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The Behavioral Health Oversight Commission met at 10:00 a.m. on May 11, 2007 at the Nebraska Health Care Association in Lincoln, Nebraska. Members present: Jim Jensen; Senator Joel Johnson; Cindy Scott; Barbra Westman; Linda Jensen; J. Rock Johnson; Carole Boye; Mary Angus; Shannon Engler; Mario Scalora; Ron Klutman; Topher Hansen; Bill Mizner; Dan Wilson; Brad Bigelow; Andrew Belgau; Susan Boust; Karen Weston. Members absent: Gordon Adams; Doris Karloff; C.J. Marr; Howard Olsen; Joe Patterson; Ellie Tompkins; James White. []

JIM JENSEN: A couple things I'd like to mention. First of all, on the screen in front of you is Nebraska Health Care Association parking. If you're not parked in those shaded areas, you should be. []

_____: Or you won't be. []

JIM JENSEN: Yeah. And so it's very important. This is a multi-tenant building and of course, if you're parked somewhere else you're taking some space away from perhaps another tenant. So if you're not in one of those shaded areas, please go out and make that adjustment. The lunch, the drinks today are for commission members only and there is coffee and some other things back here, but if you're not a member of the commission there is a charge for that and there's a sign back there that mentions that. As a matter of fact, we're not taking a specific lunch period and sometime after Item 9 I would ask that you get up and go get your lunch and come back and sit down and we'll try to continue to work right through lunch. If you wish to smoke, you're asked to smoke outside that door. I don't know if you can get back in once you go out. Yes? []

DAN WILSON: There's medical evidence that suggests that smoking has unhelpful health consequences. Just want to...(laughter) []

JIM JENSEN: Thank you, Doctor. []

_____: Now you're going to be a doctor, are you? You're going to talk like a doctor now. []

JIM JENSEN: So with those things out of the way, I'd certainly like to begin. Like I said, we do have the agenda before you. If there are no additions or corrections or if you've got any comments we'd like to have those at that time. Like I said, we have assigned time periods for each item on here and we'll try to go through that as quickly as we can. We really do have a lot before us today. Any comments? Adjustments that need to be made on the agenda? If not, the agenda will stand as presented. You have also the minutes of February 9 meeting. If there's no additions or corrections to that then they'll stand approved as presented and we're ready for then the legislative budget update. Being now as an outsider and looking in and watching some of the debate that went on it, particularly the last week or so, has been very interesting to see. Sandy Sostad is here with the Fiscal Office to help us go through that. Good morning. []

SANDY SOSTAD: Okay. Everyone has a copy of this. I don't have anything really prepared to say. I'll just go through these charts that I've provided for you. We are staff to the Appropriations Committee of the legislative fiscal offices and this is what I put together there is a...it shows behavioral health services, the funding and the budget programs since we started in LB1083. The first budget program there is program 365. That represents the funding for the regional centers. The second budget program is Behavioral Health Aid. That's the money that goes out to the community-based providers and then you see the total for Behavioral Health Aid. And then at the bottom, the new program that we started this year, the sex offender treatment program, which is located at the Norfolk Regional Center. This gives you a snapshot of what, in terms of dollars, are out there for behavioral health aid and the regional centers. If you look at the regional centers, in terms of general funds, that decreased by about 22 percent since 2004-2005. Behavioral health aid, in terms of general funds, has increased by

about 125 percent. Overall behavioral health has increased by about 24 percent with the regional centers and the combination of behavioral health aid. Then you'll see the sex offender treatment program at the bottom. I'll just run through these three sheets and then if there are any questions you can ask them at the end. The second sheet, this shows LB1083 transcripts from the regional centers behavioral health program. On the right hand side you can see the sessions that the Legislature made these transfers, and then I laid out here, in 2005-2006, what was transferred. Some of the initial year of LB1083 approximately $1 million was transferred from the regional centers to the administration program in HHS, and then you can see a $7 million transfer to the community-based programs. For the current year and the deficit bill this year, the Legislature transferred $7 million out of the regional centers to the behavioral health aid programs. That's (inaudible) showing up as 2006-2007. And then in the next year, we're transferring, in addition to the $7 million and additional $7.1 million. That reflects all of Norfolk's funding is done. We've transferred all the funding for Norfolk the initial year, 2005-2006, and some in 2006-2007. (Inaudible) We still have some money (inaudible) that will have to at some point in time. There will be statements there that will go out (inaudible). Then the third sheet I provided you just for along with the behavioral health reform and the transfers (inaudible) the Legislature has begun to fund (inaudible) rate increases and you can see in '05-06 started at 3 percent (inaudible) 2.5 percent. And then for the next biennium a 3 percent increase in (inaudible) also. So if you have any questions I'll try to answer them. []

JIM JENSEN: Sandy, you said then that all of the money from Norfolk has been transferred out. []

SANDY SOSTAD: When we go to the next biennium it will all be transferred. []

JIM JENSEN: That is going to be transferred. []

SANDY SOSTAD: Yes. []

JIM JENSEN: All that...all right. Then for the patients that are still there, the consumers that are still being served, if they move out does the dollars follow them? []

SANDY SOSTAD: No. []

JIM JENSEN: All right. How is that being charged then? []

SANDY SOSTAD: If you look at program 870, sex offender treatment, that money is serving the people at Norfolk and serving the mental health clients that are still there. But that money is needed to continue once we replace the behavioral health people with sex offenders. That money is there to continue to treat the sex offenders. So we have moved the budget of the Norfolk Regional Center out. The funding at 870, even though some of that funding may still go for behavioral health, it is really earmarked for (inaudible) sex offender treatment. []

JIM JENSEN: So in essence, all behavioral health money has been moved out of Norfolk. []

SANDY SOSTAD: Right. []

JEFF SANTEMA: And it's only program 870 money that's there. []

SANDY SOSTAD: Right, 870 is still there, but it's (inaudible) sex offenders even though some behavioral health clients are still going to be in there for the next (inaudible). []

JIM JENSEN: Carole. []

CAROLE BOYE: Following up on that question, so program 870 and looking at $13.7 million... []

SANDY SOSTAD: Right. []

CAROLE BOYE: ...is that considered sufficient to cover 120 people regardless of which column they're in? []

SANDY SOSTAD: Yes. []

CAROLE BOYE: Okay, thank you. []

JIM JENSEN: Yes. []

RON KLUTMAN: For the civilians here that don't practice medicine, but you know, this last thing is astounding. And I guess I'm always very careful about it because physicians quote are these very rich upper mobile people and everything else, but I want to show you what kind of effect when we do not give them, especially in mental health, some effect. We'll take my look at me as a primary care physician in rural Nebraska and what I get reimbursed from Blue Cross Blue Shield we'll say is 100 percent. Now the other thing you have to remember is my overhead is 65 percent. So if you look what I get reimbursed from medicare, that's about two-thirds, which is 66 percent. So any person over the age of 65 that walks into my office I probably do not make any money, but it's an obligation I have to do, and I can cost shift it because in our clinic 20 percent of them are medicare. If you look at Medicaid now, in my office we're down to about 40 percent reimbursement from Blue Cross Blue Shield. So what it basically says I'm losing probably about half every time I see a Medicaid patient. Now I think it's an obligation in a rural community like Columbus, I need to or those people can't go anywhere. But what I've seen as I've been through the chairs of the state medical, and Senator Johnson will tell you this, that we've had to go out and really kind of hammer--and I can tell you certain communities--they accept their Medicaid people because that's their moral responsibility. I guess what I have started telling the department now, we have reached

a point that I think it's a true responsibility, but I now understand why they can't afford to take Medicaid patients. In my community health center we'd love to have them, because it's income, but most of our people don't have anything to do. And I know on the national scene, the AMA has talked about a crisis in the delivery of health care to our medicare patients. We are, I really truly believe for the first time in my life and practicing 32 years, we're going to find Medicaid patients really having a problem finding a provider. And I've done what I can, you know? I've tried to and we will never turn it down, but we're also 20:10. We can afford to cost shift it. If you get into rural areas below Columbus, about 60 percent of those patients are medicare, about 30 percent Medicaid, and I don't know how they make a living. I really...they have to be, you know, given God's gift to practice in those communities. But I want all you to understand and I think the senators understand, that we can...3 percent rises when my overhead is going up 10 to 12 percent. We're going to reach a point that there is going to be a real crisis in finding somebody to practice. And I now find out, after trying to hire a psychiatrist for my mental health clinic, the reimbursement is just there. You just can't do it because they can't make a run. The only place they can do it is private paid patients, so I think that's a real problem trying in a rural area to find psychiatric care. I'm sorry. I didn't want to get on my box. And like I said, I apologize, because I know better than speak as a physician on this, but I just want to warn everybody here. We are going to have an access problem, especially in the rural areas. There's just nothing we can do. Done. []

JIM JENSEN: Thank you. Yes, Carole. []

CAROLE BOYE: Two other questions, Sandy. You said that in Hastings that there will still be some transfer needed from Hastings. Is there a ballpark figure of that? I mean, has that been nailed down? (Inaudible) []

SANDY SOSTAD: I don't think that's been nailed down. If I had to say I'd say $4 million to $6 million (inaudible) something in there. []

CAROLE BOYE: Okay. Okay. And then... []

_____: Four to six or 46? []

CAROLE BOYE: Four to six. []

_____: Four to six. I thought that's what she said. []

CAROLE BOYE: Yeah, not 46. (Laughter) []

_____: I was going to say, oh (inaudible) 46. []

_____: We could start a new rumor, but it won't get us very far. (Inaudible) []

CAROLE BOYE: And then at face value, just rough math here, is that roughly there's about a $33 million shift in behavioral health aid over the fiscal years that you've shown and yet there's only about a $12 million decline in aid to the regional centers. Are we funding the regional centers more as we...those two numbers don't add up for me. []

SANDY SOSTAD: You have to think of it from the perspective we're still funding the regional center services that are there. They have their ongoing fixed cost refund, their salary increases, their health insurance and that kind of thing. So that's what's reflective in the regional centers. Basically what we do is we look at the regional centers, say what are you going to (inaudible) funds? And then the (inaudible) makes up the difference to fund salaries, health insurance, depreciation, fixed costs (inaudible). So that's how we set the appropriation (inaudible). []

CAROLE BOYE: Okay. []

SANDY SOSTAD: So I know what you're saying, but it appears... []

CAROLE BOYE: It appears that when we started kind of with an (inaudible) of $60 million we were spending on three state institutions that we took a half step back and we're going to kind of keep progressing and probably get back to (inaudible) at some point, baseline. Okay. []

JIM JENSEN: Yes, Dr. Wilson. []

DAN WILSON: Well just a related question and it's very basic. I don't fully understand if I...you said all of the money had been shifted from... []

SANDY SOSTAD: A little bit from one budget program to the others. []

DAN WILSON: But when you say all of the money, what does that refer to? []

SANDY SOSTAD: The general funds budget of the Norfolk Regional Center. []

DAN WILSON: The general fund. So... []

SANDY SOSTAD: We have moved the general funds, yes. []

DAN WILSON: So just looking on the first page under 2008-2009 up in the upper right corner, $43 million is from where? []

SANDY SOSTAD: It's still for what's left of Hastings and... []

DAN WILSON: But that's general funds? []

SANDY SOSTAD: Right. That's general funds. That's (inaudible). Forty-three million is still funding all of Lincoln and what's left of Hastings. []

DAN WILSON: So it's not...so again, when you say all of the money from general funds... []

SANDY SOSTAD: So on the second page when we show that $7 million transferred... []

DAN WILSON: Right. []

SANDY SOSTAD: ...and the additional $7 million, that adds up to $14 million. That is the general funds that were at the regional center. They are moved now into community-based programs. The only general funds that are at Norfolk now are for the (inaudible). []

_____: Follow up on that. []

DAN WILSON: Is that...excuse me, Mario, but is that $13.7 million for the sex offenders? []

SANDY SOSTAD: Yes. That continues, yes. []

DAN WILSON: Okay, maybe I'm confused. What's program 365? []

SANDY SOSTAD: That would just be regional centers. The top program (inaudible) is all the funding for the regional centers. The second program is all the funding for community-based (inaudible) programs, and then the bottom one is the sex offenders that we just started up. []

DAN WILSON: So there's still $43 million in regional center operations unrelated to sex offenders? []

SANDY SOSTAD: Right. []

DAN WILSON: So I guess I am confused by the use of the word all of the money has been transferred to community-based (inaudible). []

SANDY SOSTAD: For Norfolk. []

DAN WILSON: What's the rest... []

SANDY SOSTAD: We still have Lincoln and we still have Hastings (inaudible). []

DAN WILSON: And it's...okay. And how much of the $43 million would be Lincoln? []

SANDY SOSTAD: I can't answer that. []

DAN WILSON: Okay. That's helpful. []

SANDY SOSTAD: They are able to allocate, you guys may be better able to (inaudible). The majority of them is (inaudible) then, I would say, of the general funds maybe $5 million or $6 million. (Inaudible) these things. I'm just guessing. []

DAN WILSON: Thank you. []

JIM JENSEN: Mario? And then Topher. []

