immediate access to a hospital level of care, these are clinical triage decisions and you do not leave somebody...you're talking about your front door, that admission. You are responsible for prioritizing, and my firm belief is that ought to be on clinical need and not on date that they were entered on the list. Now, maybe all things the same, you go by the date, but I happen to have a person right now who is in

an absolutely inappropriate level of care and getting physically harmed and should have been moved to the regional center long before now, and I guess that needs to be a private conversation. []

RON SORENSEN: Well, actually though I think that's what we're saying is that the regional have the responsibility for determining how quick they can get in. We always take emerge...you know, what this doesn't address is what we call priority one, and that's people who are violent, need immediate care. We make room for priority one. I don't know how it's described at, but if a hospital calls up and says we've got a violent person, we can't handle them, Bill moves people around. And I think we've done and been pretty responsive about that. So in terms of the...I don't...I wouldn't confuse priority one with... []

SUSAN BOUST: Okay, so you're saying all of the... []

RON SORENSEN: Yeah, a priority one is technically not on that list. []

SUSAN BOUST: So priority one can go around this and you're saying you're handling this as a triage by that. []

RON SORENSEN: Sex offenders, in the old system which we don't have so much of this (inaudible) now that LB1199 passed, but priority one was reserved for sex offenders and those who were extremely violent and we couldn't handle them in the hospital. []

SUSAN BOUST: Okay, because I... []

RON SORENSEN: This really doesn't deal with priority one. []

SUSAN BOUST: But I guess I say again then that's part of where that system is broken because I'm sitting here today. I was talking with my person that I've been working with who is absolutely in that priority one, and nobody at the hospital even seemed to under...well, I mean, they work with you all the time. Why isn't she moved? []

RON SORENSEN: AT the community hospital? []

SUSAN BOUST: Yeah, Alegent. I mean, I will follow up on that with somebody else too to make sure that that's handled appropriately. But, I mean this...so I believe that part of the thing that's broken with the system is you, our PAs, and again, forgive me, Patty, you can't even see the doctors. You don't have contracts with them. You don't...we just aren't spending enough time talking to each other, and the same is true with the state. And if you don't get the doctors on board and working with you and getting some adjustment made in those urgent outpatient kinds of things, it's very hard to turn this around. I said the second thing was my concern as a person from Region VI, and that

was the reason I handed out this other piece of paper, and I will say that I am spreadsheet...I have a spreadsheet deficit so if my numbers are wrong I actually... []

J. ROCK JOHNSON: That's not the only deficit. Are there any more papers? []

SUSAN BOUST: What? []

J. ROCK JOHNSON: That's not the only deficit here. []

SUSAN BOUST: It's true. []

JEFF SANTEMA: Some of the members may not have it, Dr. Boust. []

SUSAN BOUST: I handed out all of the copies I had. []

MARIO SCALORA: There are some extras here. Who needs one? []

SUSAN BOUST: The asterisk at the bottom goes into the $16,000 column E for Region V as an indication of the money that the state has allocated for this 18 beds at the Lincoln Regional Center which was in the neighborhood of $2.7 million. And again, I'm...most of my concerns really are about the clinical piece. You know, what is the right role for the regional centers? Are we getting local hospitals on board? Are we still having resistance from the local hospitals actually doing that level of care they can do well and not sending people inappropriately to the regional center? And are they getting paid for that time that they're doing that care or does Medicaid cut them off the minute the put the person's name on the waiting list, which is another policy issue. But them, as a Region VI person, I look at this and I say, okay, if you make Region V's deficit well by shifting these beds, they still aren't quite up to their appropriate percentage for regional service funding. But Region VI is really (inaudible). []

RON SORENSEN: Can we talk about how we allocated funds? In 1999 and 2000, the regions in the state adopted a policy in terms of allocating appropriations, and basically it comes down to allocate funds we used a formula that involved 75 percent population and 24 percent average income for a three-year income average. We contemplated poverty rates, we contemplated a whole bunch of numbers, but the one that was most workable was poverty. And the reason for that was because there is an enormous disparity in family income between the eastern part of the state and the western part of the state. And so we attempted to compensate for that by allocating...and now, what you don't see on here is any...is what that would represent. And I will say and what our plan at that point in time was we were not going to take money away from anybody to balance it out based on the formula. We were going to, as new money came in and we could split it up differently, we would help to balance that out based on the formula. Unfortunately, there hasn't been a lot of that occurred over time. So there will be some

disparities. I think there are a couple of things that have helped though to get it even maybe further out of whack, and that is the population, as everybody knows, continues to shift to the east. So I'm sure that if we looked at that formula today it would still be out of whack, but it's a function of allocations made specifically for the purpose to raise what's in the regions. So until that happens, that's what the formula is. []

TOPHER HANSEN: I still don't understand why...I agree completely; you've got to get the docs on board. It's got to be one thinking about how we go about this. There is a diversity of activity depending on the population that's being served and how you do that, and you always have recovery in mind. You always have discharge thinking in mind from the time people show up at the door. You always think about consumers, not agencies. There are all those principles that apply. I agree wholeheartedly. I think we all ought to be on the same page. I still don't understand why we aren't doing bed allocation right now at the regional centers so we can at least get started with something and proceed on and fine-tune this as we go, if what we want to do is look at it on an annualized basis or something, to, one, look at population shifts, to look at performance, all manner of things that would help us adjust so we maximize our efficiency. That's fine but we have to get started at some point. We can't delay and have a conference call and have meetings and do things that aren't going to change the end line for right now. []

SUSAN BOUST: Topher, would you be okay with this bed allocation plan if you took the 18 off the top for Region V and just did it straight by per capita? []

TOPHER HANSEN: They gave Region V the money to run 18 beds ate the crisis unit. (Laugh) I mean, the problem is, we don't have any acute care. Everybody else got money for that but Region V, so if you did that, what you're doing is just...so you would have to put in some other place. Where it is now, when everybody talked about it in the beginning, was that that be at the regional center. So I don't know. I can't speak for C.J. who has the fine tuning more than anybody in Region V, about if you took the 18 and just put it someplace else in a contract, but the point is, we need those beds to help manage our system. []

SUSAN BOUST: I will tell yo, as a commissioner with this statewide view, I would rather go to the Legislature today and ask for the money to fund Region V that they need for their crisis services than split up the function of the regional center and have it function one way for one region and one way for the rest of the state. I think we will have a healthier system if we all go together and say we have to fix this than deal with Region V using the Lincoln Regional Center in a different way than the rest of the state does. []

SENATOR JENSEN: I think Dr. Wilson had a...were you done? []

SUSAN BOUST: Yeah, I'm done. []

DANIEL WILSON: That was very much what I was going to suggest, Senator, although I think long-term, especially this idea of having the Lincoln Regional Center be an acute care hospital for Region V and be a long-term receiving hospital for the rest of the state doesn't make any sense. It may have seemed like a good idea, given the situation six or seven years ago, but we do have to figure a way or make some recommendations about how to fix that, long-term. And you...somebody, maybe it was you, Topher, well, that's come up a number of times, the idea of integrating the whole system of care. We still have the private hospital sector more or less disconnected from the public regional authority and the community agencies in an operational way. There's not anything driving clinical integration during reform that I've seen. Most other states that have gone through reform will have certainly allocated resources change and follow the patients and all of that, consumer involvement, and recovery principles, but there's also specifically clinical insight triaging in most states I've been in. In Ohio, for example, which is one of the highest rated public mental health reform, there's a chief clinical officer for each of the region equivalents who actually is the one figuring out constituents with hospitals with consumers, what needs to happen with the clinical services. We don't have that or if we do have it, it's haphazard and inconsistent. It's beginning to develop but it needs to be cultivated, I think, very strongly. And long term, the idea of the Lincoln Regional Center being the acute care psychiatric hospital for indigents in Region V doesn't make any sense. []

TOPHER HANSEN: Well, the problem is, that's where we put all our planning, all our bucks, all our focus, and to switch it at midnight is not, I think, a good idea. Now it may be that what happens is that you continue to redevelop thinking because certainly years pass and we understand a wisdom that can be more beneficial to the greater good, and maybe that's it, but I think what we have to do is we have to start operating. And if this is the system that we have right now and then we want to start talking about how can we make it better, then let's have that conversation, but to put it on hold and to set up meetings and calls and so on, this is completely hamstringing the operations of Region V to put it on hold. And I say that what we need to do is get that system going, start operating under that premise, and then let's continue to review what our policy is about what is the regional center going to be for the state. But we can't tie up the entire system while we're having a conversation that is practical, political, and all sorts of things; it will take forever. []

DANIEL WILSON: Well, I wouldn't recommend tying things up forever, but I like Susan's idea of taking a little bit of time. Unless, Ron, can you explain the clinical input into this and the consumer input into this actual development of this plan? []

RON SORENSEN: Well, actually, it was, I guess...I think we met back in September, was the first time. I'd have to help from the regions here on this. (Laughter) September 14 was when we first met and talked about this plan. (Laugh) Obviously burned in

Region V's historical records. Yeah, it was an afternoon meeting, I guess. []

DANIEL WILSON: And "we" being who? []

RON SORENSEN: All the regions, our staff, and our staff included Dr. Schaefer and Lee and the field reps. I'm not sure. I'd have to ask the regions who they brought to that meeting. I'm not sure. But that was where we started the first discussions of this. Then when we got in, as I mentioned, the hospital issues we talked about earlier was probably where the next place we took that. That was...I think I gave you the dates there, probably in November, I think, we talked about that. []

_____: November and January? []

RON SORENSEN: Yeah, November and January, is where we continued to talk about that as one of the elements of helping keep the beds moving at the hospitals was to improve the access to the regional center. But that's the further process we went through. A lot of discussions in between on individual an other basis. But hashing over how it would work, what the problems were, and all that. Did not involve...the doctors were not involved, and that's why we agreed when it was raised with us that we would involve them. We'll be having a conference call with them about it to explain it to them, as the next step. []

SENATOR JENSEN: Dr. Adams. []

GORDON ADAMS: Much of the rationale for LB1083 was this idea that we can capture Medicaid funds. And with this, as I would understand it, sending these patients to Lincoln Regional Center, you're not getting your Medicaid funds? Is that correct? []

RON SORENSEN: Correct. []

GORDON ADAMS: And they would be eligible for Medicaid funds, if they're otherwise eligible, if they were in a community-based facility. []

RON SORENSEN: Right. Right. []

GORDON ADAMS: Why in the world wouldn't we go ahead, since we've gone this far, why exempt Lincoln from the rest of the state? []

RON SORENSEN: Well, you're...the issue right now is, given the policy decision, whether it was the best decision or not, the issue right now is to compensate Lincoln to move people...or, to give them the funding required...and I don't remember what that was. It looks like it was two point... []

_____: $2.7 million. []

RON SORENSEN: ...$2.7 million that you'd have to find to give to Region V, unless you want to take it away from the other regions. That...I mean, as we've mentioned before, there is a set amount of money available as a result of reform. So you either... []

GORDON ADAMS: There would be more money available if you could capture some Medicaid funds. It wouldn't be the total loss. []

_____: Sixty-forty cut. []

RON SORENSEN: Well, you're not going to come up with $2.7 million, I'll tell you that. []

DANIEL WILSON: Well, I think, Ron, though, there's a risk, certainly, in this, I feel, of locking in this unworkable configuration long-term. And I don't...I'm all for having the allocations be essentially per capita, and having it monetized and very dynamic to reward regions that are doing well, and to not reward people who are not doing well, long-term. But we...is there any discussion about, how do we get out of this patch we've gotten (inaudible)? []