MARIO SCALORA: Are we saying basically that then we're capping any money that could be transferred out of Norfolk that there are basically 60 beds that we're going to continue to fund for SPMI? So... []

SANDY SOSTAD: Yeah, but it's really the Legislature gives it as transition. They did not

want to lose the staff at Norfolk. The beds are there, so (inaudible) fine. We've made the funding switch and the general funds are there to continue the 120 beds and who's in those beds in the next biennium will be sex offenders and possibly some mentally ill. But the money for the Norfolk budget, the $14 million, is out of community-based programs. So there's no intent to move anymore money from Norfolk. Hastings is the only area we still have to move money. []

MARIO SCALORA: So theoretically that budget that we're calling sex offender treatment is also funding SPMI treatment? []

SANDY SOSTAD: Yes. For a period of time until it's all filled with sex (inaudible)... []

MARIO SCALORA: Until shifts all to sex offenders. []

SANDY SOSTAD: Yes. []

MARIO SCALORA: Okay. Thank you. []

JIM JENSEN: Can I just follow up on that while you're on it? Then what--and then Topher and then we'll get to Linda--what is the incentive for Region 6 or any other region--Region 5 or whatever it might be--to take somebody that is in Norfolk and bring them into their community? []

SANDY SOSTAD: They've got the money now. The state has the money. They have the $14 million and they're going to bring services out to take those remaining clients out of Norfolk at some point in time. How they're doing that would be based upon their plans, I suppose, but the money is there to serve the clients that were in the Norfolk Regional Center. They have the plans to (inaudible). []

JIM JENSEN: Thank you. Topher? []

TOPHER HANSEN: Sandy, I so wish we would have given you an invitation to this about two years ago. (Laughter) I'm so glad you're here. Thanks for being here really, because I've been trying to put the numbers together in my head and I'm still wrestling with it, because it's...and let me back up and give you what I remember being the plan and see if I'm tracking accurately and if I'm off on your numbers let me know. Originally we were thinking that it would about a $29 million transfer and then there was some $29 million and then it was $25 million or $26 as it later emerged. []

SANDY SOSTAD: "Twenty-six-ish". []

TOPHER HANSEN: "Twenty-six-ish". And so what...from the regional centers and institutional care into the community-based services. And so what I'm seeing here is that we had about...well, you had mentioned the 23 number, $23 million are in. So we're still short several million dollars transfer in. But then the regional centers are only cut back $12 million or $13 million in their operation. So the other ten or whatever that difference is that we put in the community-base has come from general fund. We've just had to go dig that up somewhere in the state to fund community-based services. So the question is then if we're short and the regional centers are still occupying a major piece of that budget line they originally did, are we in a transfer process? Because you can't just automatically do this. It's not that clean. You have to overlap a little bit, but ultimately you can make the switch. So are we in a transfer process where the regional center is going to spend money for a little bit and then we'll get all of this over to community behavioral health, or are we just in a position now where we have new money into the community, the regional centers have other stuff going on, and we just have two pieces that we're having to fund and find the money for? There is no transfer, in essence. As Carole said we're going to get back to (inaudible) here pretty quick. On the regional center side and then we've got a big community-based system and we're just going to have fund the two of them. Do you see this as being a transfer in what you're doing or is it sort of fixed and you're just waiting to hear where the money is going to come from to

finish it off? []

SANDY SOSTAD: I think fixed from the point of view of we won't transfer anymore money for Norfolk. We figured that the Legislature has provided the funds for the Norfolk budget and it is (inaudible) budget community-based. You guys will not be able to spend it that fast. We just transferred $7 million and next week we'll transfer $7 million. You'll never spend that $7 million. Probably itsy bitsy bit this fiscal year and then you'll have $14 million next year that is new money to be spent on services. So the only other money that we still will have to transfer is when Hastings finally closes and you would have the general fund dollars to transfer up to the community. So what the Legislature said in LB1083 is that we will move the money to serve the clients at the regional center and that will be done as soon as we finish the Hastings (inaudible). And that, I would look at being probably in the next fiscal year. []

TOPHER HANSEN: So there will be...this deficit funding is just fronting money that you see transferring anyway from Hastings, and so it is... []

SANDY SOSTAD: Yeah. []

TOPHER HANSEN: It is transition type activity and ultimately will get to our board. []

SANDY SOSTAD: And if you looked at the actual expenditures here, these are the appropriations, if you look at the actual expenditures they're not going to match at all. []

TOPHER HANSEN: Right, right. []

SANDY SOSTAD: Because the money cannot be spent as quickly as we get it to you. So there is carryover (inaudible), but the Legislature will be (inaudible) it's commitment from LB1083 as soon as we get these things finished and closed and then we'll transfer that money. []

TOPHER HANSEN: Okay. []

LINDA JENSEN: My question is about the federal money. Now what does that include? Is that Medicaid... []

SANDY SOSTAD: It's got Medicaid rehab option. It's got their medical (inaudible) grants, substance abuse. I think there's...I think it should be a (inaudible). []

LINDA JENSEN: It doesn't include Medicaid medical money. []

SANDY SOSTAD: No. That's in another program that (inaudible) it should just (inaudible) 348. []

LINDA JENSEN: Okay, because I was thinking that's... []

SANDY SOSTAD: (Inaudible) the Medicaid rehab option and quite frankly, I mean, we use the department's request for federal funds. Quite frankly when I looked at the numbers that Mary has given you in terms of Medicaid coming in through behavior health reform. I would guess in the next fiscal year in '08-09, there will be more than the $18 million, because there's only roughly I think $6.8 million there and the numbers she's given you is probably closer to the $8 million or $9 million coming in in Medicaid. So that federal fund is just an estimate in terms of what we put in the appropriations bill that I think (inaudible). []

LINDA JENSEN: Okay, so that's not the Medicaid money that was supposed to increase? []

SANDY SOSTAD: It technically is the rehab (inaudible). []

LINDA JENSEN: The rehab, not the hospitalization, not the Medicaid money for hospitalization. []

SANDY SOSTAD: Right. []

JIM JENSEN: Okay, and we're going to have to stick to our schedule a little bit, but Carole and then Doc Klutman again. []

CAROLE BOYE: Three quick questions following up what Linda just said. So that is Medicaid rehab option money. The trend line appears to be going down and yet the goal was to build it. []

SANDY SOSTAD: And why it's actually going down there is really more block grant funding and within this program there's a lot of...there's some one-time grants for mental health, substance abuse. So that's where the decline is really. Medicaid money is staying constant, but I think it technically is going up. []

CAROLE BOYE: Yeah, hopefully we are actually succeeding in leveraging some additional dollars. Two other quick questions. You talked about a carryover. Is there any estimate that the Legislature has about carryover into this next year yet? []

SANDY SOSTAD: I don't know what that... []

CAROLE BOYE: Okay. []

SANDY SOSTAD: I'm going to say for sure $7 million. We just gave you $7 million. []

CAROLE BOYE: Okay. []

SANDY SOSTAD: You know, and it will be more than that. I have no idea how much

more, but... []

CAROLE BOYE: Okay. And then I think...I want to interpret this as good news here for a minute, so tell me if I can, okay? (Laughter) Which is that the Legislature has decided that the transition money for the...the community system--I'm not real sure how to say this--but my interpretation here is that starting next year, there is a plan by the end of the biennium for the money to be transferred out and if there are, you know, as we kind of continue to debate from a policy perspective, it appears, you know, whether Norfolk is going to be all sex offender or if it's going to be part sex offender, part behavioral health. The Legislature is going to kind of fund that up front and "delink"... []

SUSAN SOSTAD: It's funded in 870. []

CAROLE BOYE: Yeah, "delink" it--if there is such a word--from LB1083. []

SANDY SOSTAD: Right. []

CAROLE BOYE: That's my really favorable opinion of this. Is that assessed... []

SANDY SOSTAD: We are planning 120 beds there and that mix of clients in that 120 beds is going to be sex offenders and it's going to be... []

CAROLE BOYE: Okay, so... []

SANDY SOSTAD: And primarily when we looked at it initially it was going to be more behavioral health than sex offenders. []

CAROLE BOYE: Okay, but we have... []

SANDY SOSTAD: But I looked at the data today and we have more sex offenders... []

CAROLE BOYE: But we've kind of "delinked" that. Is that right? []

SANDY SOSTAD: Yeah. 870 is for sex offenders, but there will be some that (inaudible). []

CAROLE BOYE: For my admittedly very biased opinion, that is good news for community behavioral health. Okay, I just wanted...if I'm going to be happy about something I want to make sure it's real. (Laughter) []

_____: It's real. []

JIM JENSEN: Whatever you can work out in your mind. (Laughter) Ron? []

RON KLUTMAN: Quick question. So these people in Norfolk and soon to be closed Hastings and Lincoln, are they all Medicaid eligible so that we can meet the federal... []

SANDY SOSTAD: When they're in the institution they cannot receive the Medicaid. []

RON KLUTMAN: So we still are running into that problem that is quote it's a mental institute. []

SANDY SOSTAD: Right. When they get out into the community...yeah. []

KAREN WESTON: I just got to say one quick thing. It is of a concern as a hospital provider, looking across the state, the transfer of patients from regional centers and maintaining them at the hospitals is basically ends up being a loss a lot of times for hospitals. I think, you know, people have gone a long with it understanding that there was a premise and things were going to change. I find it hard to see how hospitals are going to understand that all this money is still...that's a lot of money, and very little has

been decreased. It's going to be in their eyes. When their taking the burden of these patients and also assuming a loss, because they are assuming a loss with these patients. So I just want to say that that will appear in the future. []

RON KLUTMAN: But they would be Medicaid eligible, right? []

KAREN WESTON: Not all, but if you have someone on Medicare and they're committed there's a prospective payment now. So if they need to be in the hospital two months, let's say, you get a perspective payment of 20 days or whatever and that's it. []

RON KLUTMAN: But the Medicaid is what I'm saying. They would be eligible in the community hospitals. []

KAREN WESTON: Not all. []

DAN WILSON: Many are, but not all. []

KAREN WESTON: Not all. []

RON KLUTMAN: More than what they are there in Norfolk, Hastings, and Lincoln. []

DAN WILSON: Oh yes, yes. []

KAREN WESTON: But some people have, you know, no funds, but we still have contracts, but it's the Medicare folks prospective payment is (inaudible). []

DAN WILSON: It's the same discussion you raised about individual practitioners at the hospital level. They're getting hit with uncompensated care more and more and more. []

RON KLUTMAN: Okay. []

JIM JENSEN: (Exhibit 1) I think we can pick up some more of this conversation--and this has been very, very good--when we get down to item 6, perhaps, but I think it does point out that there is some real challenges that we do have and continue to work though that. Any other discussion on that before we move off that item? Sandy, thank you so much. That's really cleared up at least where we are on the appropriation. The next item, item 5, is...as you know, anytime that we discontinue services at one of the regional centers there needs to be a notice to the Governor and to the Legislature. You have before you that notice that went to Governor Heineman and to the Legislature on the notice of the reduction of census at the Hastings Regional Center. We do need a vote on this. I will sign this and then take it forward. Any discussion on this? Okay. May I have a approval from the Oversight Commission to go ahead with this? []

RON KLUTMAN: Second. []

JIM JENSEN: A motion? []

MARIO SCALORA: Point of order. []

JIM JENSEN: Yes. []

MARIO SCALORA: This activity has already happened. []

JIM JENSEN: Yes. []

MARIO SCALORA: Is our vote necessary since it's already taken place? []

JEFF SANTEMA: Yeah. Yes, you still have to render an opinion... []

MARIO SCALORA: As to it being appropriate (inaudible). []

JEFF SANTEMA: ...as to whether the documentation comports with the statute. []

MARIO SCALORA: Thank you. []

JIM JENSEN: Doctor, did you make a motion? []

RON KLUTMAN: The motion was there and I second it, so... []

JIM JENSEN: Oh, all right. Dan made the motion and Doc seconds it. Any discussion? Yes, Topher. []

TOPHER HANSEN: You know, as Mario points out, the horse is out of the barn and... []

MARIO SCALORA: That's a nicer analogy than I would have used, but...(laughter) []

TOPHER HANSEN: Oh were you going to...we can go back to the house thing that Shannon started at the beginning, but I...the question I'd ask is what evidence do we have that sufficient services exist in the community to support the discharge of people from regional centers? Where is it in this state that services exist that are ready to receive people from the regional centers that don't have waiting lists, that have ready access, that are able to do it? I can think of a couple at best that are ready to receive people and that's because they're ramping up. But any existing services...and I think Region 5, of course, is my experience. And so what I know is if you're looking for case management, if you're looking for day rehabilitation, if you're looking for treatment, if you're looking for outpatient services, I mean, you name the list. I do a bunch of those things and I know the other providers that do them in this region as well and there are waiting lists in every program. And I'm concerned then that we do not possess sufficient capacity. Have we increased our capacity? Absolutely. Across the state we think there's plenty of evidence to say we have created more services, but we have to bear in mind

we were 50th in the country per capita on our spending for behavioral health services when we started this process--50th. We're at 43rd is the number I've seen quoted more recently. And so, you know, the horse is out of the barn. What do I say if I object? If I say no, if I say yes, I tell you my gut is going off saying that's not true. I see people standing in line for services at my program. How can I in good conscience vote for this and say yes? That's my comment and Ron I know is ready with the evidence and I'm willing to listen to that. I'm open to that, but I need that support to say yes, we're ready to receive these folks. []

JIM JENSEN: Okay. Carole. []

CAROLE BOYE: Well, I'm sure Ron can address this. I think all they have to do is look at closing 20 or 40 beds in Hastings and to say sufficient services. We're not being asked about the whole system and to me, the kind of de facto evidence is that for close to a year we had four and then three and then two people in. That particular service (inaudible) beds, those particular beds. Apparently there are sufficient services because nobody was being referred to them, you know? So I just... []

TOPHER HANSEN: They're gone is the evidence. []

CAROLE BOYE: No, they were there for a significant period of time and we had two, three, and four people there... []

TOPHER HANSEN: Right. []

CAROLE BOYE: ...for 40 beds. So all I would encourage us to do is to stay focused on what the specific action we are being asked to take here or to look at here as opposed to the much broader issue where I would join with you in terms of saying we are increasing looking at capacity issues on a much broader scale. But what we're looking at issues... []

TOPHER HANSEN: But if you look at the criteria, Carole, on what we're being asked to consider, it isn't are they gone from the regional center. It's does sufficient service exist in the community? Is there sufficient capacity to address the...and so what you've got is by implication is at best that you're saying they're not here therefore they must be receiving services. And so that's the horse out of the barn analogy, but so then I guess I'm interested, what is it that we can say...you know, the evidence is before us that these people are receiving...and if what it is is we have tracked these folks and they are in services then I'm willing to go to that and that the people standing in line at my place and the other places are people that were already in the community and not out at the regional center, that's fine. I just don't have that information right now. []

RON SORENSEN: Well, let me try to answer that, Topher. Looking back at...we probably reached a high in that unit in April of '05 when we had, looks like 38 people there. A year later, in '06, we had 18 people there. As we look at December of '06 we had 11 people there and we did not have an admission since '05 and we had not had a referral for months to the Hastings unit. By March we were down to four and we actually reduced it to two people. We had two individuals there who were not ready to go to the community and those individuals were moved to Norfolk. So you will see in the Norfolk a slight upward blip if you'll look at it. We'll get into that later. So what we did was basically find places for those people to move to that existed in the community. The regional center and people that have worked on discharges. I've got to give a lot of credit to the regional staff. All of them now have emergency system coordinators who work essentially one or two days in the regional centers to work with individuals that...I've got to tell you, years ago, some regional staff years ago would have said they'd never be in a community and today they are, and that's, in a sense, a victory in itself. So I think in this particular case, what we've seen is that we have reduced the needs for these particular services, and I would also remind you that, as we've talked about in the past, we have added what is now, I think, 26 total beds at Richard Young in about a year. We have added, in the process of adding 10 beds at Lincoln Regional Center to get up to

100. So in a way, we have compensated for that in other places if that makes sense. Okay. []

JIM JENSEN: Mary, did you have a question? []

MARY ANGUS: I believe part of it has been answered. I guess I would register my concern in 2A, 2C. We're talking about appropriate community-based services and that they possess the sufficient capacity and capability. I would not be going to the direction where we would say don't close Hastings. I would be going to the direction that we need to do more to bring up those services in the regions. Appropriate resources that are adequate for the need. []

TOPHER HANSEN: If I might, to follow up on my own comment since I raised the question that I am willing to vote yes on this with the thought that the people who are in Hastings Regional Center have had purposeful placement in the community through active case management at the regional centers and in the regional districts around the state, and by virtue of that that we know that services have been delivered to individuals who were formerly at Hastings and that we're not needing to utilize that facility because we've maybe increased our capacity elsewhere. So if there is somebody who is in need of services once again that then they can go to Lincoln or crisis centers or places like that. So on that basis, I guess I'll hang my hat that sufficient services exist. However, I still know that our community-based system is just struggling to get to capacity. And we can't rest on laurels of the kind of progress we've made over the past five years, because until, my mind, until we get to an average in this country of...we are 25th in this country per capita in our spending, which means we're an average bear, then that will be, I think, a place that we can rest with some ease. Less than that, I think we're behind the curve and hurting our citizens of our state. So anyway... []

TIM JENSEN: Yes, Susan. []

SUSAN BOUST: I just want to speak briefly for the motion. I understand all of the issues about the hospitals and the lack of adequate community-based service funding, but I think that as a commissioner I feel comfortable voting that at this point Hastings' services are not needed. []

JIM JENSEN: Any other comments? []

SHANNON ENGLER: Senator? []

JIM JENSEN: Yes. []

SHANNON ENGLER: I just need to comment that I agree with what Topher said originally. I do not see the evidence and as a provider I can say that I still receive requests for transfers from the Hastings and Kearney area even though we've opened up additional beds. Now would those individuals otherwise have needed this particular program? I don't know, but what I do know is there's not sufficient services up there to meet the needs of those consumers in their community. So this is the piece where I'm torn. I know we need to have the funding, but on the other hand with the mandates that we have to vote for, using the criterion, I don't see it and Ron, the evidence that you gave was, well the numbers are decreasing. But I can tell you I don't think any of my staff even have known how to get somebody into that program and that's kind of like well, we'll lock the door to the chicken coup. So see there's no more chickens there anymore, we don't need the chicken coup. []

RON SORENSEN: Well, I might want to make sure you understand my comments. I didn't say that necessarily there was enough community-based services. What I did say it that we have by replacing these beds in other places and through the diligent work with case managers, moved the people to Hastings and the Hastings Regional Center adult services are not needed at this time. We originally designed that program to be a backup in the Hastings area to provide subacute services. We essentially created then

instead the subacute services at Richard Young in Kearney, and I think one of the things to understand about that is that when they moved to Kearney the people who were Medicaid eligible were now going to draw Medicaid funding, which we weren't getting at... []

RON KLUTMAN: They what? I'm sorry. []

RON SORENSEN: The people who were eligible for Medicaid who now were served at Richard Young instead of Hastings, for example, or another regional center would get Medicaid match for the expenses there. So in that way it did benefit the state's expenditures of general funds money. []

RON KLUTMAN: I'm getting a little confused. I understand that the regional center is the reason that we wanted to because they couldn't be Medicaid funded. We couldn't get the grant money because they were designated mental hospitals. Is that correct? []

RON SORENSEN: Institutions. Institutes of mental disease is technically...yeah. []

RON KLUTMAN: Now what's Richard Young called? []

RON SORENSEN: Richard Young is a psychiatric hospital. []

RON KLUTMAN: So that's different and they can get... []

RON SORENSEN: Yes, they can, because they're a private hospital in the community and they are attached to--help me with the name of the hospital []

LINDA JENSEN: Good Samaritan Health System. []

RON SORENSEN: ...Good Samaritan, and so the IMD rule says that as long as a

hospital has less than 50 percent of their beds psychiatric care they can get Medicaid, but hits 50 percent or 51 percent they can't. []

RON KLUTMAN: So we could never... []

RON SORENSEN: Yeah, don't ask me why. []

RON KLUTMAN: The sex offenders up in Norfolk unless...what hospital has 1,000 beds? []

RON SORENSEN: Yeah, unless Richard Young wants to build a facility for sex offenders we're not going to get that. []

_____: Unless they want to buy it. []

ANDREA BELGAU: The distinction there is they've been placed there by the state. []

RON KLUTMAN: So has... []

ANDREA BELGAU: Oh, that's true. Yeah. []

DAN WILSON: Well, that's a...I mean, the whole sex offender thing is a parallel growing discussion nationwide and people are anticipating and beginning to implement appropriate community-based services for sex offenders wherever possible for the same financial reasons, and we're just not at that stage yet. []

JIM JENSEN: Any other discussion? []

MARIO SCALORA: Just to point out a parallel point. I think it's reasonable for us to vote in favor of this. I don't think it benefits the state to keep those beds and keep them open.

We need to transfer the money. As a commission, and I have no reason to question the honor and the integrity of the folks in behavioral health for the state. They obviously do not need our permission to do this. But for us to perform our oversight role, I'd like to know what the horse looks like before it leaves the barn ad we have to figure--I know we do quarterly meetings--we have to figure out a way to do this so that they can do their business and we can manage our's and be able to inform the Executive Committee at the Legislature appropriately. So if we could figure out a way to work that a little better I'd feel like a happier bear, to use the analogy offered earlier, and so I just raise that as a point of concern for how we do business in the future and I would throw my support behind the closure of the beds. []

JIM JENSEN: Any other discussion? All right. I'd ask for a vote. All those in favor say aye. Opposed? Thank you. Regional center discharge follow-up is set. []

_____: Dr. Galloway? []

JIM JENSEN: Yeah. []

SHINOBU WATANABE-GALLOWAY: Good morning. Thank you for having me. My name is Shinobu Watanabe-Galloway. I am from the University of Nebraska Medical Center who directs this program. I'm going to report to you the summary of (inaudible) findings from year 2 quarter 1 reports. We are currently working on quarter 2 and 3 reports. But anyway, the ones we are going to discuss today are from quarter 1 reports. []

J. ROCK JOHNSON: And those dates would be... []

SHINOBU WATANABE-GALLOWAY: Those dates would be...I'm going to show you that shortly. So very briefly, about the methods we used and five areas that I'm going to highlight. One is discharge patterns and trends, discharge status, readmission, some

information about services utilization, and lastly (inaudible) findings from psychiatric diagnosis area. So in our project, currently, we are focusing on adults who are served within the regional center units to (inaudible) Hastings, Norfolk, and also Lincoln Regional Center's short-term care unit and community transition program. The way we define the consumer to enter a follow-up system is (inaudible). They are discharged from regional centers, (inaudible) in one or more of the beginner health reform (inaudible). And these are the units that were examined for this particular reporting period. Understanding these have been changed and (inaudible) be reflective for the data analysis for more recent reports. And we receive data from Health and Human Services on a regular basis and these are the data sources we use for (inaudible). Okay. []

J. ROCK JOHNSON: Could you go back one, please? []

SHINOBU WATANABE-GALLOWAY: Sure. []

J. ROCK JOHNSON: Yeah, there you go. Up to previous. []

SHINOBU WATANABE-GALLOWAY: Okay. Yes, I understand that. I just don't know how to do this. This one? So Magellan, Medicaid, and N-FOCUS data, AIMS/Avatar, and Axis data comes out of separate database when we receive the data. []

J. ROCK JOHNSON: Is that a database that you maintain? Axis? []

SHINOBU WATANABE-GALLOWAY: All of these come to us and we merge data sources and (inaudible) database. []

J. ROCK JOHNSON: So Axis is a state-maintained database. []

SHINOBU WATANABE-GALLOWAY: Yes... []

J. ROCK JOHNSON: Thank you. []

SHINOBU WATANABE-GALLOWAY: ...we do use and maintain the database, including Axis. So the reporting period, which I'm going to discuss further, but the findings cover January 1, 2005 through August 31, 2006. So during this reporting period, a total of 822 consumers enter the follow-up system meaning they were discharged from specific behavioral health reform units of the three regional centers. []

MARIO SCALORA: Doctor, are they unduplicated or are these potentially duplicated numbers? []

SHINOBU WATANABE-GALLOWAY: All of these numbers that I'm going to present here are unduplicated (inaudible). And this shows the trend in monthly entries to follow-up system. Again, the number of people discharged from specified behavioral health unit each month during this reporting period. And going over quickly about demographic information about these individuals. Comparing Nebraska population to follow-up population you might notice some differences such as older age group. Usually follow-up population much smaller population. And now male and female ratio again comparing follow-up population to Nebraska population. Sixty percent male in follow-up compared to close to 50 percent in Nebraska population. Race and ethnicity, this one is just for follow-up population. The census data categorize race and ethnicity differently than the data we receive from Health and Human Services. So we cannot do side by side comparison, but this also gives you some idea to Nebraska state population about 91 percent white and the follow-up population that is about 80 percent. So there are some differences. And this is insurance status information at the time of discharge from regional center. Medicaid is about 25 percent and medicare is 17 percent, and some type of health insurance that you notice here too, including Blue Cross Blue Shield. Small percentages, but it's there. According to the data, no insurance quoted as 34 percent and for some people we do now have the information

about the insurance status. We might (inaudible) people do not have insurance or whatever the reason, we do now have the information. Yes? []

CAROLE BOYE: On the Medicaid specifically, is this at the time of discharge the Medicaid is in place or is it Medicaid is pending or they should be eligible? Do you know? Are there any qualifications on that? []

SHINOBU WATANABE-GALLOWAY: Unfortunately, we cannot make the distinction. We just have to...Jim. []

JIM HARVEY: Carole, these are the data, if you look at the footnotes, this is just prior to discharge from the regional center. Keep in mind as you're looking at this table that regional centers have a financial responsibility unit that goes and tries to get payment where people are eligible to do it. So I do think this gives you a reasonably accurate reading on the insurance that the consumers that Shinobu is following, what money they have. []