RON SORENSEN: Well, there are a lot of alternatives, Dan. We have talked about, as part of a group, other options. In fact, one of them was the Ohio model, where--you're probably familiar with--where actually they organize it a little differently. They have...they don't call them regions; I think they call them mental health centers, don't they? []

DANIEL WILSON: They're counties (inaudible). []

RON SORENSEN: Counties do, yeah. But what they do is, all the money goes to the counties, and the counties then contract back with the state hospital for a certain number of beds, depending on what they think their need will be. I mean, that's something we've talked about long-term. I got to tell you, in the last two and a half years, I'm not sure anything has been permanent at this point. We keep trying to adjust the system as things change. We keep trying to find what's popping up lately that we can solve. And this is the strategy that we wanted to go forward with at this point. We would be looking, long-term, I would think, at something like how we contract with regional centers to deliver services. []

MARY ANGUS: Okay, I've got a couple. One is, Susan and I talked a little bit about this on Wednesday, and in conjunction with the physicians being involved in all of the planning for, you know, diversion, if you will call it that, prevention, and designing some type of a plan to keep people out and to keep them moving out. Having consumers involved is...any one of us in this room could sit and brainstorm all we want, and I'm not going to come up with as many and as varied solutions as Susan and I could come up

with together. So having that--and this goes back to what Dr. Wilson is saying--having all the people at the table can come up with so much more variety and creativity. Secondly, to use the Lincoln Regional Center for acute care setting, I don't know how many times when I have gone into the hospital--and boy, am I self-disclosing a lot tonight--when I've gone into the hospital, how difficult that is to just be in that...in the waiting room, the assessment room. I have curled up on that couch and just not known what to do, the trauma is so great. You walk me into a regional center building, and I'm in the regional center. It doesn't matter what somebody else calls it. It doesn't matter that you call it acute. Does not matter. I'm in the regional center. That is a hundred times more traumatizing to me. At the same time, the state is involved in reducing and eliminating coercion of all types, including restraints and seclusions. And for us as a state to be using a regional center or to be using any kind of involuntary, if we can avoid it, is not in keeping with some of the policies that are happening in the state and that are changing in the state. And so I think we're talking about a potential policy change at this point. Thirdly, when we talk about Medicaid paying...and it's about a 60-40 split for most services in the state of Nebraska. When you're in an institute of mental disease, which is a regional center, any place that has greater than 50 percent of the people in there are there for behavioral health, over 16 beds or people, then you're talking about no longer getting any Medicaid cut. So financially is part of what we're talking about right now. It doesn't make sense to use the regional center. It is also illegal to keep people in regional centers past discharge. And I know, Senator Jensen, you talked about this at another meeting I was at, where there have been lawsuits against the state for illegally confining someone to a regional center. And for those of you who are not familiar with theOlmstead decision, that was the decision that said that people have a right to community treatment, and that states cannot hold people longer than they are discharge-ready in a facility, and money does not, does not give an excuse, it does not exempt you from being...havingOlmstead applied to you. And when we talk about LB1083, one of the biggest impetus for LB1083 was thatOlmstead decision. This state does not have anOlmstead plan. And in terms of the effect, this is ourOlmstead plan. So for us to in any way not do what needs to be done, Ron, I know, even when we can't find the money, we're still in violation of that federal decision. []

RON SORENSEN: And I understand concerns about that. I think technically the law says, if there are services available in the community. It's not a law, technically, it's a court decision. But that's the... []

MARY ANGUS: No, it's a Supreme Court decision. []

RON SORENSEN: Yes. []

MARY ANGUS: And one of the things that those funds need to be available for is community services, so that someone who is discharge-ready can come out. And I'm not a lawyer, so...and I don't play one on TV. []

RON SORENSEN: Yeah, and it's not much...I think we're all on the same page of what needs to happen. []

MARY ANGUS: Yeah. []

RON SORENSEN: And I understand that. All I can tell you is that the decision was made at that point in time to have acute services at Lincoln. I don't know all of the background for that. I don't know...I can't speak for Shannon. I don't know if the hospitals weren't willing to do that, if that was part of it. I have no idea. []

DANIEL WILSON: Ron, I think it doesn't even matter. What matters is, going forward, there needs to be a transition from that plan, which served whatever purpose it served, to full implementation of mental health reform in the state that includes Region V and includes deinstitutionalization from state care as much as possible. []

MARY ANGUS: Right. Do we need to or do we want to, as a body, suggest that we look at policy change, so that that doesn't happen? I'm asking the commissioners. And if I'm going off topic, I'm sorry, but... []

MARIO SCALORA: I don't disagree with what's being said. But you know, I've been sitting with all of you for two years. This was not a surprise to us for the last two years, and now all of a sudden we're acting like we found something new. And I agree we need to figure out what to do with the regional centers. That's long overdue. We need to make sure the triage issues are managed. But the fact is, right now, we put Region V in a very difficult bind. []

MARY ANGUS: Yeah. Yeah. []

MARIO SCALORA: And I know you're not suggesting turning the switch, but in the short term, we need to allow them to work with the rules that were set for them. They've been one of the hardest working regions for preventing hospitalizations, protective custodies, commitments. We need to allow them, in the short term, to get going. And in the long term, or the intermediate term, if we want to sit down and change the rules, let's do that. But let's talk about that mechanism as a separate issue, without putting that in jeopardy. And I think, frankly, we're punishing Region V for doing what we told them. And when you look...and from someone who works at the regional center, and being pressured from all sides to get people in and out, yes, we do get the emergency people in, and without question. And by the way, six regions have six very different views of what an emergency is. And your point is well taken with regard to that. We need to look at the clinical triage piece there. But regardless of that, we're bringing in people. There's also six very different sets of priorities about when to move folks. What I saw as valuable with this...and we can play with the numbers, and maybe the numbers are not right, and

I certainly am open to looking at that. The problem is, until there's incentive for the regions to declare their priorities, basically you're putting it in the hands of the state, who do not control anything other than the recommendation of when people should leave. And so there is some benefit, even at a bare-bones...as a triage administrative piece, to do that. And is it ideal? Absolutely not. But it's certainly substantially better than what we have now, and I would look forward to our bringing something to the table to do something better. And Susan, I know I triggered something, so please. (Laughter) []

SUSAN BOUST: Yes. The trigger was, for me, I guess nobody has been surprised that the Region V area has been using the Lincoln Regional Center... []

MARIO SCALORA: Right. []

SUSAN BOUST: ...as a very good partner for them, for a very well functioning system. And as we've been having...reaching this crisis level in the state about beds, and as we've downsized, and now Region V is having difficulty getting folks in, what triggered this discussion today was the process. This was discussed as a potential, in November, at this meeting, and said, we don't even need to talk about it, and then was going to be a policy before we could talk about it again. So... []

MARIO SCALORA: And I respect that. I do. []

SUSAN BOUST: ...so it isn't the fact that Lincoln Regional Center and Region V have a special relationship and we need to do something different. The issue is a new policy that fixes what is now a statewide crisis in access to acute care for Region V when we're all in crisis. []

MARIO SCALORA: The difference is, though, Region V's crisis was state-driven in many respects, because they were told to...they were told where to purchase their services. []

SUSAN BOUST: And Mario, that is my other real concern about this policy, is, this is the first time that I've heard this kind of heated region against region: This is your fault; this is...Region V has done really great things. So has Region VI. []

MARIO SCALORA: I don't think I was contrasting Region V to Region VI. I was saying, basically, if we all of a sudden change the rules on them at this point,... []

SUSAN BOUST: And don't just leave the rules as they are. []

MARIO SCALORA: As I think we all are in agreement. []

SUSAN BOUST: But that's not a new bed allocation policy. That's a new policy. []

TOPHER HANSEN: But the rules as they are keep Region V under what is projected as our need. And we need to get at a level that we can utilize this. We're... []

_____: You know, Topher,...I'm sorry. []

TOPHER HANSEN: And what I'm saying is, if the calculations are this, and we're saying that there's a certain number of beds, whether it's acute and long-term together or not, that's what the plan was, and we need to get in and be able to operationalize, so we can open the system, everybody knows what to expect in terms of use. I am in agreement with Mario. We need to sit and look at all this as a policy matter and decide, you know, this isn't really the right way we want to use this, or we have a better idea, or whatever it is. But conversations have happened at the management level, in terms of all the regions and State Behavioral Health. We have known about it since the beginning, that Region V would have acute services there. That was the plan. We didn't decide that at Region V provider meeting. We were told that's how it was going to be. And so now what we need to do is be able to operationalize it to continue to help our system flow. And I think people, providers and administration, everybody at Region V, are open to the conversation. But we really need to operationalize some system we can count on. We don't have a system now that we can count on. []

SENATOR JENSEN: Can I just interject a couple things here? First of all, when we passed LB1083...and for those of you who have not experienced that, but to be in a Legislature, and you submit a bill, and it isn't too often that that bill comes out exactly as it was introduced, and LB1083 certainly was not, and...from where I introduced it. And there was a great deal of negotiation, negotiation to...we took out some dates, we did some other things. We wanted to satisfy, certainly, Hastings and Norfolk, and I think we've done a pretty good job of that. And along with that, yes, Region V was kind of a unique animal, and in order to not upset the applecart, we continued along that process. Again, if you were to start from scratch, you'd do things differently than what we had here, with a system. I'm also very, very pleased with the progress that we've made. Now, when we also passed LB1083, we had no idea that the Lincoln Regional Center was going through a complete revitalization of its building, where we've actually closed, in some cases, 40 beds that we thought were there, weren't there. Douglas County has dropped ten beds, I think, isn't it? []

_____: Eleven. Eleven beds. []

SENATOR JENSEN: (Exhibit 3) Eleven beds, and we didn't realize that was going to happen. But all those things come along the way, and so we've kind of moved back and forth with the flow. Lincoln, Region V, it seems to me, one of the biggest things that it's missing is the subacute care. Well, prior to LB1083, we really didn't have subacute care anywhere in the state. Now we've found that a very, very important factor. Well, in light

of all that, and certainly discussions with Jeff, and I have prepared--and maybe we could start with this and work on it--a draft of a resolution that I'd like to put before you, and it might help in some of this. Now, whether we delay this a month or however long...certainly, we need the physicians, we need the...all of the input, and the docs working on this. But what this resolution would do is establish a regional center commission of all the three reg...recognizing that, you know, Nebraska became a state in 1867, the University of Nebraska was established in 1869, we opened up the Lincoln Regional Center in 1870, and about in 1871 or '72 we did Hastings, and the following year I believe we did Norfolk. So we've got regional centers that have been there now 135 years, and I think it's time that we look at a long-term approach as to what should be the role of the regional centers. And so with that, I brought forth this resolution. I was going to take it up at a later time, and we can do that at a later time. Let's finish where we are here, particularly with the department's presentation. But that the commission, under the direction and consultation with Health and Human Services Committee of the Legislature shall oversee, support implementation of the Nebraska Behavioral Health Services Act, and shall administer such funds as appropriate by the legislation from the Nebraska Health Care Cash Fund. So we've got some dollars that we can actually bring forward to hire experts that will look at facilities' needs, and so on and so forth, perform such other activities as necessary and appropriate to carry out its duties under this section. Members of the regional center task force shall be appointed by the chairman of the commission, and consulted with the Chairperson of the Health and Human Services Committee. The task force shall develop research and recommendations that will assist in the development of long-term plans for the regional centers at Lincoln, Hastings, and Norfolk, but not limited to the long-term disposition of land and buildings at the regional centers, the population to be served at the regional centers, and the core mission and function of the regional centers in future implementation of behavioral health reform. One thing government doesn't do is really do long-term planning on very many things. We work on a budget year, biennial budget, and we try to satisfy that. We don't look much further beyond that. So like I said, in light of the discussion, this is a resolution I'd like to present before you, that we can take up in a little...after this discussion. How long, Susan, after meeting with the physicians and the docs, would you anticipate some kind of resolution? The department has said, okay, we'll pull this back from February 1 for 30 days, and what happens? What can you do, and what, if anything, will change in that period of time? []