CAROLE BOYE: So that 25 percent is probably a Medicaid reinstatement status as opposed to down below the 34 and 16 percent of known/unknown may potentially be eligible, but we don't know. []

JIM HARVEY: Actually with the unknown I would project that that means they don't have insurance, because if they had insurance then financial responsibility would have been billing it. []

CAROLE BOYE: Right, right. []

JIM HARVEY: So in my mind, I'm comfortable in adding the no insurance 34 percent and the unknown 16 percent--which is, what, 50 percent--have no insurance at all, and then you've got your Medicaid and medicare. So actually those would...third party health

insurance is a very small number. []

TOPHER HANSEN: Carole, was your question then going to that 50 percent that a portion of those may be eligible, but may not have gone through the process? []

CAROLE BOYE: Right. []

TOPHER HANSEN: Yeah. []

LINDA JENSEN: It may not have been finalized, but they got... []

TOPHER HANSEN: Finalized or even sought after. []

LINDA JENSEN: Yeah, I mean how long does it take to get it these days? []

MARIO SCALORA: And my understanding of how the records people enter that, if it isn't finalized or certain they're going to put it in one of those other categories. []

CAROLE BOYE: Right, and that's really my question. []

MARIO SCALORA: Yes. So yeah, it's hard to know how many. []

CAROLE BOYE: That we have a potential (inaudible) of 50 percent of folks coming out from these units of potentially Medicaid eligible that we have a lot of work to do on. All right, thank you. []

SHINOBU WATANABE-GALLOWAY: Okay, of those 822 consumers entering the follow-up system between these two dates, 100 people exited the system, which means those consumers met one of these criterias. One is the person was discharged out of state with no records of Nebraska services (inaudible). Then we consider that person to

have left our follow-up system. Secondly, if the person was discharged in Nebraska (inaudible) at least 90 days, about three months, but we did not find any record of service (inaudible), or we found the data indicating that person died after the discharge. []

MARY ANGUS: Excuse me? []

SHINOBU WATANABE-GALLOWAY: Yes? []

MARY ANGUS: I have a couple of statements. One is that we've got 100 people that we don't know if they got services at all, which goes to my concern of earlier that they're not getting services or at least they're potentially not getting services. And I believe earlier we had asked for numbers on what cause of death was and I don't even know how many of those folks died. Do you have any answers on that? []

SHINOBU WATANABE-GALLOWAY: Do we have quotes of this information in the data? We do not receive that. []

MARY ANGUS: Do you have number for us about how many died? []

SHINOBU WATANABE-GALLOWAY: Yes, we do. We do have the number of how many died and the quotes of this information can be pulled out from the death certificate so it's not (inaudible) we know who died. Then that information will be able to tell you, but the number...(inaudible) this is the (inaudible) each month how many people have left, and here is the reason. So that's (inaudible). []

MARY ANGUS: I would really like to see the cause of death as much as absolutely possible, yeah. []

SHINOBU WATANABE-GALLOWAY: And we are taking notes for the questions you

might have, so... []

MARY ANGUS: Yeah, because I know we asked that the last time we got numbers. []

_____: Yeah, we've asked that before. []

MARY ANGUS: Thank you very much. []

KAREN WESTON: What does the no service data mean again? []

SHINOBU WATANABE-GALLOWAY: The data we received indicate that there is no evidence that somebody received service from the state. []

LINDA JENSEN: So they're receiving no services? Now with what percent...I'm sorry. []

JIM HARVEY: It doesn't necessarily mean they're receiving no services. It means they're receiving no services paid for through the data sources that we're reporting from. So there's nothing in that focus. There's nothing in Medicaid. There's nothing in Magellan. Doesn't mean they're not receiving any services. It's just not showing up in the system. []

CAROLE BOYE: So those Blue Cross Blue Shield insured folks may be seeing a private outpatient... []

JIM HARVEY: And we would have no capacity to know that. []

CAROLE BOYE: Right. Okay. []

MARIO SCALORA: If they're not under your funding streams, but they're getting service... []

JIM HARVEY: Any you might recall that with the insurance one there was a group who did have insurance. Don't know why they landed in the regional centers. That's not explained by this data. []

MARY ANGUS: I believe that was about, what, 5 percent total? []

JIM HARVEY: It's a relatively small number, but (inaudible) show up in a couple slides. []

SHINOBU WATANABE-GALLOWAY: And now moving on to region of admission among those people who enter the follow-up system. This is a breakdown. And where these individuals were discharged to the different regional centers. And we look at the same information but breaking down these numbers into specific so the stipulations are not here. Now this table shows the region of admission and where these individuals were discharged from for each regional center. So 26 percent of consumers were discharged from Hastings, 35 percent from Lincoln, 38 percent from Norfolk within those categories where they came from. That's what this table tells you. []

SUSAN BOUST: And this is where they came from or where they went to? []

SHINOBU WATANABE-GALLOWAY: Admitted from each region. []

SUSAN BOUST: Okay. []

SHINOBU WATANABE-GALLOWAY: And this is the discharged status information. According to the data, we see 42 percent, they have discharge status of home and (inaudible) care. But some people went to other health care facilities--intensive care, short-term hospitals, transfer to home health agency and (inaudible) hospitals. []

SUSAN BOUST: Shinobu, can you talk about that just a little bit more? Transfer to other hospitals. These are people leaving the regional center... []

SHINOBU WATANABE-GALLOWAY: Um-hum. []

SUSAN BOUST: ...and they're leaving there to go to another hospital? []

SHINOBU WATANABE-GALLOWAY: That's what they are (inaudible). []

SUSAN BOUST: Thirty seven percent of them? []

RON KLUTMAN: I would think it would be medical problems. []

SUSAN BOUST: But we don't know that. []

RON KLUTMAN: I mean I...intensive care facility I would expect... []

_____: But I mean...Jim, do you know what that means? []

JIM HARVEY: No, actually on this particular item I don't know how to interpret this. []

SUSAN BOUST: Our second highest level discharge plan from the regional center is to send them to another hospital? []

JIM HARVEY: That says transfer to short-term hospital. One of the problems we do have is that... []

MARY ANGUS: No, no, no, transfer to other hospitals 308 people. []

JIM HARVEY: Okay, well (inaudible). []

MARY ANGUS: There you go. Linda, do you know? []

LINDA JENSEN: I would suggest that several of those are transferred to the subacute level of care at hospitals in the community. No longer...I'm just suggesting that might be it. []

MARIO SCALORA: I think it's pretty rare we're transferring directly to patient from (inaudible). []

_____: Could it be like transfer to Center Pointe? []

_____: How many subacute beds did we have up August of '06? []

MARY ANGUS: Apparently 306. []

_____: No, no. []

SHINOBU WATANABE-GALLOWAY: If I may, the data we are working here does not exactly tell us what is the real discharge and what is not, because there are a lot of movements within the regional center units. People might have moved from one unit to another and maybe went out of the regional center to receive medical care service within a community. It doesn't make sense? []

_____: No. []

SUSAN BOUST: But Shinobu, just a point of question on this. This looks, from the title, as you are looking at the data from the point of view of where they went when they left the door of the regional center, not transfer between regional centers, right? Is that accurate? []

SHINOBU WATANABE-GALLOWAY: This particular table does not show the transfer within. []

SUSAN BOUST: Right. So this is when they leave the front door of the regional center to go to the next place that 308 or 37.5 percent of them transfer to other hospitals. My contention is that that is either a tremendous problem or meaningless data and that we have to drill down into this, because... []

SHINOBU WATANABE-GALLOWAY: Okay, so that's the area that we need to (inaudible) be taking notes on that. Okay. []

CAROLE BOYE: And adding upon that nowhere does it appear that we're capturing data that intuitively those people, hopefully, are being transferred to community-based services that are not hospital-based. It doesn't look like we even have a category to capture outpatient services, rehab option services, community-based services, which is what I think we're supposed to be overseeing. So I don't know what our form... []

JIM HARVEY: One of the challenges here, and you'll notice it at the very bottom, it says data source AIMS/Avatar. A lot of the data are in the old AIMS system, which was notoriously inflexible in terms of making adjustments as the hospitals made adjustments. I was told yesterday that Avatar is installed at Hastings, Avatar will be fully installed at Norfolk by the end of June, but that means that Shinobu is stuck with the old data structures. []

_____: Right. []

JIM HARVEY: Okay. I think part of our problem here is the old data structure and our ability to tease it out. One of the instructions I gave UNMC in working with this data is if the person left the facility to a hospital and came back and the length of discharge was

seven days or less they don't count it as a discharge. If the discharge was longer than seven days then you do, but we don't know where exactly it went. It has to do with a problem with the data structure itself. []

CAROLE BOYE: So just based on that, home and self-care and all that, this almost looks like where are they going to sleep the night after discharge? These are fairly home, residential kinds of categories as opposed to community centers. []

JIM HARVEY: That's, I think, what the intent was at the data field. That's correct. []

CAROLE BOYE: All right. All right. (Inaudible) []

JIM HARVEY: Because there's some other slides she'll be getting to that will show you some other interesting tidbits which should create as much discussion as this. []

CAROLE BOYE: Okay. []

JIM JENSEN: Doctor Wilson? []

DAN WILSON: Again, I think this transfer to other hospitals, we need clarification of what that is because they're clearly not going to acute care hospitals. []

MARIO SCALORA: Being aware of what's happening in Lincoln and talking to my colleagues, it's pretty limited that people are being transferred to a like level of care, so this is probably more of a categorization issue than it is...and given that more people are going to be discharged from Lincoln than other places in the future, I have a feeling this is just what Jim pointed out and the practice. []

SUSAN BOUST: And maybe if we can just try and get through all the data. This is so important to us. At some point we need to have the chance to actually look at this and

talk it over in-depth. []

JIM JENSEN: Shannon? []

SHANNON ENGLER: I just want to point out to my fellow commissioners, which this parenthetically, we have 41.8 percent of these individuals that were discharged home and 37.5 percent that are under this transfer to other hospitals. That's like, what, 80 percent of clients leaving the regional center that either went home or went to another hospital or whatever this data definition is. I'm seeing that leaves, what, 20 percent for community-based services. []

DAN WILSON: I suspect that the transfer to other hospitals is including the whole bunch of community services, and this is a meaningless category presently. One final point from my area of concern is data not specified for 12 percent. We don't know where 12 percent of those... []

MARIO SCALORA: It's the old system. []

DAN WILSON: Yeah, yeah. That's a problem though. []

LINDA JENSEN: But doesn't Magellan have some of these data? Could you merge that in here? []

JIM HARVEY: Don't forget this is a regional center discharge follow-up contract and the question being answered here is what was their status upon discharge? This is what we've got for 822 unduplicated people, but the criteria for joining our system. []

CAROLE BOYE: I vote for Dr. Boust's option B that we declare this meaningless data as opposed to troubling Dan. []

JIM JENSEN: Barbra? []

BARBRA WESTMAN: I have one comment. During the time period that they're talking about, some of those could have been at the Hastings, transferred from Norfolk and Lincoln to HRC to the residential care facility and considered hospital, because we were open during that time. []

RON KLUTMAN: Let's look at the other slides and then... []

_____: Okay. []

SHINOBU WATANABE-GALLOWAY: Okay, the next one is a demonstration of discharge. []

_____: Well, here you go. []

SHINOBU WATANABE-GALLOWAY: And also you can see the number. []

_____: Forty percent. []

MARIO SCALORA: If these are adults, do we have adult foster homes prevalent? []

LINDA JENSEN: Yes, there are. []

MARIO SCALORA: We do? []

_____: Yeah. []

MARIO SCALORA: Wow. []

MARY ANGUS: That many? []

MARIO SCALORA: Seems like a lot of placements. []

_____: It is. []

SHINOBU WATANABE-GALLOWAY: Okay. Any question on this slide? Then I'll move on to some services data. Again, these are (inaudible) for 822 people according to the data we received. 83.6 percent received both mental health and no mental health services after they're discharged. Nine percent of the consumers in the follow-up system, they received only mental health services. A little less than 1 percent we did not find any data indicating they received services after discharge, and some consumers that had out of state discharge status and we did not have the data available, so we cannot determine whether these individuals received any service or not. []

RON KLUTMAN: So that basically means they're coming into the primary care offices for their physical health carrying along with their mental health? Is that...or we can't tell? []

_____: Can't tell. []

RON KLUTMAN: I'm sorry. []

JIM HARVEY: Data sources are Magellan, N-FOCUS, Medicaid, (inaudible), oh, AIMS/Avatar. So the community-based systems here are just three--Magellan, Medicaid, and N-FOCUS, and N-FOCUS is an HHSS-supported system supporting 39 different types of programs such as food stamps. So where you see it says non-mental health services only that's probably data from N-FOCUS, maybe some data out of the non-behavioral health Medicaid (inaudible). []

SHINOBU WATANABE-GALLOWAY: So, yeah, that's essentially (inaudible), said the data sources used for this analysis, three different data sources--Magellan, Medicaid, N-FOCUS, and we try to categorize what services these individuals received using those data sources. So if somebody had actually received the services but we do not have the (inaudible) then that's not captured here. These are unduplicated for each category, but across different categories there are some old ones. So the first (inaudible) shows regional center outpatient service use. That's about 40 percent of 822 consumers. The second category is Magellan authorized community service. These are the exact wording we used to (inaudible) again look at the Magellan and look at the data which indicates what authorized service and identified service and just simply categorizing to these groups. And some receive...about 56 percent receive Medicaid mental health service. Yes? []

CAROLE BOYE: What is a regional center outpatient service? []

JIM HARVEY: That would be our LB95 medications primarily (inaudible)... []

SUSAN BOUST: Oh, so anybody who gets LB95 would be captured in that? []

JIM HARVEY: I think that's the predominant amount of regional center outpatient stuff. []

SUSAN BOUST: Okay. []

_____: Okay, because... []

SUSAN BOUST: This doesn't mean that they go there to see a doctor. []

RON SORENSEN: No. The ACT Program in Hastings (inaudible). []

BARBRA WESTMAN: Yeah, during this time ACT in Hastings and the outpatient...there

was an outpatient clinic. So that would be captured there. []

CAROLE BOYE: But that's part of what's being discontinued or... []

JIM HARVEY: Well, we also used to have some (inaudible) figures. []

CAROLE BOYE: Okay. All right. And our data collection system wouldn't be able to separate out LB95 from medication assistance from all other outpatient surgeries? []

MARIO SCALORA: The newer one should be able to tease that out better now, wouldn't it? []

JIM HARVEY: Just so happens, earlier this week, and I don't think UNMC has received the transfer yet, but we were looking at just those types of things, trying to get a finer grade of data to them, and I was noticing that the new lines included some LB95 exclusive stuff. So I'm hoping we can get to that. []

MARIO SCALORA: The record will reflect it, but it may not be computer entered. []

_____: Correct. []

MARIO SCALORA: And that's...because there are certain forms that will designate all those issues that Dr. Watanabe-Galloway and her staff had to go through Herculean tasks just to make sense of the data they had. Unfortunately, the data lines aren't always going to reflect some of those meaningful pieces of data, so... []

SHINOBU WATANABE-GALLOWAY: So looking at N-FOCUS authorizing payments data, and now mental health Medicaid services about 68 percent received after the discharge. Again, this deal we consider as (inaudible). We are now getting into more, you know, the deeper data analysis to understand the services data better to say

specifically what kind of services people receive after the discharge from that regional center. And those findings are not included in today's presentation, but hopefully in the future we (inaudible) to you. Yes? []

J. ROCK JOHNSON: Could you repeat your first statement of what is not included, but will be in the future? []

SHINOBU WATANABE-GALLOWAY: Okay. More detailed analysis for services consumers receive after they are discharged from the regional center. []

J. ROCK JOHNSON: Meaning both mental health, substance abuse, primary care... []

SHINOBU WATANABE-GALLOWAY: Mental health and from Medicaid data we can find information about non-mental health services information (inaudible). So right now we are sorting out the information in the data, again, working with people from the (inaudible) of the region to understand what the data means. []

J. ROCK JOHNSON: Thank you. []

SHINOBU WATANABE-GALLOWAY: You're welcome. Okay, now switching gears to readmission, okay? So again, we are working with the same number--822 consumers discharged--and the bottom row shows 704 consumers that did not have any readmission information, meaning they were not admitted back to regional center. Eighty-nine people, after they were discharged, they came back again to regional center, and 29 people had readmission of two or more. And again, we broke these numbers by behavioral health regions. []

MARIO SCALORA: Now is that the region that readmission that they were discharged to when they left the regional center? Or was it the region they initially entered the regional center from? []

SHINOBU WATANABE-GALLOWAY: This based on (inaudible) discharge and we used the first discharge record if they were more than one. []

MARIO SCALORA: So if they lived in Region 3, for example, but discharged into Region 5, and they readmitted, Region 5 would have the credit for the readmission so to speak? Okay. []

SHINOBU WATANABE-GALLOWAY: And there are some that's part of the data issued here. []

MARIO SCALORA: Is there a way of knowing how much floating there is across regions? I don't know how meaningful... []

SHINOBU WATANABE-GALLOWAY: We have been looking at the data and trying to understand better. There's some floating, but there are some patterns. []

MARIO SCALORA: It's hard to get a sense of how pervasive that is at this point. []

SHINOBU WATANABE-GALLOWAY: That's going to be part of the next report that we are producing right now. []

MARIO SCALORA: Wonderful. []

LINDA JENSEN: On that slide back there...well, I guess that's the same one. Is that the same one? So some other...well, a lot of the regions you have only about maybe 50, 60, 70 percent of the data as to whether they were admitted. You don't know about the others? Is that what this is telling you? Like for instance, Region 3 or let's see...Region 5, that adds up to 75 percent if you go across, right? So what happened to the... []

_____: I think their percentage is (inaudible) down (inaudible). []

LINDA JENSEN: Yeah, the percentages in the parentheses, is that right? []

SHINOBU WATANABE-GALLOWAY: (Inaudible) that's 200 percent at the bottom. We then... []

_____: They go down. []

LINDA JENSEN: Oh okay. []

SHINOBU WATANABE-GALLOWAY: Not by... []

LINDA JENSEN: They don't go across. Well, they would though, wouldn't they? []

_____: No. []

SHINOBU WATANABE-GALLOWAY: Because it doesn't add up if you (inaudible), you know? []

LINDA JENSEN: Oh okay. It's a percent of the column. Okay. I was trying to add them from the front. Okay. Can we have a copy of this at some time? []

SHINOBU WATANABE-GALLOWAY: I sent the file to Jim, so Jim should be able to distribute that. []

JIM JENSEN: I'll send it to Jeff and then we... []

LINDA JENSEN: Okay, because that would be helpful. It's kind of hard to absorb all these (inaudible). []

JEFF SANTEMA: And I think Jim said that there's maybe just one additional slide before we're able to move on that... []

JIM JENSEN: Go to the diagnostic ones. []

SHINOBU WATANABE-GALLOWAY: This one or the next one? []

JIM HARVEY: This is a good one and then there's one other one that... []

SHINOBU WATANABE-GALLOWAY: This is the one? []

JIM HARVEY: That's the one. []

SHINOBU WATANABE-GALLOWAY: Okay. So different categories of diagnosis and by number of readmission. So a lot of people in the first category is the combination of three types of disorders--serious mental illness, substance-related disorder, and personality disorder. We have a lot of people in this category and you can also see other categories are usually combination of two different types of mental health conditions, including substance abuse. []

JIM HARVEY: I think the other important thing to note on this slide is on the people who have had two or more readmissions to the regional centers, 79.3 percent have been combination of serious mental illness, substance-related disorder, and personality disorder. So I think that has some implications in terms of where we need to make some efforts in order to help certain types of individuals in their community tenure, if I can say it that way. []

SHINOBU WATANABE-GALLOWAY: Okay, so maybe my time is up then? (Laughter) Okay, thank you for your attention. Again, the handouts can be distributed later, so if

you have anymore questions let me know. []

JIM JENSEN: I think that I would like to appoint a committee to perhaps look at the data and make recommendations for the next meeting, because I think we do have some areas here that are not clear and maybe perhaps could be made clear. So if you would allow me between now and the next Behavioral Health Oversight Commission, I"ll appoint a committee to work with HHS to see if we can fine tune this to give us a little better idea of where we are, because I think we do have some holes in this system. Okay? With that, there is food here and if not everybody get up at once, but if you'd go back and get your meal and we'll go ahead and proceed through the rest of the agenda. And with that, Ron is next with the regional center update. []

RON SORENSEN: It's going to take me a minute to find (inaudible). []

JIM JENSEN: Okay. And you will get a copy of that report so we can do that. And if any of you have a strong desire to serve on that committee, please why don't you call Jeff Santema and he'll do that. I think it's very important. []

RON SORENSEN: (Exhibit 2) Okay, we're going to talk just about two or three subjects here and then we'll be back on the program later, but I wanted to talk about, first of all, bed allocation plan and what we're doing in relation to hospitals and law enforcement in terms of emergency custody situations. (Inaudible) This slide unfortunately did not make the presentation, because we weren't sure exactly how to present or look in a different way, Sue (inaudible) here will find different ways to present it so it will be understandable and what we got down to was let's just put the numbers out the way they show up and not try to make any grand analysis of the numbers (inaudible). Oh, wait a second here. As you know, we talked briefly about this at the last minute. I guess it wasn't so brief now that I think about it. It was the bed allocation plan and we had, as part of the effort to work with hospitals, providers, regions, and so on, consumers as well, to identify ways to make the system flow more smoothly so there would be proved

access at the hospital entry point. One of the strategies we decided to use was called bed allocation plan. If you'll look at the chart--unfortunately I don't have it on the screen here, you'll have to look at your chart--we had considered doing this back in September and spent some time working on it and analyzing it and finally got it approved. I think the perspective date was April 2. And the whole purpose of this was to allocate the beds at the regional centers based on the population of the region. So if you had 40 percent of the population you got 40 percent of the beds, and so on. We started with 90 beds. What you'll see on the chart on the first row of columns here it says December 2006, is at that point in time--we took a specific day--we set out the plan in the left hand column and you can see it totals up to 90 beds, and then in the middle column you'll see the beds occupied. And what you'll see there is that Region 6, in particular, had more beds occupied than what the bed allocation plan said and then Region 1 is on the other side of the picture, had three fewer beds occupied than their population says they should have. Well, we talked about this and eventually got the implementation to (inaudible) April 2, as I said, and what you'll see then in the right hand column, you'll follow through the three columns here, on the right hand column you'll see where we are at the first part of May in terms of implementing this. And as the numbers will reflect there, we have one region, Region 2, which has more individuals in regional center beds than what the outreach plan calls for. And I really want to point out Region 6 and Patti Jurjevich, the Region 6 regional administrator, sitting in the back there. Region 6 really put forth the (inaudible) effort in getting this accomplished. They've got a person who spends a lot of time now (inaudible) regional center, working with regional center staff, working with the social workers to help identify where people can go to facilitate discharge when people are in fact ready for discharge. And so I really, you know, everybody's worked on this. Region 5 sort of got this started a few months ago and done it on their own until we actually implemented the plan. So all regions have really participated and made this work. Region 2 is a little unusual in that a number of their people are court ordered, and so those present unique challenges in terms of getting people out. It has to be approved, obviously, by the court, and so those take a little more effort and a little more work than normally would be the case. So what we will be

tracking as we go into the future, our goal with the plan was to reduce the length of stay for people who aren't committed and end up at the regional centers for treatment. Now we will be tracking, as we go into the future, whether or not this plan is working. An aside here, just so you know, in the intermission passed out to you--I think it's passed out--if you look through there you'll see that the referral list has actually dropped that down to 15 this week and it was 10 a week ago. So we have not seen a spike in the referral list in the last month. That is people actually waiting either to be referred from hospitals to community-based services or to the regional centers. So I think one thing you notice when you look at that chart is also you can really tell the cyclical changes in the system. And something, as we go forward, we're going to have to plan more diligently for is the wide variance between the times when we need beds and when we don't need beds. We end up with probably a difference of anywhere from 20 to 30 people on that list. That's worst point and best point. So that's something we're going to have to carefully look at as we go forward. So I'll move on there from the bed allocation plan if there are no questions. It looks like we've managed to keep everybody busy eating, so that's good. That helps the time slide. []

RON KLUTMAN: Good timing. []

RON SORENSEN: Yeah, it was good timing, wasn't it? Just to remind you of what we're doing in working with trying to improve the access to beds in hospitals, we have brought up the beds we discussed earlier at Richard Young. We've created 10 additional beds at Lincoln Regional Center, which are slowly being brought up...I think we're up to 93 today. We are doing the bed allocation plan and we are working within the communities to look at length of stay and program services, and we have preliminary report on that that we've seen in the office. It's not ready for distribution until we...I guess, what the data people would call scrub the data. We've got a few...as we look at the information from Magellan there are a few questions that aren't answered and a few bits of information that don't seem to fit. But what appears to me, this is strictly somewhat anecdotal, is from the length of stay we're seeing (inaudible) now to what I saw three or

four years ago in the community, we have reduced the length of stay and that's the result of the availability of services, particularly at the lower end--support services--and the work of the regions and providers to identify people in their facilities that are ready to move to court or lower intensive services. So as we get that prepared we will bring that back to you, but it does take some scrubbing. The newest thing I want to add to the list to just close this out and ask questions is that we are going to expand the work with the hospitals and law enforcement. We will be meeting in each of the regions with our staff, regional staff, providers, consumers, law enforcement officials to discuss how we might continue to address access to hospitals or emergency rooms where you can get (inaudible). So expect that to happen in your regions. I think we're going to start in Region 3, so be looking for that. If you want to participate contact the regional administrators. []