SUSAN BOUST: I think the physician involvement is a long-term thing. As I said, I'm pleased that the department has recognized the lack of physician involvement and done something about it. I think this one task force doesn't fix or change anything, other than to let the physicians know what's going on and the state to once again recognize that they've got to find some way to work with them, and maybe get the regions involved with working with that. I fully expect that this policy...impact on this policy is going to come out of today's meeting, not that conference call, is what I think. []

SENATOR JENSEN: Okay. Yeah. []

SHANNON ENGLER: Senator, I just need to say, because I don't want the...I wouldn't want the main intent of this to be derailed with a lot of other discussions that are going on. And I'll thank J. Rock. This is about people, when we're talking. And it comes out in the term "bed crisis," but you're right, it's about people. There are people that can't get into inpatient units because they're backed up, or that are sitting in emergency departments. That was why a collection of hospitals went to Ron, talked with the Governor, has had several discussions, as a result of...and what we requested was an immediate solution, because as you're aware, the legislation, why we're all here, is to oversee that there is an appropriate number and array of services present to reduce regional center beds. And if you hear the theme that's going through these conversations, what I hear is, whoops, there aren't. Okay? And so that's what we asked for, was a solution. And Ron listed several solutions here, one of them being a bed allocation, which as Topher said, that's not the be-all, end-all. But as we move along, some things need to be implemented and then tweaked, adjusted, however, reworked. We talked about the original plan, and that whole thing needs to be re-looked at, because we're a long way from, you know, all those original phase one meetings and things like that. But I would just really ask my colleagues here to not get caught up in some of these other things. We do not have an appropriate number and array of services, or we wouldn't be having this conversation. And we need to do something about that. I mean, that is our charge, whether it's to inform someone, or, you know, try to approve a plan going forward. Whatever that is, I hope we don't lose that, and I hope that is what we do. And the bed allocation model is one model which, it does seem to serve a purpose. And whether or not we get into how Region V was, you know, originally allocated beds and all that, I mean, that isn't going to help today or tomorrow or next week. And that's what we need to do. So if we can move ahead with this, I don't know. But I just don't want everybody to lose sight of what the big picture is here, so. []

SENATOR JENSEN: Bill. []

_____: Shannon, I...oh, I'm sorry. []

SENATOR JENSEN: Excuse me. Bill. []

BILL MIZNER: I just would like to say that I don't have a problem with what Shannon said there. I think that that sounds good, because to stop creates issues in Region V. I understand that. I also recognize what both Susan and Dan are saying about, we can do this better. My concern about moving forward with what was planned is that generally, when you implement plans, then any further work on it stops, because now it's been taken care of and there's no real impetus. What I see as being a real impetus to dealing with the issues that were brought up is that you don't do anything with Region V, because that keeps the feet to the fire to get it done, because there's the issue to

deal with. If we could still focus on dealing with that,...I mean, as Dr. Adams said, if we are losing money that could be coming in because we've got these beds at the Lincoln Regional Center, that seems to be pretty poor management on our part. I mean, that's why this whole thing came about in the first place. So why are we stopping short right there? If we can agree to focus on dealing with that, and really pursue it, even through the task force that you suggested, and make that the priority to really focus on that and deal with an issue to get that separated out,...if it means going to the Legislature and asking for funds, I understand that the emphasis this year and every year, last year, next year, and 27 years from now, is to cut taxes and hold them down. But that's the Legislature's concern. Is our concern to really focus on holding those down for whatever reasons we want to do that? Or is our focus to deal with the mental health issues that are faced with those people in the state? And if that's the case, and it needs some more funding, then I don't think we should be afraid to go to the Legislature and request that we receive that additional funding. Otherwise, we'll find ourselves in Florida, where Ron's counterpart down there is being charged with contempt of court because they refuse to remove people from the jails because they've got no place to put them. Now, I don't want to see us come to that point, partly because I'm concerned about... (Laughter) []

_____: (Laugh) Ron doesn't want it there either. []

BILL MIZNER: (Inaudible) does not do the consumers any good to sit back watching all this other stuff happening and they're not being dealt with. So I don't have a problem moving forward with it, as long as we can commit as a commission to really focusing on these issues that have been brought up to deal with these things, to really make the process as efficient and effective as it could be, rather than just leaving it as-is because that's just kind of what we worked on. []

SENATOR JENSEN: Yeah. Linda. []

LINDA JENSEN: I think it's a consumer recovery issue, if we really think about it, because like Mary said, the trauma of going into the regional center can be enormous, and, yeah, maybe another couple weeks that you end up being hospitalized, or whatever. Now, I don't have any stats as to how that's working out for people, but it just seems to me like, are...you know, are we really recovery oriented, or are we just concerned about where we're going to put people? []

SENATOR JENSEN: Topher. []

TOPHER HANSEN: Well, I think one of the...that's true. And I don't think the plan was a good idea at the outset. But it has been the plan... []

_____: And so you've got to do something now. []

TOPHER HANSEN: ...all along. It's what we have, and the 12th hour has come. And so to all of a sudden pull back on the plan I don't think is good, because people are being harmed by not having access, and we have to minimize that, and then rethink how we're doing it. Region V has the most interest in this, and have all...although not a provider in Region V, you live within that world, Shannon does, I do. We're all saying, we think it's a good idea to rethink this. But in, for instance, one of my previous lives when I had to go make argument to courts about temporary injunctions, one of the things the court, the arbiter system thinks about is, what course of action is in place, and if I stop that, is there harm that's going to...irreparable harm going to result from that? And here, that I think there can't be shown irreparable harm by moving forward with this plan; whereas if we don't take course of action, where the region can begin to count on its resources and manage that, we do show irreparable harm of individuals. And therefore, I think we ought to move forward with the plan as stated, not delay it, continue to have the doctor input, the consumer input, continue to rethink it at a policy level here, and revise our plan. We have to all have our eye on the same ball and be heading in the same direction. And I think to have quick access to leverage money, provide quality services, is what we're all talking about. And right now, we have kind of a broken idea maybe, but it is the idea that's on the table. I say we implement it and begin action on how to revise it. []

HOWARD OLSEN: Senator, is this resolution, this draft resolution, one of the focuses of that task force would be to work on this issue? []

SENATOR JENSEN: Well, you know, I just thought that perhaps it could be included into it. Again, this will take some time. I think I was asking for a report back in six months, and final report December 1, before the next session. But... []

RONALD KLUTMAN: So this is for information to be (inaudible)? []

SENATOR JENSEN: Well, no, I was going to present this later on today. []

_____: No, this is a resolution. []

_____: If your presentation as a motion, I'll second it. []

MARIO SCALORA: But do we have to talk about buildings and land disposition as part of this? That strikes me...or is that legislative language that you throw in anytime some (inaudible)... (Laughter) []

SENATOR JENSEN: (Laugh) No. []

MARIO SCALORA: Because I don't know how much we're into real estate. []

_____: (Laugh) That sounds like a legal and real estate...yeah. []

C.J. MARR: Well, but that really is one of the key issues about maintaining these three centers. []

_____: Yeah, money. Yeah. []

MARIO SCALORA: Got you. That makes sense. Thank you. []

_____: Yeah. The money that's involved in that is incredible. []

MARIO SCALORA: Yeah. Never mind. (Laughter) []

SUSAN BOUST: I have a question on implementation of this policy... []

TOPHER HANSEN: There's a motion on the floor. []

SUSAN BOUST: Oh, I'm sorry. []

TOPHER HANSEN: I don't quite understand the...can you state what you thought the (inaudible)? []

_____: Adoption of the resolution. []

_____: It's four paragraphs. (Laugh) []

TOPHER HANSEN: Oh, but you didn't add to it? Oh, okay. []

MARIO SCALORA: Just as is. Motion to accept, as is, the draft resolution. []

_____: Can we have discussion, or...? []

MARIO SCALORA: What we...we need a second before we discuss. Is that correct? []

_____: Oh, okay. Okay. []

_____: Second. []

MARIO SCALORA: We have a second. Discussion, please? []

MARY ANGUS: If I may, I would add to...another couple paragraphs. (Laugh) No. In terms of the composition of this task force, I firmly believe, again, that families,

consumers, physicians, everybody needs to be at that table. So maybe we would want to describe some of the composition, so that we have in place a plan for including all of the people that are involved. And so given that, and given the discussion, which sounds to me like it's pretty strong, about looking at policy change, this task force could very well be exactly what we need. []

MARIO SCALORA: Are you suggesting a friendly amendment, Mary? []

MARY ANGUS: Yes, I am. And that friendly amendment would be that we determine the composition to include X amount of people on the committee, or at least X amount of people in committee, at least X amount of family members, consumers, and at lease X amount of doctors, at least X amount of administrators, not to exceed 150 people, of course. (Laughter) I know a workable group is a lot more like 20. []

MARIO SCALORA: Here's what I've got so far. Composition of the committee to include X amount of families, and consumers, and then I left you. I got 150 people, not to exceed 150 people. []

MARY ANGUS: Oh, X amount of physicians, X...not 150 people. Yeah, is it that blah-blah-blah part in between? Yeah, okay. []

MARIO SCALORA: Yeah, I...you lost me there. I...so you're wanting to suggest...do you want to suggest a specific number of people as part of your amendment, or are you wanting to just say, it should include? []

MARY ANGUS: Should include? Um... []

_____: I don't think that's a friendly amendment, is it? []

MARIO SCALORA: Is it? []

_____: It isn't going to be accepted, anyway. []

_____: Oh, what was the problem (inaudible)... []

_____: Representative of the... []

HOWARD OLSEN: You know, I think we ought to have confidence in the chairman of our commission, along with the Chairman of the legislative committee, to put those on the task force that they believe need to be at the table. []

DANIEL WILSON: If it even gets enacted. []

TOPHER HANSEN: I have a question. I don't read this as impacting the question that was on the floor about bed allocation. Is there any interpretation in that respect? []

SENATOR JENSEN: No. And as a matter of fact, I think what you're saying is exactly right, and I would ask the maker of the motion and the second to maybe hold off on this until we conclude the bed allocation discussion. Well, I... []

HOWARD OLSEN: I want to vote on the motion. []

JAMES WHITE: I just...I wanted to go back to the discussion about the allocation, if we was finished with the motion. []

_____: We aren't. []

_____: We haven't dispensed with the motion... []

_____: (Inaudible) defer it. Defer it for the moment. []

_____: We haven't dispensed with it. []

_____: He could call the question. []

_____: Call the question. []

SENATOR JENSEN: We have a motion before us, and it's to proceed with the recommendation that is before you all. You have a copy? Yeah, any other discussion? The question has been called for. []

MARY ANGUS: Could I have the motion read, please, or...? []

_____: It's right there. []

_____: It's documented in front of you, Mary. []

MARY ANGUS: Okay. That is without the inclusion? []

_____: No amendment. []

_____: I didn't get an answer to my question of discussion, I guess, which was... []

JEFF SANTEMA: It implies in that...it implies including that. That issue is implied in the resolution. []