MARIO SCALORA: Ron, hopefully a constructive suggestion. I'm very happy you're making that outreach because it's obviously very necessary. We notice on the forensics side, and these people would not necessarily be reflected in the numbers, that we're getting folks who are coming in under forensic rubric a little more often. Not an overwhelming number that we have to scream at (inaudible) about, but obviously we're seeing the trend moving upward of folks who have rather significant substantial problems for whatever reason, either because of lack of desire for services in the community or just a bad fit, whatever, aren't engaged in services in the community. They're coming into the forensic system for rather small charges, often misdemeanors of low level felonies that would not get them significant time. These are obviously folks, when you look at how they got there, or folks who law enforcement had worked with a lot and tried very patiently to steer toward other services, may have been EPCed in the past, but came in and out very quickly. Obviously when we see that kind of trend coming up somebody is very concerned that the individual needs services, and in all these cases these were folks in very dire need. Ultimately, the forensic issue goes away and we can move them to the civil commitment system where there's more flexibility. Why I bring this up is a key player with that are often the county attorneys. And if I find

county attorneys going to that effort that tells me that they're finding fewer options or that they may not know what options are there and I recommend, if you can get law enforcement to the table... []

RON SORENSEN: Actually, I should have said county attorney, because they are on the list as well. []

MARIO SCALORA: Wonderful. Thank you. Because they certainly are the big gatekeeper between the criminal and the civil side, and we've found them to be very amenable to working with the less restrictive side if we're not talking about violent crimes. But what we hear is just frustration about how do we access parts of the system. []

RON SORENSEN: Right. []

MARIO SCALORA: And particularly in communities outside of Lincoln and Omaha. So I'm very happy that you're reaching to them also. []

RON SORENSEN: Okay. []

MARIO SCALORA: Yes, J. Rock. []

J. ROCK JOHNSON: If I heard you correctly, you were recommending that people who are interested talk with their regions and it seems to me that many of the organizations (inaudible) law enforcement organizations are, in fact, statewide. So it seems to me there needs to be... []

RON SORENSEN: They're what? []

J. ROCK JOHNSON: Well, if I understood you, you were referring people to go to their

regions if they had an interest and I'm suggesting that, for example, the chiefs of police is a statewide organization. I don't know if the county attorneys... []

RON SORENSEN: Oh, yeah, well okay. Yeah. []

J. ROCK JOHNSON: ...but they... []

RON SORENSEN: No, I was suggesting if you know anybody that's interested (inaudible) contacted. We will be contacting county attorneys, law enforcement officials, the sheriffs organization. That's who we will be contacting. I'm suggesting that there may be people that aren't in those organization or aren't associated with somebody to contact if you know that are interested that they can contact their region administrator. But we will be going through all the organizations to make contact... []

J. ROCK JOHNSON: Well, and this is not just going to be at a regional level was my first question. That was just a conduit for people to contact. The other aspect is the inclusion, of course, of consumers at every aspect of this. So this is going to be a significant undertaking at the organizational and the state and the regional levels. []

RON SORENSEN: Right and I had consumers on the list too. And we are working...we're starting on the regional level. We are going to work with Region 3 and work that way, because we are discovering there are unique issues between the various regions. You'll see more volunteers at hospitals, for instance, at Mary Lanning as opposed to Faith where voluntary admissions aren't creating as much of a problem in terms of access as they are at Mary Lanning. So we've got to look at each one of these regional situations differently and that's why we initially decided to work with the regions to get that done. And obviously the regions are the people that contract with providers, contract with the hospitals, know the law enforcement officials face to face, and we don't know if (inaudible) know that. So that's another advantage. []

JIM JENSEN: Any other questions of Ron? Yes? []

DAN WILSON: Ron, as you know, when we spoke about the bed allocation plan, I think there came to be an appreciation of the current need for the present structure, but there was also certainly I felt that looking ahead the commission, I believe, should not support long-term a different type of system for one region as opposed to the other regions, which currently exists in Region 5. I don't think any solution should involve unfavorable treatment of Region 5, but the idea that we're going to have Region 5 rely on a state hospital for indigent care and the rest of the state is doing something differently, I don't think is going to make very much sense in future years. So is there any mechanism by which that problem can be addressed? []

RON SORENSEN: Well, I think we're addressing it through the motion, I think, we passed last time regarding the study in rural regional centers and I think Senator Jensen's got that on the agenda for later today. []

DAN WILSON: Okay. []

RON SORENSEN: And I to close this session, I want to introduce Scott Adams who's sitting over here. I think we all know Scott Adams. Scott Adams is the director of Health and Human Services until June 30 when we become the Department of Health and Human Services and then he'll be the administrator for the division of Behavioral Health Services. Okay. []

JIM JENSEN: Thank you, Ron. The next item on the agenda is the regional center task force and this...we waited until we were ensured that there was funding available, which took a little longer than what we had anticipated. So consequently, this is just getting started at this point time. We will be looking into contracting and I'm waiting for some terms coming back from that with HDR, Deb Sanders primarily, and other people from that office, Dan Koraleski who's with KPMG and a couple others that we will...this will be

a small committee, but we'll really be looking at the regional centers, their long-term future and working through those facilities, and so like I said, we're just getting started. We'll have a lot more information to come later on then and we'll be doing the things actually that Ron did suggest. That's all I had to really report on that unless there's some other questions. We'll be giving you updates as we move along. Yes? []

CAROLE BOYE: What's your target date for completing that? []

JIM JENSEN: December 1. Yes? []

MARY ANGUS: I just talked to you Wednesday about this and I'm just wondering if you could tell us where the consumer involvement will be in that committee? []

JIM JENSEN: There will be a consumer on the committee. []

MARY ANGUS: And the number of total... []

JIM JENSEN: We're talking about six people maybe. []

MARY ANGUS: Okay. []

JIM JENSEN: We don't want to get into politics. We want to really stick with facts on this. []

MARY ANGUS: Thank you, Senator. []

JIM JENSEN: Also, the next item on the...item 9, the recovery center update. This is the Lasting Hope Recovery Center in Omaha. Most of the contracts have been left. It is moving along with the completion date--a director has been hired by the way--in the latter part of this year, might not open until early 2008 for patients, but it's going along

well. They have...and in their space allocation they do have space for Salvation Army, a peer group, losing family services. I'm missing one other within that. They've been meeting also with consumers in the area and so that is moving along well also. Any questions on that? Now we're up to item 10, children's behavioral health update. []

JEFF SANTEMA: (Exhibit 3) Senator Jensen, why the...there were two parts to that particular agenda I did that Senator Jensen had in mind. One was to give the commission an update of the state infrastructure grant or the SIG grant. That was focusing on children's behavioral health. And second was, which is where I could start briefly with an update of a bill that is before the Legislature this session. The Legislature again this year is being asked to address the issue of children's behavioral health. I believe you have in the packet of information, some amendments to LB542. If you could locate that a moment in your...we want to make sure that you have that. Senator Synowiecki introduced LB542, the bill in its original form was focused on transferring all of the money associated with adolescent services at the Hastings Regional Center to the community. The bill would have created a separate fund for community-based adolescent services and that funding then would have been transferred to the community. In further conversations with Senator Burling and others, on General File, the Legislature adopted this amendment, which you have in front of you, AM1202, which took the provisions of the original bill and focuses strictly on a children's behavioral health task force. And you can see on the amendment the makeup of the task force. Senator Jensen as chair of the Oversight Commission would be on that task force and would be actually designated now in this amendment to chair that task force. And in Section 2 of that amendment you can see the requirement that this group prepare a plan, again, by December of this year, and the contents of that plan. The issue of children's behavioral health is a different issue, as you know, from adult behavioral health services, which has been the focus of much of LB1083 implementation to this point. Although children and adolescents aren't excluded from the Nebraska Behavioral Health Services Act, they are included within the bigger picture of our public behavioral health system. But with adolescents and juveniles there is a

connection also with other parts of HHS, child welfare, the juvenile justice system, etcetera, which adds different factors into addressing children's behavioral health. So one important update that we wanted to give you today was on that aspect of LB542 and what version of that has been approved by the Legislature to this point. The bill is on the agenda for second round debate next Tuesday, the very next day that the Legislature meets. In addition to that work there has been, as you know, this SIG grant, which is a five-year, I believe, grant funded program, which is also looking at a comprehensive system of care for children. And they are, I believe, on their way to give the commission an update on that particular...also, the Health and Human Services Committee of the Legislature chaired by Senator Johnson is considering an interim study resolution which would involve the Health Committee and further follow-up on implementation of LB1083 in identifying specific issues that should be the focus of that follow-up. So I guess if I may, Mr. Chairman, I'd just like to ask the commission members for their input if they would like on two particular points and to invite their continued input to Senator Johnson's office and to Senator Jensen. Where should children's behavioral health go? You know, if the state is going to turn more of its attention to children's behavioral health and systems of care for children, etcetera, your input on where that should go, input on the SIG process, for example, input on these other processes, that would be welcomed. And secondly, if you have input on particular areas that you'd like to see the Health and Human Services Committee of the Legislature follow up on with respect to LB1083 implementation, areas of particular importance, particular need, would you please forward those to Senator Johnson's office as well? So Mr. Chairman, I think at this point I'm not sure where...Sue? []

_____: David is also presenting at the Nebraska Commission for the Protection of Children and that's now, so I just told them as soon as they get done... []

JEFF SANTEMA: And maybe Mr. Chairman would like to move on then as soon as... []

JIM JENSEN: Sure. []

RON KLUTMAN: Just to...I mean, this is a heavy hitter's committee you've set up here. There's the real players across the state. Help me a little bit for the background what germinated this and what the initial concerns of the Unicameral are. Am I making sense to you? []

JEFF SANTEMA: When LB1083 was adopted in 2004, Dr. Klutman, the...and there's confusion because many people will define behavioral health reform, when we use that terminology--behavioral health reform--they'll define it in one of two ways. Sometimes it'll be talked about...behavioral health reform is really only about adults coming out of the regional centers. That's really behavioral health reform. The other broader sense, which I think is the more complete and correct sense is the Nebraska Behavioral Health Services Act, which is the key part of LB1083, includes all consumers served by the public behavioral health system--adults and children--and the provisions that address regional centers, for example, in 71-810 is doesn't differentiate in that section of law whether their adults in the regional centers or adolescents. So when LB1083 was passed it was comprehensive rewrite of the statutes covering our public behavioral health system, but the specific focus was on adults because of the need to transfer funding from the regional centers to the community. Along with that, there had been parallel legislation considered by...when Senator Jensen, for example, was chair of the Health and Human Services Committee, dealing with children and adolescents and their families. Many families who came to the Legislature and said we're being forced, if you will, to make our children wards of the state in order to access needed services, which is a critical concern to many parents and families. So then the urging to the Legislature was well, now that you've done this with adults don't forget about the children, and we need to go there as well. But in the past few years, different legislation has come before the Legislature and before the Health and Human Services Committee. This year, again, the repeated request, the SIG grant is going on now. This particular legislation, which is getting particular emphasis this year because it's a personal priority bill for Senator Synowiecki and he has an agreement with Senator Burling over the provisions

of this amendment. []

RON KLUTMAN: So this is not so much...the driving force is not, say, the initial thing to drive to bring people from the regional centers into the public so we capture Medicaid dollars and things. This appears to be, say, it's not so financially driven for that we have all these--I may be simplifying this way too much--we have all these organizations out there. Is there a better way we could interreact to deliver health care for the children? []

JEFF SANTEMA: It seems to be more a need driven or reform driven...address reform in this area as well. []

RON KLUTMAN: Now they will...were the oversight part of that? Are we part of it or we're just not... []

JEFF SANTEMA: The Oversight Commission addresses implementation of LB1083 in the Behavioral Health Services Act to oversee and support implementation. There was no...and as a part of LB1083 and the major focus obviously was upon regional centers and transitioning patients from the regional centers to the community. So that's why there's...there are two ways of looking at reform and sometimes they get confused. And members of the Legislature said both things the other day on the floor. For example, one member of the Legislature said I spoke with the author of LB1083 and it deals with adults coming out of regional centers. And another senator, some minutes later, said I've spoken with the author of LB1083 and it deals with everybody in the system. (Laughter) []

MARIO SCALORA: LB1083 better be more consistent then. (Laughter) []

JEFF SANTEMA: So Senator Jensen has...you know, that's been a part of the children were never excluded from the focus of the entire system, but as you know, the main focus...Governor Johanns, at the time in November 2003, when he presented the plan

to transfer funding from Norfolk and patients...it was all adults, it was all regional centers, etcetera. []

RON KLUTMAN: Okay, because the reason I'm kind of driving that and I really haven't sat down and looked at all these things, but I guess that is one place I would urge them to consider having someone in pediatrics or adolescent psychiatric care. I mean, I guess I...you know, I work mental health and physical health and I have pediatrics and I have adults, but I think someplace in there if they can look at--and there's certainly a large group of pediatricians very involved in this area--I don't think it's specifically here...if the chairman, whoever set up this, could make a...I guess the chairman is the chairperson of the... []

JEFF SANTEMA: Oversight Commission. []

RON KLUTMAN: (Inaudible) I guess I would...you know, I gently would urge you to...there are some superb pediatricians, very interesting (inaudible). []