_____: It's implied that the bed allocation be frozen and not go forward? []

JEFF SANTEMA: No, no, no. []

_____: Okay. []

_____: No, no, no. It would be a matter of discussion, but not necessarily, if I hear correctly, impact whether it goes forward or not in the short term. []

_____: Okay. []

JEFF SANTEMA: No, it has nothing to do... []

_____: Okay. []

SHANNON ENGLER: I'm sorry, I want to completely understand that. Bed allocation is an issue over here, motion for this amendment is here; they're not connected, except for in the long term? []

MARIO SCALORA: Right. Right. []

_____: In the long term they would look at the bed allocation also. []

SHANNON ENGLER: Okay. Okay. Thank you. []

SENATOR JENSEN: I think that's good...yes, Chief. []

BILL MIZNER: As I understand this, this would be a task force or subcommittee of the commission. It concerns me that if it's a subcommittee here, that the language in the last paragraph says that the task force will submit a preliminary report of its research and recommendations to the Governor, the committee, and the commission. And it seems to me tat it would be most appropriate, if it's a task force of this commission, that they would report back to this commission, so that all commissioners could have a chance to discuss and whatever, and the decision would be made then by the commission whether or not to forward that group...that report or recommendation. Otherwise, you have a subgroup of the commission actually taking action, making recommendations, and forwarding to the executive officer and the Legislature without the actual review and input of the commission itself. So the way it's worded, I would just as soon that they report back to the commission, and then the commission could act upon it, as opposed to just (inaudible)... []

MARIO SCALORA: So practically speaking--and I don't know if we could call this an

amendment--you would recommend striking the words "the Governor, the committee,"... []

BILL MIZNER: And just report back to the commission. []

MARIO SCALORA: Right. So that, practically speaking, you would strike out the reference to those two entities in that last paragraph? []

_____: (Inaudible) make a motion. []

_____: I'd accept that amendment. []

MARIO SCALORA: That...so you'll accept as a...? []

_____: Yeah. []

MARIO SCALORA: So to clarify, we would accept this as is, with the exception of the words "the Governor, the committee, and," because it grammatically is incorrect if we keep "and" in there. So, to read: The task force shall submit a preliminary report of, I presume it means its research and recommendations to the commission no later than August 10, 2007, and a final report no later than December 1, 2007. That is the spirit, Chief, of what you were recommending? []

BILL MIZNER: Yes. []

J. ROCK JOHNSON: It may be redundant, but it might be helpful (inaudible) final report to the commission (inaudible), just to clarify, so there's no misunderstanding at all. []

MARIO SCALORA: Okay. []

DANIEL WILSON: Just as a brief discussion point, Mario, could I ask, Chief, if...was it your intent to suggest that Senator Jensen appropriately retired, because he can no longer write really good legislative proposals? (Laughter) []

MARIO SCALORA: There you go. There you go. []

BILL MIZNER: I was just hoping to demonstrate once again the Senator's willingness to listen and to... (Laughter) []

SENATOR JENSEN: Now who's the politician? (Laughter) []

_____: I'll support this, and Bill's application to law school. (Laughter) []

MARIO SCALORA: So are we taking as a friendly amendment J. Rock's recommendation of adding the phrase, after...report to the commission no later than December 1, 2007? []

HOWARD OLSEN: Yes. []

MARIO SCALORA: C.J., would you accept that as a friendly...? []

C.J. MARR: Um-hum. []

MARIO SCALORA: Do need to read that over again, or are we good? Thank you. Did we have the question called? So the question is called. Do we need the roll read, then, or do you...? []

_____: We're prepared to do that. []

MARIO SCALORA: How do you want to do that, sir? Your call. []

SENATOR JENSEN: Well, let...why don't we first see a show of hands. Okay. Maybe we don't have to do a roll call. All those in favor say aye...or, raise your hand. Opposed? Okay. Motion carried. All right, thank you. Now,... []

RON SORENSEN: The bed allocation plans. []

SENATOR JENSEN: Yeah, bed allocation. []

RON SORENSEN: I want to clear up one thing. And I'm not disagreeing with you, Topher. This does...obviously, Region V has an interest in this, a strong interest. But I...we didn't see this as a plan for Region V. I think the plan we thought would benefit consumers at the regional center, regardless of what region they're from, because it would hopefully focus on helping people get discharged in a more timely manner when they're discharge-ready. So...and that's for all the regions. I know it presents some problems for those who have in excess of the number there initially, but I've seen...I guess I'm very positive about what's going on in Region 6 in particular, in terms of managing that number. They're making very strong efforts to manage that population. So I think it benefits everybody in the long run, particularly consumers, because you get out when you're ready to get out, hopefully sooner than what you would have before, because we're focusing on that relationship between the social worker, the region, and the provider, to make this work for the consumer. So I think that's what's positive about it. And just so you know, Region II, the other region that's over, their comment about this was not to change our number, because we want to work with the hospital to learn to manage within the resources. So...and the other...I guess the other part is, somebody raised the issue of, does this create conflict between the regions? Well, I would say we

always have issues that we have differences of opinion on, but I haven't seen conflict between the regions. And in fact, I would suggest that this may alleviate the potential conflict, because I know the resources I have to manage. Right now, if I'm Region "X" and I am under my allocation, and Region "Y" is over, and the only people on...you know, somebody comes on the list from Region "Y" before Region "X," I could be not happy about that, that some in another region would have access first to a bed, when I am way under what proportionately I should have as my resources. So I think this solves for everybody what we can expect at the regional center, what capacity we have, and can define for them what the process is, to help get people in and out. []

JAMES WHITE: I guess it's about the word "allocation," with me. I agree, I...when Dan was talking, I had already wrote yesterday about the triage thing for everyone. I think that would be...I'm not trying to say stop doing what you're doing now. I'm not even into that. I'm just into the word "allocation." The word "allocation" sometimes connotes some form of bias or elimination process, when there's no need to do that. If we had a triage system, I think it would be more appropriate for the whole mass of regions. Not...that way, if I'm in Region III, or V, or whatever region I'm in, I can say...if I need somebody to go to the hospital, I can go through the triage system, do it as fast as we can. But sometime or another, the word "allocation" is going to create a problem, just that word alone, because when you allocate something, you are simultaneously eliminating something. You're creating a people bias that we need to take a strong look at. Like we said, we're not necessarily talking about beds; we're talking about people. So I think...I don't know how to do it per se, but I think that's something we need to take a strong look at. []

SENATOR JENSEN: A military man knows what "allocation" is, don't you? (Laughter) []

JAMES WHITE: Absolutely. Absolutely. []

DANIEL WILSON: Well, Senator, if I could add to that, I think that is an important factor. I mean, ultimately, I'm in favor of an allocation of resources based on...basically, on per capita population, maybe adjusted a little bit by realistic other factors. That seems the fairest to me. And that's long-term. Short-term, we're not there yet. And in fact, I'm concerned, Mario, if I heard you correctly, you're saying, sitting at Lincoln Regional Center, you see different regions using the facility for very different reasons,... []

MARIO SCALORA: Oh, absolutely. And I'm not being critical,... []

DANIEL WILSON: ...at very different levels of care...no, no, but... []

MARIO SCALORA: ...but that is the fact. []

DANIEL WILSON: ...but variance in utilization of medical services is huge quality and

efficiency concern that we're missing here. And we're missing it because, again, there's not a clinical oversight process in place at the regions, or even, really, at the state. And that needs to change. []

RON SORSENSEN: And actually, Dan, I'm hoping that if we do...you know, when we get to this point, that in fact that may be a natural outgrowth of what happens here. I mean, if I'm in a region and I've got ten people on a list at the hospital that have been committed, and I've got one bed, I would hope what I'm doing is triaging, to see who should go first. It may not be the person who's been there ten days. It may be the person who just got there. []

DANIEL WILSON: Well, and some replicable criteria for admission that really has some meat to it. So there shouldn't be this variation. I'm...following up on Chief Mizner's comment earlier, too, it's good to hear that things are...people are responding to the possibility of an allocation plan. And I know that Region VI, for example, where I live, is working very diligently. It's not so good to hear that telecare was half-empty for however long it was, until, if I understood you correctly, until this sort of process casts some light on it. Maybe I'm missing (inaudible). []

RON SORENSEN: Well, I wouldn't say this process alone casts light on it. I think the region has been working for some time, trying to work through whatever the barriers were to getting that working effectively. And now I think some of that has been worked through and resolved. []

DANIEL WILSON: But again, this speaks to a lack of clinical oversight and optimization of care of consumers in our system. []

SENATOR JENSEN: Again, I'll come back: We've delayed this for 30 days, and what will be the outcome at the end of that period of time? []

SUSAN BOUST: Are you looking at me? (Laughter) []

SENATOR JENSEN: I think I am. []

SUSAN BOUST: (Laugh) I'm pretty sure I don't get to decide. []

SENATOR JENSEN: I see Beth in the background, but...yes, I mean you. (Laugh) []

_____: You didn't know you had that much power, did you? []

RON SORENSEN: Well,...but it's a question, then, will they take a position, I guess, is basically...you could take a position (inaudible). []

SUSAN BOUST: I'm not taking a position for a whole state full of doctors (inaudible). (Laughter) []

RON SORENSEN: Okay. []

TOPHER HANSEN: Right. As you said, that's a long-term process. []

SUSAN BOUST: It is a long-term process. []

TOPHER HANSEN: May I...? []

SENATOR JENSEN: And I can understand. You thought, Region VI thought, that this was not going to be implemented now, that it was on...discussion on the table. But now it is to be implemented. []

SUSAN BOUST: At the...me, as an individual, heard at this meeting that a bed allocation plan was being considered in November. And then I heard--rather through the grapevine, because I got no E-mail or any formal notification--that this was going to be a policy implemented January 31. And that made me angry. I sit on this commission, I see this as one of the places where I can represent doctors, and that was inadequate, that wasn't right, because my one place to say something about it was...and so that...I mean, that was the peak. []

TOPHER HANSEN: And a couple of things. I agree, but we can't tie the ankles together of management, because we meet infrequently, and I think we have to try and let day-to-day business go on, and create...and I think this resolution that you bring forward helps us to create smart policy based on experience and so on. And Dan, to your point, that's exactly how we do it, and if you...and you know, in a fairly large agency, of trying to assess, not only do you meet criteria, but what's your need, what's your fit to the program and what's your need, and if you're dying on the streets, you're in the door, because we know you'll be dead tomorrow. And that has to be coming up in a clinical way, to really make judgments to help make this...I think it makes for a better-quality system. So anyway, with all that said, I move to direct the department, to the extent we can do that in an advisory capacity, to move forward with the bed allocation, with the thought in mind that we are going to undertake this larger review of the system and adjust it accordingly. []

_____: How long...(inaudible) motion, I apologize. []

SENATOR JENSEN: Is there a second to that motion? []

DORIS KARLOFF: I'll second that. []

SENATOR JENSEN: Doris seconds it. Yes. []

MARIO SCALORA: The only question I have, how much is this necessary? How soon are you all getting together and caucusing, would you guess? []

_____: Do you recall the date that we...? []

SUSAN BOUST: Oh, we...next week. []

MARIO SCALORA: Practically speaking, this could be delayed? Presuming there's no major umbrage, we're talking a couple week delay here, maybe? []

RON SORENSEN: I would think so. []

SUSAN BOUST: But I think Topher's point was to get this commission on record; not the fact that this commission is the decision maker, but to get them on record. []

TOPHER HANSEN: Right. We're advisory. (Laugh) []

SENATOR JENSEN: Any other discussion on...yes, J. Rock. []

J. ROCK JOHNSON: Yes, if we could,...I do have one comment, but could the resolution...the motion be read? I couldn't hear it. []

JEFF SANTEMA: What I've written down is, Mr. Hansen moves the implementation of the proposed bed allocation plan, with the understanding that the plan will be subject to ongoing review. []

TOPHER HANSEN: Ongoing review by way of Senator Jensen's motion that we passed earlier, the task force. []

SUSAN BOUST: Discussion? []

SENATOR JENSEN: Yes. []

SUSAN BOUST: I am... []

JEFF SANTEMA: Was there a second? I'm sorry, was there a second? []

_____: Yes, there was. []

_____: Yeah, there was Doris. Doris. []

SENATOR JENSEN: Doris Karloff. []

JEFF SANTEMA: I'm sorry. Thank you. []

SUSAN BOUST: The urgency of this, from Region V's point of view, is not clear to me, because I do see this as a policy change. Even though we've talked about having...you know, Region V is going to use the regional center, I hate to see this commission going on record as saying, we think it's a good policy decision to have the Lincoln Regional Center be acute care beds for Region V. It...what is the urgency of this right now? []

TOPHER HANSEN: Managing known resources. []

SUSAN BOUST: But how is it different now than it was in...? []

TOPHER HANSEN: The alloca...as I understand it--and I'll look to C.J.; he has the most current information--but we're how many under our current...what would be our allocation? How many, in terms of what we're utilizing versus what we could? []

_____: Eight. []

TOPHER HANSEN: Eight. Is that current? []

_____: That's pretty current, yeah. Two days ago. []

_____: But I guess I...that's not your question. []

SUSAN BOUST: Well, I guess it is, because I'm just saying, what is the urgency of having this policy change right now, and asking this commission to go on record that it is a good policy to have Region V use the Lincoln Regional Center, even short-term, for their acute beds? That's what's been happening all along, but why have a policy change on that right now? []

TOPHER HANSEN: I don't think it is a policy change. It's been the plan since the beginning. It may be a number that was fixed, but it's the plan since the beginning. To not do it would be the policy change, I think, because it has been...you know, we've, since the outset, we've been told, here's where your acute beds are, that's where they're going to be, and then we'll give you some beds beyond that. Finally, we got a number on what we could use, because that's been going up and down, we didn't know where it was going to land. It landed, it's been discussed for at least four months, and so to not do it now, in my mind, would be the policy change. []

SUSAN BOUST: So would it be the same kind of issue if we took all of the other numbers off of there and only said Region V has 18 beds off the top and the rest of

them are first come, first serve? []

SHANNON ENGLER: May I respond to part of this? And this is not...I'm not responding for Region V, but I'm going to respond as one of the members of several hospitals that have raised this issue. This gets back to, this is a solution, hopefully a positive solution, that we requested to help with the throughput issue, because it doesn't seem like other things are working, for whatever reason. And so while I'm not sure that this is going to work, from the hospital's standpoint, we would like some action taken, and rather than just everybody continue to sit around and think about it and talk about beds that are going to be open again next fall, that, again, we've been waiting for two years for these things to happen. And with Topher's comment about, in the interim, we potentially do have irreparable harm occurring with clients that are, as you know, unable to access services. So... []

DANIEL WILSON: Actually,... []

SHANNON ENGLER: ...not from a Region V perspective, but from that perspective, that's why I think that there's a sense of urgency. []

DANIEL WILSON: I'm missing a little something in that, Shannon, because I sense urgency all around the state. I certainly sense urgency in Region VI. And it...I'm reminded of C.J.'s comment earlier, that, looking at all the statewide hospital beds, what's going on in the emergency rooms seems relevant. This is directly relevant to EMTALA. They do...there is access to service. It's very expensive, often inappropriate access, which is the emergency room. But do we even know what the distribution of unpaid EMTALA services is, from region to region? Because everybody is struggling with the same things you guys are struggling with, I think, or most certainly Omaha is. []

SHANNON ENGLER: You bet, because I'm receiving many patients from the area. Yeah. []

DANIEL WILSON: How many...I mean, may I ask how many indigent, uncompensated bed days, on average, your hospital has, for behavioral health? []

SHANNON ENGLER: I could go back, I keep a list of the number of transfer...EMTALA transfers in. But I...we don't ask funding source, so I couldn't give you that information. I don't know what it is. []

DANIEL WILSON: Well, I can say, for example, at St. Joseph's Hospital in Omaha, which doesn't have a psych unit, we typically have five to six patients in the hospital whose primary reason for being there is psychiatric, and very frequently, they're in the intensive care units, and usually unpaying, for whatever reason. Not appropriate care, extremely expensive. You know, there are some issues on the hospital sector, probably

statewide, but I think perhaps more in eastern Nebraska, that really need attention. And I'm not sure it's worse in Lincoln than it is in Omaha, by the way. I mean,... []

TOPHER HANSEN: I know in our services, we have people who are referred for an inappropriate level of service because there is no place else to go, and are being pushed...you know, this person...and it's inappropriate. And we have to...it becomes difficult, because we understand the need of the referring agency, but we don't want to harm the person, and we think, in some circumstances, harm would come by being at inappropriate levels. And so it's not just hospital. We see it in different levels. And so, yeah, I think it's going on. But one of the keys, I think, is being able to have known resources and manage those resources within a system. []

SUSAN BOUST: And I guess I'm saying, again, it's...and maybe instead I need to say what I think and let you tell me I'm wrong, rather than trying to understand. I think there is a tremendous bed crisis across the state, but particularly in Region V and VI, if I look at the referral list. And if I understand this policy correctly, between the numbers on the current referral list and the numbers up there, Region V, with this policy, this new policy--I'm sorry, it still seems that way to me--would be able to take everyone off their list, plus two more admissions, before Region VI would be in a position to admit anybody, and probably for a good long time after that, because we're over four. We've got to take four people out, right, before we can put anybody in,... []

_____: Yes, assuming you don't...assuming Region VI gets nobody out,... []

SUSAN BOUST: ...and Region V, as of the date of this, would be able to admit all of the people on this list, and a couple more, before Region VI could admit anybody. And that may be appropriate down the road, but I say that right now we are all in a bed crunch. And this policy right now seems to be based on the bed crunch, not the long-standing expectation that the Lincoln Regional Center would be the acute hospital, but rather that everybody is in such tight spots that now Region V is also in this backed-up admissions position, as is true for Region VI and Region IV, and Region III, who has somebody who's been waiting since October. []

MARIO SCALORA: Susan, with respect...if it...if, for example, some of the Region VI beds were being discharged, you would get priority to those beds, regardless of whether Region V...I mean, you would get still priority access to beds that designated, allocated, whatever the appropriate term is. What I hear you raising as a question is, how would that be laid out so it's not first come, first serve. []

SUSAN BOUST: I guess I don't want to continue debating this. I will say that I think it's a bad idea to have this body go on record that a policy for Region V to use the Lincoln Regional Center for acute hospitalization is not a good thing. I understand that there's been lots of work to try and figure out how to deal with the current crisis in the

long-standing commitments, so I'm not saying that I know what's best. I just don't think it's a good idea for us to say that... []

DANIEL WILSON: Well, it's actually antithetical to the law and our job. Our job was to advise the Legislature about the enactment of LB1083, and that did not include...it did not envision long-term status of state hospitals as acute inpatient beds. []

SENATOR JENSEN: Dr. Adams. []

GORDON ADAMS: I'd just make it clear that I'm voting against the motion, because I don't think that the issues have been resolved sufficiently at this point. []

SENATOR JENSEN: All right. Thank you. Dr. Klutman. []

RON SORENSEN: Could I give you a little history here, real quick, on these numbers? Region V shows 27 there, and I think probably three months ago you had 38, or something like that, right? So what Region V has done is discharge 11 people in that period of time. They were over what these numbers would be at that point, too, but they put a real effort into getting people out. Now we're seeing that same activity in Region VI, and I would expect the same sort of thing to happen. But what happened in that case, when Region V took the people out, they weren't able to get anybody in when they got on the list, because other people there had a longer time on the list, and so they would go in first, from other regions. So, by...over time, as...the better you do at getting people out--and assuming other people don't do a good job--you lose beds, on the current plan. So it's a disincentive to get people out. And that's what we're trying to provide, is an incentive to encourage people to move on people getting out. So... []

DANIEL WILSON: But you know, Ron,... []

RON SORENSEN: ...I know there are some problems with one region right now, or two regions. But I think the incentive is provided in the long term for that. []

DANIEL WILSON: Ron, I don't disagree. But we've heard that we don't really have any standard about who goes into Lincoln Regional Center, clinically. []

RON SORENSEN: Well, technically, we do. Technically, we do. []

DANIEL WILSON: Well, but we've heard that we don't. (Laugh) []

SUSAN BOUST: Clinically, we don't. []

DANIEL WILSON: And technically...well, I don't...yeah. []

SUSAN BOUST: Ron, that's, bureaucratically, we do; clinically, we don't. (Laugh) []

RON SORENSEN: Well, I can only trust what hospital doctors tell us about the acuity of the patients that leave the hospitals. That's what we depend on. It's not...a region doesn't make the choice about that; the doctor makes the choice about that. And they tell us, we get orders all the time that say, this person needs 60 to 90 days at a hospital. Personally, I object to that sort of thing. It's kind of like a sentence--you're going to the regional center for 60 or 90 days. I don't like that. And so I think there is some work that needs to be done with doctors. But the point is, the doctor in the hospital makes a decision as to the acuity of the person, and puts them on the list. We don't put them on the list, the region doesn't put them on the list. The region tries to get them off the list by going somewhere else. []

DANIEL WILSON: But there's no process to evaluate the clinical needs of people who are going to Lincoln Regional Center, other than just whoever is on a list, wherever they're on a list, for whatever reason they're on a list. []

RON SORENSEN: I guess I thought that's what the... []

DANIEL WILSON: But the institution itself doesn't have internal standards for appropriate (inaudible)? []

RON SORENSEN: We have standards for acute care. Yes, we do. []

DANIEL WILSON: But there's a great deal of variance. []

SENATOR JENSEN: Dr. Klutman. []

RONALD KLUTMAN: I'm on the clock for ten seconds. I think I hear what everybody is saying. You know, I bring a different expertise, in the sense that my practice is only probably 10 percent mental health. We have, for a long time, in primary care, tried to bring mental health into our practice. As we set up people getting kidney transplant, liver transplants, it's not where they live or what region they're in; it's whoever is the sickest, and that's a fine diagnosis. This person's BUN:creatinine is falling terribly, he's near the end, he needs to be transplanted. If the state can guarantee me the sickest are getting in to where the beds are, then I'm willing to go along with it. I'm not quite assured of that at this point in time. And I guess I can just say...try to explain my "no," that at this point in time, I don't think the sickest are getting to where the beds are, and I think that's anti-what physicians really stand for. The sickest comes first. []

SENATOR JENSEN: Any other questions before we vote...or, comments, I'm sorry. []

TOPHER HANSEN: I have a question. In the management group, the regions and the

state and the folks that met to talk about this, was there 51, two-thirds, or unanimous support for this? []

RON SORENSEN: Well, I don't know. I couldn't speak for Region VI. I think the others were for it. I'd have to ask...I'd have to poll Patty on where she stood on it. I think the other five regions were for it. []

TOPHER HANSEN: So...okay. But I'm just trying to get a ballpark on where the agreement was. Okay. []

SENATOR JENSEN: J. Rock. []