JIM JENSEN: Well, there isn't any question about it. First of all, I'd like to say a couple things. This is a very needed area and without a doubt, you know what happens to adolescents with mental illness? They soon become adults with mental illness and I think generally, just like medicine, earlier treatment, earlier diagnosis has much greater results than later on in life. And so it very much is an interest. And also the children advocates have really been pushing for this and that's where a lot of this emphasis comes from. Also then along with that, we're kind of making Hastings the adolescent center and there are some that think that's great and some that think that's bad. And so all of that lends it with...let me just say one other thing and, you know, I am a former senator. Yes, you still have that title, but I think very quickly LB1083 and mental health reform...and I can tell you because I was there for 12 years, once you pass a bill...you know, LB1083 was passed, mental health has been solved in the state of Nebraska. It's done. It's over with. And so that institutional memory, in many cases, is gone. We have

22 new senators of which...well, as far as that goes, if you take the 49 senators, I would really say that there's probably 15 percent of those senators who have ever been to Lincoln, Hastings, Norfolk Regional Center. So there's a tremendous amount of education that needs to take place along with that, but that institutional memory, boy, I noticed it this year just kind of watching the Legislature is kind of gone. And so a lot of these people are very, very dedicated people. And I tell you, the new crop of senators is very talented, I believe, but there's a lot of education that needs to take place. []

RON KLUTMAN: See, when you're a country doctor who's poor, you know, it's nice to come to the big city and learn up why we're really doing these things. So I do appreciate the insight, because, you know, I'm seeing this whole bill again and...but like I said, it's got some real players in it and I think that's what's driving to solve the problems rather than to take care of old things and I think it has a lot of worthwhile things. []

JIM JENSEN: Mario and then Topher. []

MARIO SCALORA: This is related legislative issues, but I'll (inaudible) the boundary between child and adult systems. I apologize for springing this on you without warning. Is there any news on the efforts to change the age of majority? Is that going through, not going through? So the age of majority is going to stay where it is for awhile, so people who are kids now will still be kids at the end of the session? (Laughter) []

JIM JENSEN: Not necessarily. []

MARIO SCALORA: Yeah, or at least in the eyes of the law that you're not seeing that changing in the near future? []

_____: I don't think it is. []

_____: Just through birthdays. []

TOPHER HANSEN: I just wanted to...Ron, I heard from the author of LB1083 and he's saying this is a much needed thing, so...(laughter). But the other thing I'd say, too, is there are a number of efforts going on. I know Nebraska Association of Behavioral Health Organizations has an effort to look at adolescent services. The SIG grant is happening and as a focused effort that same way and they're dovetailing, but also at the national level, the National Council of Community and Behavioral Health Care is conducting meetings nationwide that are actually happening in Omaha. There's been one and there's going to be another this fall to help coordinate services and we ought to be gathering in this effort, gathering all that wisdom that's being developed in those groups to see how we can fit in with that and what makes sense to us as a state and what doesn't. So we're not reinventing the wheel. We're gathering some of the activity that's gone on already and I don't know how many people are aware at the national level. Certainly the state level activities, a lot of people are aware of that. But the national level activity...is anybody here participating in that in Omaha? []

_____: I have in the past. []

TOPHER HANSEN: With national council? And there's a meeting coming up in September. Yeah, see? Not many, but it is going on. So... []

JIM JENSEN: Yes, J. Rock. []

J. ROCK JOHNSON: I think the transition, so we aren't making these kind of artificial, disingenuous distinctions between children and adults that we need to really focus on that, which will bring these two kind of reform efforts together as they go forward, the state has been relatively assertive. I think there's been a bout $36 million in say the last 10 years that has come into the community through primarily federal grants for children. We have not had the same kinder quality of assertiveness in getting those sorts of grants for adults. So I think that having that expertise could help across the board. Now

I'll borrow from the doctor's analogy about the heavy hitters. What I'd like to see on here is a couple of the balls that get batted around. I'm talking about youth representatives. Two people between the ages of, say, 18 and 24, somewhat arbitrary, but who have been in the system such as in foster care or within the juvenile justice system with the expectation that they would be accorded reasonable accommodations and that they would have the supports that they need in order to participate. Some of you are familiar with the latter of participation that we've talked about sometimes. That comes out of the national youth movement and there are youth organizations around the country. So I think that this is something that these folks need to be on this and they need to be hooked up with what's going on in other places and to have that support, to have a budget. []

JIM JENSEN: Yes. []

MARY ANGUS: In very strong support of that, NAMI as well as many other organizations for advocacy in the state have been very strongly urging that this include transitional age or whatever age youth that can be brought into it, because they have the expertise. They are the experts. []

RON KLUTMAN: To bring some light to things, I have three group homes in my town--Columbus--that must be wards of the state, and so they have a psychiatrist, and I don't have medical diagnoses of what's wrong with them psychologically, but they come in with five or six major psychotropic drugs and I'm just sitting there going wait a minute. You know, I have an understanding of some medicine, but this is way big time, but a communication between me and the psychiatrist is slim or none. And I need to understand the system because these kids get put in Columbus for some reason. They get stuck on a tremendous amount of drugs and I don't know how they ever get out of it. So that's why I said I think it's got to be at least educational for the practicing physicians, because there's so many things going on. It's just like when school personnel people tell me, what's the diagnosis on these people? Well, it can be released to them. So they're

all of a sudden trying to deal with these problems. Yes, Linda? Did you say... []

LINDA JENSEN: Even if you're the doctor taking care of them? []

RON KLUTMAN: Yeah, I...it's... []

LINDA JENSEN: They can't tell you what the diagnosis is? []

RON KLUTMAN: Yeah, tell me if it's... []

_____: HIPAA. []

RON KLUTMAN: Some rule...although I think... []

MARY ANGUS: That's not it. []

RON KLUTMAN: Well, it's...yeah. It gets to the point where the school system has no idea what's going on. The primary care physician has no idea what's going on and the group home is just locking these kids up. So I guess if (inaudible) information for us so we can at least take a look at it. []

JIM JENSEN: Yes, Carole. []

CAROLE BOYE: What is...a little clarification...is this a decision yet to be made or is the Oversight Commission going to, under the auspices of LB1083, oversee...what's the role of this group relative to this discussion? []

JEFF SANTEMA: There's no specific formal decision, Carole, that the Oversight Commission would need to make with respect to this. At this point, it's informational to the commission and asking for the commission's feedback. In terms of your monitoring,

generally, of the system and your support of what's going on and your feedback to help support what's going on is what's being sought. The expressed purpose of LB1083 was...one of the main purposes was integration. The definition of public behavioral health system in the law is the statewide array of behavioral health services for children and adults provided by the public sector or private sector and supported in whole or in part with funding received and administered by the Nebraska Health and Human Services System, including behavioral health services provided under the medical assistance program. So it's an expressed statement of integration. []

JIM JENSEN: And along with that, a great deal of these services are being done at a regional center, so that's all part of it too. Yes, Mary? []

MARY ANGUS: If this were to pass, and I hope it will, I would offer this information to those of you who would be on that task force. There was, in the beginning of this year--well, just late last year--there was a...CMS offered a demonstration project, which was called the Alternatives to Psychiatric Residential Treatment Facilities for Children and Adolescents. The state chose not to apply for that demonstration project saying that it was already covered by other waivers. I've been assured by CMS that that's not the case--that's the Center for Medicare and Medicaid Services--that that's not the case, that the waivers that we have do not cover that. The difference is that this would waive the inclusion of the families income in their Medicaid eligibility once they leave a residential treatment facility. Currently, if the family's income is not low enough to be eligible for Medicaid these kids have to go into the system in order to get that level of treatment. However, once they are stabilized--and this is just all interims of the system, not necessarily my view of how it should be--once they stabilize and they're ready to go out, they lose Medicaid coverage, because their family's income is being considered. Under that, the PRTF, the demonstration project as an alternative to Psychiatric Residential Treatment Facilities, that would not be the case. That would be waived and we would be able to get kids out of institutions. Kids don't need to be institutions. They should not be in institutions, neither should adults. But for such a vulnerable population

and there are ways that we can do this so that they don't have to be in treatment facilities. And perhaps, Dr. Klutman, what I am finding from the county attorneys in Region 6 is that many times the kids in the judicial area that would ordinarily go under a...I'm not sure exactly what the names for it are, but we would be coming under a mental health move-in to the system, are oftentimes coming into it as more of the out of control kids for a couple reasons. And what I'm being told is that one of those reasons is that it's very difficult to get all the paperwork in order for that mental health entry and there is some reluctance on the part of law enforcement to give them that label, and so sometimes we aren't getting adequate information on who's under that. So the number of...and just for a piece of information, one of the things that we're not having is the data may not let us know exactly how many kids are coming under the mental health realm, because they're under-reporting by virtue of the fact that they're coming in it from a different (inaudible). So we've got a lot of work to do in that respect. And thank you. []

JIM JENSEN: Andrea? []

ANDREA BELGAU: Actually, I want to address a question and probably one of the best ways to do it is to compare the structure of an adult mental health care hearing versus juvenile mental health hearing. An adult mental health hearing comes before a mental health board. That mental health board is appointed by the district court judge of each jurisdiction. They must undergo certain training and in it's skeletal form there is an attorney member who's a chairperson. There is a physician or mental health provider and then there's a layperson, and that's its skeletal form. Each person is represented by their own attorney and then the county attorney or their assistant attorneys represent the state's interest. They're confidential proceedings. For a juvenile case, they don't go before mental health board. They come before the judge who handles juvenile cases, which may be in the larger jurisdictions' juvenile judges. In jurisdictions in the rest of the state, they would come before the county court judge. In Platte County, we do have a judge who does just juvenile hearings though he's not designated as a juvenile judge. And when a juvenile comes under the auspices of the juvenile court system as what we

call the 3C. There's basically--what is it--43-247. There's basically three prongs of that. One is the A, which is the no fault, which can also be uncontrollable and no fault could apply to the juvenile. It could also apply to the guardian or parental supervisors. There's the B prong, which would be something if it was filed in criminal court would otherwise be a crime, but we have it in juvenile court. And then there's the C, which would be the mental health provision. What we do sometimes...well, first, when a juvenile goes into the system, HHS is involved if they've come under a mental health crisis. Every avenue is explored to try and not file that petition, to try and find alternatives to bringing them into the court system. If that's not possible then we do file the mental health petition, the 3C. And often we will file the other prong, the no-fault prong to it, partly because it does help get services, but also then later we can dismiss that in 3C and they don't have that particular stigma. But you're right. It (inaudible) statistics. Another difficulty, too, is the juvenile court judge may find that this juvenile is in need of, say, psychiatric services. They still have to do the same prong that we would do in a mental health hearing: 1) that they have to be mentally ill and dangerous; 2) that that is determined by a degree of medical certainty and whatever alternative is the least restrictive. Those still apply. But so the judge has ordered some sort of treatment and then I guess Magellan or whatever would come in. And it really irritates judges because the judge has ordered certain treatment and the Magellan or whoever say well, I'm sorry. We don't think they qualify. So then you've got this ridiculous circle. []

RON KLUTMAN: Is the system screwed up? (Laughter) No, I mean I'm serious, because I don't...I'm just learning today, I guess. It's very frightening. []

ANDREA BELGAU: Well, and those were...we're doing the best we can and I think the juveniles get much more attention because we try that gatekeeping exercise of discretion initially now with HHS trying to find placement or...but that works if parents have some sort of funds or insurance. It's much more difficult if they don't. []

MARIO SCALORA: It's a very fragmented system. That example alone highlights you

have child welfare, child protective entities who write some of the biggest behavioral health checks. You have juvenile justice/delinquency issues potentially. You may have other family functioning issues. The judge may put all those within the order or maybe, maybe not. All those issues, you have providers and infrastructure for each of those areas using the same behavioral providers with different goals in mind and families and the youth may be competing across different goals. Bottom line, you have different people writing checks, using similar providers at sometimes cross purposes or sometimes not even having a provider accessible. And so it is extremely fragmented because of the number of decision makers who are involved, and so... []

RON KLUTMAN: So that would be what this committee that this chair would be supposedly (inaudible)... []

MARIO SCALORA: Right. They're defining what the system is is going to (inaudible). Yeah, they're coming from the other direction. I mean, there are going to be some folks who don't see certain things as behavioral health even though they're using the same services. So just getting their arms around what is "the system" is going to be an interesting challenge in that regard and that's why I'm grateful Senator Jensen is willing to do that as he's cutting back more and more on things (laughter)...but it's going to be a challenge. []

RON KLUTMAN: But it is...I mean, from what I'm hearing here, it's difficult to quite understand where we're going with this. []

JIM JENSEN: Yes, Joel? []

SENATOR JOHNSON: Well, I was just going to say that one of the things is that this did start out as just a money transfer bill. []

RON KLUTMAN: Oh, okay. []

SENATOR JOHNSON: And to Senator Synowiecki's credit, he brought forth this amendment. He brought forth this amendment, Synowiecki's amendment to his own bill. We've completely changed it to make it so that let's look before we leap sort of thing and see if we can get a comprehensive look at things as the discussion has shown here today. []

RON KLUTMAN: Yeah, this would be one place before we leap let's see what we have. []

SENATOR JOHNSON: Yeah, and so... []

RON KLUTMAN: The Legislature has the ultimate wisdom always. []

SENATOR JOHNSON: Once in awhile. []