J. ROCK JOHNSON: I may abstain, but with the idea that I'm going to do my very best to keep myself well, and everybody that I know well. (Laughter) []

_____: Thank you, J. Rock. So you don't... []

J. ROCK JOHNSON: (Inaudible) like to see the principle underlying this change from, we can't get them in, to, we are unable to provide the services and support to keep them out. That, I believe...(cell phone ringing)--with fanfare--is (inaudible)... (Laughter) []

SENATOR JENSEN: Any other discussion? Jeff, would you read the motion, please. []

JEFF SANTEMA: And Senator Jensen, maybe I should add two more words to that. Mr. Hansen moves support for implementation of the proposed bed allocation plan, with the understanding that the plan will be subject to ongoing review by the commission. []

SENATOR JENSEN: Okay. You want a show of hands, or do you want a roll call? Show of hands. All right, let's start there. []

_____: Or we could try a show of hand. Hey, remember that he's a no, that went out of the door. (Laughter) []

SENATOR JENSEN: Okay, so all those in favor raise their hand. []

JEFF SANTEMA: Seven. []

SENATOR JENSEN: Opposed? []

JEFF SANTEMA: Eleven. []

_____: Stick a fork in her, it's done. []

SENATOR JENSEN: Motion fails. That was the end of your report, Ron? []

RON SORENSEN: Yes, I think so. (Laughter) []

_____: (Laugh) Ron is done. And look at what a good job you did with the old computer. []

SENATOR JENSEN: The next item is on the Recovery Center, which is the old Richard Young facility. Jeff, go ahead and pass these out. I also have another resolution I'd like to present before you. First of all, the Recovery Center is moving very well. All of the funds, the $17 million from the private sector, have been raised. They are in...have started some construction on the facility. They have entered into a contract with Immanuel to operate the facility. The...what was interesting about the private sector, they...in going to individuals to ask for funds, nobody turned them down. And it's kind of amazing that they were able to raise those kind of dollars. The did have a meeting then also with the consumer group. I think both Mary and J. Rock were there. Is that right? []

MARY ANGUS: Cindy and Linda, all four of us. []

SENATOR JENSEN: Great. And they very much want your input into this process. It is a different culture, what they're talking about. And to me, I guess that excites me more than anything, that they're looking at a whole different approach to individuals with mental illness, on everything from the time they come in, until the time they leave or are referred on to some other treatment. Also, I think, certainly to me, as I've traveled around the state, one of the most important factors is the educational part of this, in that I think you will see a lab and you'll see an education, academic process to this that we can start beginning training for individuals where we have a great need in rural Nebraska, and also even in the metropolitan areas, for individuals with any kind of psychiatric training. And so there's a real need for that, and we continue to work with the two schools of psychiatry in Omaha, and also the psychology, UNO, and others, to look at this issue and even the public health and social schools. So I would like this commission to really take a look at this resolution, and support it. I think it is a very important factor. It's kind of a missing link, I absolutely do feel that. And also, by the way, the time table is probably being ready for opening sometime in November. Staffing is probably the greater issue than even the improvement of the facility, or to reconfigure it. So I lay this before you. Yes, J. Rock. []

J. ROCK JOHNSON: I think I was about to enter into discussion, so since I have the floor, I'll do it anyhow. It seems to me that we really don't need this, that these are individuals, and the people that they are working with, and the way that they have been working, are highly motivated and continue to be motivated. And while it may be a nice thing to show some support for their efforts by passing such a resolution, for several reasons (inaudible), I don't think we really need this. []

SENATOR JENSEN: Any other discussion? Shannon. []

SHANNON ENGLER: Excuse me. Are there some additional...are you referring to an actual document? []

SENATOR JENSEN: Oh, yes. Oh, I'm sorry. It got on that side. We got this side this time, but not that side. We were trying to compensate. Any other discussion? []

SUSAN BOUST: I guess, although I'm in agreement with J. Rock that I don't know that it's necessary, or any more that this body is advisory, our opinion is going to matter any more on this question than it did the last, but you just never know. I'm certainly hoping that especially the educational aspect of this and some statewide outreach with it would be very much supported by this group. And if it's not, I guess I would like to know that. []

TOPHER HANSEN: I guess I'd add, I don't know,...this becomes a statement, but I don't know that action will change either way, based on this. It's...we see it, good idea, I mean, that's what it amounts to. So I don't think there's an action change, a push for direction, or things like that, as a result of this. So it, I guess, depends how much we want to just make a statement that might be superfluous to the issue, but a statement nonetheless. []

SENATOR JENSEN: I don't see any other hands or discussion. []

GORDON ADAMS: I guess I'd like to hear who the private parties are. If this a public-private partnership, who are the parties who are (inaudible)? []

SENATOR JENSEN: Okay. The...Ken Stinson and Rhonda Hawks were the two individuals that began meeting in December of 2004, and began to look at, particularly after the Kim Foundation, who worked so diligently bringing Region VI together in working on this issue, then began to look, and they also employed a number of experts, facilities engineers, doing surveys, assessing needs, and then it wasn't until sometime later, probably 2006, early in the year, that they, rather than start a facility from scratch, decided, well, here, this Richard Young Facility has been sitting there empty since April of 2004, that to look at the possibility of purchasing that piece of property, and then through a chain of events, actually did close on the property in December. But...I don't see any other comments. We'll... []

SENATOR JOHNSON: I'll throw one in, Jim. []

SENATOR JENSEN: All right. []

SENATOR JOHNSON: I haven't said very much here today, but...and I don't know as

this resolution, in a sense, means a whole lot. But I think it does mean this. One of the things, this last fall when we went around the state of Nebraska, the consistent thing that we found was that everybody was saying, we need more mental health workers of all kinds. Where are we going to get them? Right now, they're...the source, or construction department for all types of these workers is rather meager. And you know, I think Region VI both has the obligation and the opportunity to create a facility and a training program for all types of mental health workers, to really supply the state of Nebraska. What I see here is just the encouragement, someday, somewhere, for the Legislature and the Governor and the people in Region VI to accomplish that. So it might not be a big thing, but I think it's kind of a thing that shows the agreement with the direction that things are going in, and I think may influence the direction. []

SENATOR JENSEN: Well, if...and if you'll remember, part of LB1083, there was that component in there, to encourage all sources of funding, both the public and private. Public is Medicaid. Private, you know, I look at...well, I'm not going to go there. (Laughter) Any other comments? J. Rock, and then we'll drop it. []

J. ROCK JOHNSON: Yes, another of my reasons for voting "no" is, again, I don't really think this is necessary. I think that folks know that people appreciate what they're doing. Another aspect is, is we've had the first meeting of consumers with these principals a couple of weeks ago, so that's the first time in well over two years of the planning that we came together. And it was a very cordial meeting, and I assume there will be more meetings. But when I look at the overheads that we had, there's absolutely nothing in here about the inclusion of consumers and families in LB1083 or in the process. So...and I don't mean this to sound harsh at all, but in law we would call it assuming a fact not in evidence. There are statements here about recovery-based and community-based services. Providers of behavioral health, you know, it doesn't include peer support yet. Consumer-focused behavioral health services, we really have just started, we have just taken the first step of consumers and families working with the primary decision makers. And I think that that is of such significance that we need to allow that to continue to move and develop and move forward, and then I think there will be a point where I would be willing to bring forward such a resolution without any hesitation. But I just think we're still in such a state of fluid decision making, and the various principles being developed, and the discussions that are being had. And I have done some research into, for example, the demand supply, or Planetree, which is a membership accreditation association, if there's an intent of being involved in it. I just feel like, as I say, you know, we've started in a new phase, a new path, and I think we need to let this...play this out for a while. And certainly, I think those of us, those six of us who represent consumers and families could bring back a report that (inaudible) significant. But I would like to...what is it you say when you gamble? Let it roll? (Laughter) []

MARY ANGUS: Let it ride. Let it ride. []

J. ROCK JOHNSON: Let it ride. Thank you. Obviously, there are a lot of people... []

MARY ANGUS: But I'm not a gambler. (Laugh) []

J. ROCK JOHNSON: ...who are familiar with that in behavioral health. []

SENATOR JENSEN: All right. Next item on...is there any other business? []

BARBARA WESTMAN: I would just like to say... []

SENATOR JENSEN: Pardon? []

_____: Aren't we going to...? []

_____: Yeah, what are we going to do with the resolution? []

_____: We have...don't we have a...? []

SENATOR JENSEN: I didn't hear any action from any other members, and so we've moved off of that item. []

_____: Oh, okay. []

BARBARA WESTMAN: I just would like to say that I've been a state employee for 28 years, 26 at the regional center, and back in the early nineties to mid-nineties, late-nineties, we had taught...or, we had training out at the regional center, we had psychiatric interns, we had nursing interns, we had pharmacy interns. We did a good job of training those people. I don't know...you know, doing different things in the flow and ebb of things, that went away. But we did have that at one time. []

DANIEL WILSON: Barbara, I think that reinforces my notion that part of...a big part of LB1083, at least in intent, was to address exactly those sorts of problems, certainly using the strengths that are present in Omaha, but trying to branch out across the state. []

BARBARA WESTMAN: And I... []

DANIEL WILSON: And we haven't talked much about that. []

BARBARA WESTMAN: And I would hope...I guess my hope would be that if it starts...the training starts in Omaha, that somehow some of that can be taken into the community. []

SENATOR JOHNSON: Not saying that...that was not my intent when I made those comments. []

BARBARA WESTMAN: And I'm not saying that. I'm just saying that I would hope that this would move forward. []

SENATOR JOHNSON: But the two medical schools are in Omaha. []

BARBARA WESTMAN: Right. []

SENATOR JOHNSON: And there are family practice programs that are throughout the state, there's internal medicine programs throughout the state, out of medical school. []

BARBARA WESTMAN: And I agree. []

SENATOR JOHNSON: But the medical schools have to be the heart of the training program. []

BARBARA WESTMAN: And I agree. I just hope that it would not stop with just training in Omaha, that it would go outstate. []

DANIEL WILSON: We are training in Omaha. The expansion needs to go out, absolutely. []

SUSAN BOUST: If I could encourage you to look on the behavioral health, LB1083... []

_____: Oversight commission. []

SUSAN BOUST: ...oversight commission... []

_____: Web site. []

SUSAN BOUST: ...web site,...thank you. (Laughter) []

_____: (Laugh) It's long into the day. []

_____: It is. []

SUSAN BOUST: There is a paper there that outlines the statewide planning. So just do "academic support work group" on Google, and "Nebraska," and it will come up. And it is about getting it up. []

MARY ANGUS: Right. That's in...that's actually in the language of LB1083, is it not? []

SENATOR JENSEN: Yes. []

J. ROCK JOHNSON: I was the only civilian member of that academic work group, and I'd encourage people to look at that, but I'd also be glad to talk with any other folks about the things that "coulda, woulda, shoulda, if"...there's a whole body of knowledge and literature out there about consumer inclusion. I think that we've got some of the principles in there, you know, but if...again, it's a good starting place. []

SENATOR JENSEN: Any other items of discussion, other business? Because of the lateness of the day, I've asked that Beth and Ingrid hold their presentation to our next meeting. We're ready for public comment. Yes, Alan. []

ALAN GREEN: Good afternoon. I'm Alan Green. I'm executive director of the Mental Health Association. First, I want to thank HHS. Too bad Ron had to go. I think that too many times we, at least on the advocacy end, fail to appreciate that there has been movement, very positive movement. Maybe it's not quite as fast and as strong and as sweeping as we would like it to be, to date, but there is progress. That being said, one of the things I wanted to talk about has...actually, was just going around, too, was the question of inclusion. Up until...well, start with the Recovery Center. Up until what J. Rock just said, with the ability for consumers to be a part of the process now, as opposed to when it was first set up, that was always a concern to us, because it just seemed like something that was growing, and nothing...nobody knew anything about it. So our question now, or from the MHA's point of view, is, when you talk about the training that will be done, will it be the traditional clinical model, or will it be more open to the recovery principles that have been proven nationwide to be very effective. On that point, I'd like to thank Dr. Boust for bringing up the story about the veterans hospital. That is exactly what the recovery principles are, is increasing the involvement of the consumer in their own care delivery, give them more responsibility, give them choices. And it bears out that everybody wins. The doctor has more time to do other stuff, as opposed to micromanaging. On inclusion, also, I think it's slide 26, when it was shown there, dealt with the hospital...response to hospital issues. What struck me about that slide was that it had all the different levels of providers and everything else there, but no consumers. When you redo a hospital...I don't hang around hospitals too much, luckily, other than visiting a friend or going to meetings. We have a lot of meetings at BryanLGH. It's a beautiful facility. They put a great deal of effort into that. Aesthetically and physically, it's a very comfortable environment. I would be willing to bet you took in the considerations of your patients when you designed and built that place. That's what we're talking about, inclusion. Also on inclusion, with the regional consumer specialists. In the intent, what came out of Joel's office and HHS was that consumers would be involved, at the very least, in the development of position descriptions, ideally, in the process (inaudible) helping with the interview questions and through the interview

process. MHA is a part of a group called CIRC, Consumer Recovery...Consumer Inclusion and Recovery Coalition, which is a statewide group of NAMI, MHA, consumer-run organizations, consumers, family members, trying to address these issues, try to apply a little bit of oversight. But when CIRC wrote a letter to all the regional administrators individually, asking for what exactly Joel said we should do--contact them directly on an accounting of their practices--we got back a joint letter, one letter signed by all regional administrators, that basically didn't say anything other than, yes, we're doing it and we're doing it our own way. Their letter has since been rewritten and gone back out to the regional administrators. Hopefully, especially after this meeting, maybe we'll get a little more accounting as to the individual regions. Personally, I know one region that bent over backwards to include consumers, from the very beginning, all the way through. And I'm not saying that, at least from our point of view, we're looking at people that didn't do it. I know for a fact that people did do it. We just want to know for sure who did it and how they did it. In a way, it's a way for us to be able to show on a greater scale that it does work, inclusion does work. Then on the last, I want to talk a little bit about Lee's presentation about the community-based services. And I guess...and it's basically been the whole discussion today is, how do you allocate beds, how do you allocate dollars, how do you allocate the care that's delivered? But all I heard was the other end, the high end of care. It's reactionary. You're...we're looking at providing at a crisis and above, and not looking at prevention and recovery before, which would be...has been shown across the country and across the world as an effective way of lessening the demand on the crisis end. Now, the dollars are going to come down to...I mean, the pie is only so big. The Governor has come out with his budget. We're not going to get any more money. If it comes down to push comes to shove as to where these dollars are going to be allocated, who is going to get pushed and who's going to be the receiver? I want to make sure, to my best of my ability, that it isn't the recovery end, the consumer empowerment end, the proactive end that takes the cut. We want more. There's...the allocations that are being done in this state now is a very, very small fraction of 1 percent of the total behavioral health dollars that are going directly to recovery-based practices. That can change. And when it does change, the whole state will benefit, and it will be felt across the board. Again, MHA has been and will continue to be an active advocate for recovery-based practices, working in conjunction with other advocacy organizations and consumers and families to help Nebraska realize what the future is and help us all get there. Thank you. []

_____: Thank you, Alan. []

JIM JENSEN: This is public comment. []

J. ROCK JOHNSON: Well, I wanted to call people's attention to an item in their materials, which is selected Nebraska statutes. (Exhibit 6) These are ones that are specific consumer inclusion, and they're marked. Unfortunately, this bottom part of the first page should have been marked, it's the duties of the advisory and the planning

advisory committee, one of which is monitor, review, and evaluate, not less than once eacy hear, the allocation and adequacy of mental health services with the State. And I don't know, in the time that I've been watching, I've ever seen anything that really actually fits that definition. But I did want you to know that you do have the specific statutes and the specific language in your materials. []

SENATOR JENSEN: Yes. Jonah? []

JONAH DEPPE: If you don't mind, I'll sit, because of my arthritis. []

JIM JENSEN: Certainly. []

JONAH DEPPE: Mr. Chairman and commission members, I appreciate the opportunity to talk to you about an issue that I think has been neglected, and I hope it's being (inaudible), because when I look at LB1083, I see that it does also include children, and in fact, if you look at Section 4, Item 11, it states that (Microphone malfunction). I'll talk louder, okay? (Inaudible) Section 4, Item ll, does state that the public behavioral health system means a statewide array of behavioral health services for children and adults, and goes on to say that they should be provided by the public sector and the private sector, and supported in whole or part, etcetera. And so as I read LB1083 in a couple of other places in it, it does, to me, read that the behavioral health commission in the state should be...and their behavioral health plan, should be addressing children's services. If you...and I understand that the state decided to make a priority of adult services and moving the adults out of the regional centers and getting community-based services in place (inaudible), but it's also very important that we have community-based services in place for children and their families. Because...and I say children and families, because children are a part of a family unit, and as a grandmother of five...I have 14, and a mother of five, I understand that well. But it seems like the community services movement has really begun for the adults, but it really seems to me that if we want it to be effective, we also need to get it in place for children. Because what happens with children, as they move into adulthood, will set the stage for what happens to them as they become adults, and also can really (inaudible) the types of services and the needs for services that they might have when they become adults. So I'm asking you as the behavioral health commission to recognize that it's time to make children's services a priority, also. LB1083 also includes references to prevention. And again, as I said, if you could look at providing children's services, it's part of the prevention process for adults, and certainly it's not primary prevention--it's more secondary. But we do need to really look at it, and an appropriate array of children and family services, because as those of you who serve (inaudible) I've been on some committees with you, you know that you also have to serve families and have families participate, not just be involved, but participate. When I listen to the discussions, I get a little concerned that we're talking about beds--and I've heard that in (inaudible) program, talking about beds, and I really liked the comment that we're talking about people, because the beds is the service, and

we need to be really looking at that. And I also have...I am also concerned because, although the funding piece...I think a lot of it is Medicaid, then I look at that as an insurance piece. And we need to be looking at how we can get services paid for outside of Medicaid, because some of the things we see with children is, that they get put into the Medicaid system because their families do not have insurance that covers mental health, which is a bigger cost than to the state. So I'd like to see us work for more appropriate services and more appropriately funded services, and I think also we'll start seeing maybe some federal initiatives for healthcare. I know Mr. Marr has been part of one, looking at mental healthcare as included in healthcare for children and adults. So the reason I'm bringing this to you today is that I feel that there should be an infrastructure for children's service needs, and how they can be addressed. And I know that Health and Human Services will tell you that they are addressing this, that they had a SIG grant from SAMSA, the state infrastructure grant. They have a five-year grant through the Medicaid department to develop a surface infrastructure, state infrastructure for children's services. They're getting $750,000 a year to do this. They are now in the middle of the third year. They still have not identified or defined children's services, or what the children's service array of services should be. You cannot build an infrastructure if you don't know what you're building it for. And I'm not sure, maybe the issue is, they don't know what infrastructure should (inaudible), and that is for sure, if you don't know what the children's services then should contain. So I would really like to see you put one task force in place. I'd like to see put in place a task force that addresses children's behavioral health services, and in Section 19 of LB1083, it does call for a behavioral health plan, and again, it does include children's services. So I would like you to consider no longer your benign neglect of children, but to take some action through the behavioral health commission. Thank you. []

SENATOR JENSEN: Thank you, Jonah. Any questions, comments? I don't think you stated your name. It's Jonah Deppe. []

JONAH DEPPE: Oh, I'm sorry. Jonah Deppe, and I'm a family child advocate from Omaha, Nebraska. []

SENATOR JENSEN: Thank you. Any other persons? Yes, C.J. []

C.J. JOHNSON: I'm C.J. Johnson, region...I don't know what I am any more. (Laughter) (Inaudible) Region V system. I wasn't planning on speaking today, but I have to be honest. I was rather surprised by the vote of lack of support to enter into the allocation piece. And part of that reason is, is number one, I'm...it's unfortunate this has become Region V discussion. You know, the reality is it's really kind of a Region V experience discussion that it should be. And if you talk to a lot of the other regions, they're (inaudible) this. But the reason it's a Region V experience discussion, is because when behavioral health reform first started, we did not receive dollars for acute care, and so that forced us to look at our system and say, you know,...and the cry for the day, by the

way, was we're going need more...we're going to take any money we get, we're going to buy more crisis beds, and we're going to buy...we need more acute care beds. And we said, no, we're not getting money for that. We're not going to get those services. We have a limitation of our crisis beds and our acute care beds, and we have to invest in our system in a different way, so that we're not putting people in hospitals, and we're keeping them out of the crisis center, and we're not putting them in the Mental Health Board commitments, etcetera, and that's what we did. And through that process, 80 percent of all our EPCs that have gone into the crisis center never end up in in-patient care. That's not even the diversions we do prior to them having to be EPCed, which we've significantly reduced. We also reduced our post-commitment days, which are people sitting in a crisis center, not getting care--down to 1.49 average length of day. In other words, somebody would be committed for in-patient care, and within two days, within 48 hours, they'd be getting that care that they needed. Today we're talking about weeks--we're talking about weeks that they're sitting there waiting for that care. We also got our post-commitment dollars down, our days down so much, that before the implementation of the current system that we're dealing with, we only spent $58,000 on post-commitment care. We were positioned to take $400,000 that we were saving in post-commitment costs and invest them in those low-end services, as everybody calls them, into peer support, into all those front-end services. But because this year we're going to have almost 2,000 post-commitment days--which means people are sitting there waiting for services for weeks--we don't have that $400,000, that half million dollars, to invest in those low-end services. This wasn't about a Region V allocation thing, and you know, I don't know if you guys can reconsider this. This was about our experience. All that vote today did, as far as I'm concerned by saying you don't support it, is you opened the discussion for more acute beds, more money for more beds, more money for more beds. And our experience tells us that we didn't have to have that discussion, we couldn't have that discussion, because here was our limitation. This is what you got, this is what you've got to work with, so figure that out and then invest your dollars in the services that are lower end, that keep people out of the hospitals, that keep them out of that. And I've got to be honest with you, that vote today to not support that, has opened the door again for more beds versus everything that I heard everybody talking about today, because our experience was, when you have a set amount of capacity for in-patient care, and a set amount of capacity for crisis, you make decisions that are based on putting services in that prevent people from having to have those cares, and you put services in that move people out of state hospitals when they're sitting there, like discharge ready. We don't have people sitting at LRC that are discharge ready. When they're discharge ready, they're out of it. And I would challenge you to look at the other systems that are struggling and ask yourself, how many people are sitting in the state hospitals, discharge ready? And ask yourself, how long have they been sitting there? It's because they're so busy worrying about how many beds and all this stuff, they're not focusing on the real issues that need to be...and they're not investing the money where it needs to be. That's not to say regions aren't doing their job. It's just that we had an experience that said, here's a limitation. We understand

what that does to you. And alls this has done is continue the process of every region having hundreds...or thousands of post-commitment days that they didn't have a few years ago. Ours have gone up 600 percent in the last year and a half--600 percent--that people are sitting there waiting for care. And so, you know, I'll answer any questions. Obviously, I'm passionate about this, because it became a Region V issue. It's not a Region V issue. We just...it became a this-is-what-you-have issue, and what do you do to keep people from out of the hospitals and actually try and shift money around to a different kind of job. Yes? []

DANIEL WILSON: C.J., thank you for your comments, and I agree, it's not a Region V thing. My main concern today is the...I was not aware that there was such widespread concern from persons working in some of our system, that it's not being consistently utilized, including Lincoln Regional Center. That is a clinical issue. I'm concerned to hear you say that there are regions that have people who are in regional centers who don't need to be there. That needs to change. Who's to change that? It's not fundamentally going to change through resource allocation, I don't believe. It's going to be changed fundamentally through... []

C.J. JOHNSON: I don't disagree with that, but I also... []

DANIEL WILSON: ...clinically sound... []

C.J. JOHNSON: ...disagree with that, because when you know what your...when you know...every (inaudible) allocation, and I don't like that any more than anybody else. It's when you have a certain amount of capacity, you have to make certain decisions, and you have to look at those decisions based on need. And I heard triage today. When you have a certain capacity, then you make decisions based on those people who need the most care at the most immediate time (inaudible), and you shift your services for that, okay? []

DANIEL WILSON: Right. []

C.J. JOHNSON: And so it is, in some ways, driven by what your capacity is. []

DANIEL WILSON: I don't...I completely agree, but you know, another problem that I see here is, we haven't yet monetized the care. Regional center care is free to the regions, if they can get people into the regional centers, and as long as that's the case, there's an incentive to have people in regional centers. []

C.J. JOHNSON: Well, I don't disagree with you. In Phase One planning, my original proposal to the state was, give us the money and we'll contract with the regional centers. So none of that is... []

DANIEL WILSON: I agreed with you back then, and I still do. []

C.J. JOHNSON: ...unrealistic. I just guess what I'm trying to say is, this isn't a Region V issue, and it's not an allocation issue. It's about our experience issue, and we found that by having...knowing your capacity and knowing that that's going to be limited, doesn't allow you to play with other ideas of, maybe we can get more beds somewhere, or maybe we can do this. It forces you to invest in your system to prevent people from ever getting there. It does allow you to free up money to invest in peer support and other funding. In fact, I think it was Lee said earlier, we're investing in a blended case management, which involves a peer support person, etcetera, etcetera. But you know what? You know where that money was coming from? From our post-commitment dollars that we weren't spending. And you know where that money is going to come from this year? I don't know, because we're going to spend all $400,000-plus on post-commitment care, because we can't manage our capacity, okay? So I just again want to say, I really felt like that vote today not to support that, is a horrible idea, because it's based on everybody's whatever, and all you got to do is look at Region V on 6/30/05 and see what they were doing, based on the fact that they knew what their capacity was, what they had to do, and all things were (inaudible), and since then, when a different system got put in place, that all changed, literally, in 30 days, literally. We have more post-commitment days already this year than we had last year, and like I said, a 600 percent increase. And what that post-commitment means is people are sitting in places, not getting the services, and we have fewer EPCs by 29 percent than we had, and we have less in-patient commitments than we've ever had, and yet we have people...we're going to have more post-commitments. So what is that telling you? The people who have the most need and the highest need and who need that care are sitting there longer than they ever have in the last six years, because of this system that you wanted to continue to support, versus supporting a different system that has proven to be effective and to shift resources around. And so with that, I'll answer any questions. []

MARY ANGUS: C.J., if I may, my nonvote, my vote against or whatever you want to call it, that particular resolution, really, really did not--now I've lost what I wanted to exactly say--was not a vote against Region V being able to provide that services. And I... []

C.J. JOHNSON: No, it's against all the good things that happened, that's what I'm saying. []

MARY ANGUS: No, no, no, no, no, no. That is not the purpose of my vote. []

C.J. JOHNSON: Well, that's what I'm saying. []

_____: We spent an hour on this. Let's... []

C.J. JOHNSON: I'm just trying to share with you that this is going to delay this even more, and by the end of the year, we're going to be over our costs for post-commitments, so are a lot of the other regions. People are going to sit there longer. Alls I'm saying is, to delay it and delay it and delay it,...you know, it's been a year and a half (inaudible). It wasn't a surprise. I walked in here in July, the first time you guys had an oversight commission, and after that it was implemented and started showing you the impact that it was having on the system, that was limited in its acute care capacity already, and the good thing...and the negative impact it was already having. It is not a surprise, okay? []

DANIEL WILSON: This commission actually doesn't make that decision. []

C.J. JOHNSON: I understand that. I'm talking about... []

DANIEL WILSON: We voted to not support it. []

C.J. JOHNSON: By voting not to support something just gives fuel to the fire, to those people who think we need more acute beds, we need to blah, blah, blah. That's all I'm saying. I'm expressing my opinion, as well, based on experience and data, hard data. That's what I'm expressing. Not any analogies or anything else, which I know those who know me, can't believe I'm not using analogies. (Laughter) Hard data, that's all. Thank you. []

J. ROCK JOHNSON: C.J.? []

SENATOR JENSEN: C.J.? []

J. ROCK JOHNSON: You know, it may be that your experience is the result of what some might say are unforeseeable consequences, but what's the real crux of it to me is, look what you've done! And I think that that--I don't have a trophy or anything, but you know, you managed to make significant changes. I have a question about the crisis center at the Community Mental Health Center, where those post-commitment days happened. I've been told that they cannot deliver emergency services. They aren't accredited, they aren't qualified to deliver emergency services, or treatment services--treatment is what I want. They're in an emergency...treatment is what I'm trying to say. I don't know what the reason is, and I don't know why that continues. What can't treatment planning begin when people are there? It seems to me there needs to be more innovation around those post-commitment days, at least the way I understand what happens for people in there. []

C.J. JOHNSON: Well no, there's a...in fact, there's a lot of treatment planning goes on, because that's why 80 percent of all individuals who go into the crisis center never have a in-patient commitment, because treatment planning is taking place, as far as what are

community-based services they could benefit from, you know, what can we do so we don't have to go before the Mental Health Board? []

J. ROCK JOHNSON: I understand that. []

C.J. JOHNSON: Yes, when people are placed on in-patient commitment, okay, number one, we have to look at any facilities, based on either licensure or its function, okay? That would be like, the same comment would be as a clinician, a licensed clinical social worker, if I couldn't get my client in to see a psychiatrist for two months, then why don't I go ahead and administer the meds, or make the decision for them? I'm not...that's not within the scope of what I do, and doing acute care in that sense, is not within the scope of a crisis center, okay? It's not within the scope of a crisis center. Their function, based on national accreditation and everything else, is to evaluate, make recommendations, and stabilize. That's it, okay? It's not to provide acute care over a period of time. That's all. []

J. ROCK JOHNSON: Yeah, I understand that. What I'm asking, is there any feasibility to consider their being able to provide that acute care? []

C.J. JOHNSON: Well then, we don't have a crisis...I mean, then we'd have to have hospital accreditation in there. []

J. ROCK JOHNSON: All right, fine. Thank you. That was the answer I needed. Thank you. []

SENATOR JENSEN: Any other public comment? []

JOHN PINKERTON: Yes, I do. []

SENATOR JENSEN: Yes. Let me just follow up on something that C.J. was saying there, a little bit. And I hope that the February 9 meeting doesn't go down as one that we look back on and say, did we make any mistakes? And perhaps we did, and perhaps we didn't. But I hope, also, in the name of inclusion, we don't exclude other people that want to help. And I kind of felt that a little bit, by the resolution I brought forward, in that we excluded people that wanted to help--private sector. Not public dollars, not government dollars--private sector. Every one of those people that contributed had families members with mental illness, had a heart for mental illness, and I kind of feel that we're saying, we don't want your money. We don't want your involvement. I hope that's not the case. But boy, having been in government and knowing how hard it is to get dollars for even a $50,000, $100,000 project, and then to have individuals...and by the way, this ad hoc committee, there were a number of people on there who represented and were providers of people with mental illness, and yes, certainly had a heart for that, also. And so I really do hope that what has happened

here today, and we will think about that, think about the Region V issue, the Region VI issue. I really felt that we had a great working relationship between all the regions, and I hope that continues. I hope nothing that happened here today will discourage that in any manner. And it is about people, and it is about the consumers, and I hope that we can provide a good system and provide care for those who need those services. But...well, I'll just stop there. Yes. []

JOHN PINKERTON: I would agree with you wholeheartedly. I don't think you want to discourage any private investment at all. It's pretty hard to come by. I think some of you have seen my wife in here at these meetings before. I think we've probably been at more oversight commission meetings than anybody in this room, as a matter of fact. And there's some good news that we have that you may not know about, but we run four regional centers. We have our own psychiatrist, which we do not get reimbursed for at all. We have people that, I guarantee you, should be in regional centers, and I guarantee you there's people in Norfolk right now that are worse...that are better off than some people that live with us, and this is what has happened since the regional centers have started closing down. We are forced to take people that are more desperate than they have been in the past, and that's the reason we hired a psychiatrist. We thought we were going to get reimbursed for him, but Magellan's infinite wisdom said, just because he's a licensed psychiatrist in the state doesn't matter, and you don't need any more psychiatrists in western Nebraska, besides that. But we have tried to do everything we can. We've tried to get on this commission and have been turned down. We would like to have a voice for private enterprise on this commission, a voice for small business. We think our ingenuity in hiring our own psychiatrist--and you know, we've got a therapist--and doing what we've done, proves that you can do a lot with very little, which is what we have. And...but I sit a lot of meetings and bite my tongue, because I have some very good suggestions, at times, but because of the format of the meeting, you can't speak up if you're not a member on the commission. But we think we're doing a lot for behavioral health, and matter of fact... []

RACHEL PINKERtON: I'm going to take your role. I'm going to get the hook here. I do have to speak. I'm Rachel Pinkerton. I think we need to make a distinction, Chairman Jensen, between philanthropy and investment. We have a philanthropist in Omaha, John Hoich. He handed us $400,000 for the Hoich Recovery Center, raised another $400,000. I don't see people doing cartwheels and appreciating that. These...we are investors, and I venture to say (laugh) we have more on the line, in terms of risk, and I know we have more on the line, as far as 24/7 on the phone, listening to people directly, hearing from consumers who are experiencing stress at being (inaudible) contending with in the community. So I...with all due respect, the fact that these investors have come forward, that's great. For us to say, well, beggars can't be choosers, we can't hold them to account, to LB1083, to include consumers and families in a meaningful way, at every step of the line, for two years people have been saying, please, please, please, could consumers maybe get on the inside track with this. I celebrate the fact that I hear

that Susan and Linda and J. Rock and Cindy--wonderful. That's very, very encouraging, and I expect to hear good things, at least on that foundation. Thank you. []

JOHN PINKERTON: Anyway, we pay a lot of taxes...on top of everything else, we pay taxes. We kind of think that private enterprise is poo-pooed by HHS and the state, in general. We found a law recently that said they were going to put out contracts, but if weren't a nonprofit, you weren't eligible. If we get a contract, we give half our money back to the state in taxes, and so anyway,... []

RACHEL PINKERTON: (Inaudible) because people are ready to get out of here. []

JOHN PINKERTON: Yeah. (Laugh) But we're trying, alls I can tell you, and nice talking to you. (Laugh) []

SENATOR JENSEN: Any other comments at all? That will conclude the meeting. We are adjourned. Thank you very much. []