RON KLUTMAN: Oh. []

SENATOR JOHNSON: (Laughter) But this, I think, we're heading in the right direction here and Synowiecki deserves a lot of credit for, you know... []

MARY ANGUS: Do we have any idea where the task force on foster care kids using psychotropics, which addresses Dr. Klutman's other point? I think when you said that the kids come to you in foster care and using so many different psychotropics. There is something in the Legislature. Do we have any sense if it's going to pass or... []

JEFF SANTEMA: There were a couple of years, Mary, that that bill was introduced by Senator Howard... []

MARY ANGUS: Right. []

JEFF SANTEMA: ...and the Health and Human Services Committee and the Medicaid Reform Council received some testimony. Mary Steiner talked about how in the context of Medicaid reform that they're doing that very thing in working with providers, etcetera, looking at prescribing patterns, etcetera. I don't believe Mary's here to comment further on that or if anyone from HHS could comment further, but there is an effort going on. []

MARY ANGUS: I just was wondering if that bill has... []

SENATOR JOHNSON: Yes, I was going to say it kind of yeah, it's kind of overall consensus that it's a duplicate bill or service that would occur out of that bill and maybe can just redirect what's going on already a little bit to cover it rather than having a new law in place to theoretically do pretty much the same thing. []

MARY ANGUS: So basically it would emphasize that the already existing information to be looking at that maybe a little more closely than they would have? []

SENATOR JOHNSON: Yeah or a little different way, but... []

BRAD BIGELOW: I think one of the things you're finding with kids going into institutional placements, residential care facilities, you've got people misdiagnosing. There's a fine line, and you can correct me if I'm wrong, but a fine line between ODD, ADHD, bipolar, conduct disorder, adjustment react...you know, you can go through the whole list of diagnoses and there's so many carryover characteristics that apply to each one and you've got a lot of mislabeling. And as a result of mislabeling, which oftentimes is done by GPs, not by psychiatrists, that are diagnosing as anxiety reaction or depression, prescribing medications. But those labels are following that child or that adult through a myriad of different programs and interventions that may or may not be correct. And you're seeing some of that. []

RON KLUTMAN: Well, and that's what I was hoping our medication oversight thing with the psychiatric association would center in on some of these places where these kids are being on multiple medications. And I think we do review that, don't we? Because I probably have 15 kids that are at least three psychotropic drugs. So consequently they should be reviewed by that joint committee to see if they're adequately done. []

DAN WILSON: That's just recently started. []

RON KLUTMAN: The kids? []

DAN WILSON: Well, really even the review of adults has recently started with letters to practitioners and (inaudible). []

BRAD BIGELOW: There's not much of a checks and balances. Again, rural areas are primary culprit because you don't have the psychiatric support systems to accurately diagnose. []

RON KLUTMAN: But that becomes a matter of education, because once I get past the antidepressant drug in a child, they go straight to the child, because I'm not messing with it. And that's hard to get in at times, as you all know from Columbus, but if there are family physicians and pediatricians making these very difficult decisions then we need to know it because that's my job to educate. []

BRAD BIGELOW: You see a lot of people coming into juvenile correctional, which is kind of my deal, beg to get off medications, you know? You have all kinds of well-meaning caretakers that said you are this, so you're going to take this. You have parents who need to have their child be mentally ill rather than effective parenting, you know? It's better that they're bipolar than undersocialized or parent-child relational problem. []

BARBRA WESTMAN: You throw in the drugs along that and you get a whole different thing too, because a teenager using drugs could show as bipolar, but it's really the drugs. So you have all that to throw in too. []

TOPHER HANSEN: Well, if I might, because Center Pointe does both adolescent and adult and specializes in co-occurring disorders, we have about 75 percent of our kids who have a diagnosed mental illness and an addiction. Your other 25 are just addiction. And one of the things that's important in any business is accurate assessment up front, whether it be primary health care or psychiatric or, you know, walking into a construction project, you've got to be accurate up front or you can really take a turn. And what we find, it actually cuts both ways. We have people who did just what you say, Barbra, that they mislabel and diagnose somebody because symptomatically it's presenting one way and it's a transitional issue that they label as permanent and they don't take into account that fact and guard for it. But mostly what we see in our adolescents and adults are them having been through multiple substance treatment programs and never been identified with a mental illness that is part of that prohibiting factor to keep them from sustaining their recovery and the stabilizing on some medications. But, you know, in our case for instance, it's just good psychiatric medicine. Our psychiatrist is really good at picking that stuff out and she watches for what's transitional versus what's permanent, because we're big believers if that's not wrong don't count it in. But it's all good up front work and competence, competence, competence is what it's about. []

RON KLUTMAN: Well, I think you have your work cut out, because it's...for me, I've never quite understood what all the systems are in child psychiatric care and after this nice update here I know even less I'm afraid. (Laughter) []

BRAD BIGELOW: But the thing that you'll find is that child advocates, agencies in the state, I think are more intent upon overdiagnosing as opposed to underdiagnosing. []

RON KLUTMAN: That's what I see, but you know I don't know this. This is a field out of

my expertise. But I think that part (inaudible) in Omaha with the old--which hospital is it, Senator? []

JIM JENSEN: Richard Young or... []

RON KLUTMAN: That public private...what? []

_____: Douglas County? []

J. ROCK JOHNSON: The Lasting Hope Recovery Center. []

RON KLUTMAN: Is that what it's called? I think part of that was for the education of primary care physicians in psychiatric...and as you can see, it's a huge problem and I know the family practice department would love to be able to have their kids go through a--you know, their residents' kids--residents go through two to four months, because it is a big problem for rural Nebraska. []

DAN WILSON: No, on that score, I think it's worth sharing with the commission that the focus now is on getting the clinical service up and running sometime in the next six to eight months with an expectation that UNMC and Creighton will be involved at least initially from a psychiatric resident training or faculty point of view. But with the hope that it will also involve social work, pharmacy, and so forth in Omaha as a starting point for interdisciplinary statewide education, but we're going to need some external support to take it much beyond provision of care in Omaha. []

JIM JENSEN: And Senator Johnson has introduced a resolution to look at that issue and I think it will be a major issue next year in the Legislature. []

DAN WILSON: And I'm looking forward to the strong endorsement of the commission as that unfolds as you learn more about it. []

SENATOR JOHNSON: Some of us had some conversations about this and we intend to look at this very intently. As Doctor mentioned, it might start out in Omaha, but this is...as we went around the state last year, every place we went they said there was a shortage of mental health workers of all types, and so that was kind of the stimulus to go back to the original plan. And so some of us have been talking since then and we're going to do it in a formal structure here probably early fall and go back and see what we can put together with the idea of submitting legislation next year that will bring this along. []

JIM JENSEN: J. Rock. []

J. ROCK JOHNSON: I just wanted to...the comment that I had added to that is every single one of us with a psychiatric diagnosis could have a live-in psychiatrist and still not recover. So there are broader aspects. We have shortages, yes, but having that medical expertise is necessary but not sufficient. And that also includes the development of the various consumer run services, people in emergency rooms, patient advocates that are mushrooming really around the country, and we're getting more information on that all the time. But I'd like to see that be part of the consideration, because there's a possibility of going into a certification or licensure as well as having some funding for people to be in the medical schools as lecturers, as people doing the teaching. []

SENATOR JOHNSON: J. Rock's been in my office. We've had conversations like this and she's right and fully intend that that will be part of the (inaudible). []

J. ROCK JOHNSON: Thank you. []

JIM JENSEN: We were talking the SIG grant and we do have individuals here who are before us and if you would just introduce yourself. Go through this briefly and then if there's any questions from the commission they can do so. []

SUE ADAMS: I'm Sue Adams and I'm with the Division of Behavioral Health. []

MARK DEKRAI: I'm Mark Dekrai. I'm with the University of Nebraska Public Policy Center. []

PAT LOPEZ: I'm Pat Lopez and I'm working with Health and Human Services Medicaid Division for implementation. []

DAVID CYGAN: (Exhibit 4) And I'm David Cygan. I'm the administrator for this grant and I'm also an administrator for the state Medicaid program. Jeff says I have ten minutes so let's see if I can do that. The state infrastructure grant, the Strategic Infrastructure Grant, is a grant from SAMHSA. It's a five year grant. It's approximately $750,000 a year. It's a little bit less than that. Congress kind of went into the grants for all states and tweaked them down just a little bit. The grant period runs from October 2004 to September 2009. It covers both mental health and substance abuse services for children. It's specifically designed to build infrastructure. We are expressly prohibited from paying for any direct delivery of services. So we are looking at various mechanisms to build and design infrastructure for the program. Nebraska is pretty much one of only seven states that receive this grant. There was also a federally recognized tribe that received the grant also. We tried to sort of model ourselves after you all a little bit. We're for children though. And we instead have a couple of other--because we're with children--we've got a couple of other players at the table. So we reached out and reached out across agencies so we incorporated both the Medicaid program, we've incorporated behavioral health. We also though have to work with and incorporate child protection services. We've also reached out and incorporated the Department of Education and brought them to the table and talked about where we have, you know, common strategies, common issues, common problems that we have to necessarily work with. We've also been talking with juvenile justice and with the court systems. So we've got a lot of other parties that are involved in the children's arena for children and mental health, and we're

trying to reach out and contact as many and involve as many as possible. If you take a look at the handout, you can see that our steering committee, we've tried to be as comprehensive and inclusive as possible. We wanted both rural and urban representation. We wanted representation from family members. We wanted representation from providers. We actually wanted youth representation at the table. So we've tried to be as inclusive as possible. This is just a steering committee on the front. You'll see it talks about five other committees. We've had three other committees that were heavily involved in this that also had members running the realm of 30 members each that were heavily involved with developing a number of the recommendations that were advanced to the steering committee. So what I'm going to do is kind of jump right into what we've been doing here the past couple years with the grant program. We just do recommendations at this point. As indicated earlier, we don't provide services. We make recommendations to HHS, to the Department of Education, to other entities about what we would see would be good infrastructure needs. So with that in mind we started and initiated a couple of projects. We're looking specifically at projects that would be sustainable and would exist sort of beyond the scope of the SIG grant. We've looked at the past projects that have been developed. Specifically, we've looked at the childhood mental health program and early childhood mental health and intervention and some areas that we could build on some of the other earlier initiatives and build them forward and to get them further advanced and have them be a little bit more successful. We've also looked at specifically targeting some issues that seem to be perennial issues for the state. Issues that everyone can sort of agree on are ongoing problems. And when we go to the families, we talk to the families, we talk to providers and we talk with advocacy groups, the principal issue we keep coming back to is the fact that children have to be made state wards to access services. So that's one of the issues we're going to try to tackle head-on. And when we look at our database in the child protective system, there's approximately 6,000, 7,000 children in that system. We look at how many are coded what's called 3C and that means they've accessed those services. They've become state wards solely for accessing mental health services. When we look at that actual number we're dealing with just a very small handful, no more than 12 kids

at any given time that are in the system, as reported by the system, to access mental health services. And honestly, no one in this room and nobody at SIG and nobody at the agency really seriously believes that number. We hear too many stories out there from the judges. We hear too many stories from the county attorneys and from the families that the principal reason this child or that child was made a state ward is because the family can't afford $400 a day to receive residential treatment for that family. I could not afford $400 a day for 30 days for my daughter to receive residential treatment. I don't know how these families facing stays of 90 days, 180 days, 9 months could afford something like that. So they're brought into the system, they're made state wards. We don't know a good number. I think this is one of the issues we've wrestled with with some of the past legislation that's come forward. So we're (inaudible). We've retained the University of Nebraska College of Law and Psychology to go back through a thousand case files looking at both state wards, looking at non-state wards to see if they can identify how many in that sample really came on board for the purposes of accessing mental health services. When that study is complete we're hoping we're going to have a representative enough sample that we can impose into the rest of the population and say okay, we've got 20 percent of these children are here because they got mental health issues and the family brought them here because they need to access care. If we know what that number is and we can get our arms around that number, we can also get our arms around some of the expenditures for those children, too. If we can do that, we can look at designing a fiscally responsible program to provide services for those children. Kansas has a similar sort of waiver where families who are in risk of having their children becoming state wards can enter the program. The parents pay a premium or a monthly fee towards the program and they're provided with the mental health services there. That's one of the areas we're looking at. I'm going to quickly go through these other ones. One of the other things we're doing is I heard you all talking about pharmacology and some of the mental health and psychotropic drugs. We're working with the NMA on a project right now to identify in the Medicaid database, which pays for the state wards and pays for approximately one-third of every child out there, children who are receiving psychotropic medication that's inappropriate. We've got a

couple of criteria that we're using our Medstat database, and out Medstat database takes every client, every drug that was ever purchased, puts it into a relational database and says this child is prescribed this many of Seraquil on this date by this physician. And we're looking at children that are receiving five or more mental health behavioral health drugs, which we are told is clinically inappropriate. We're looking at children that are receiving three or more psychotropic drugs, atypical psychotropic drugs. Sorry, Dr. Klutman. I'm going to get all my terms mixed up here. (Laughter) []

RON KLUTMAN: No, I always lean on my psychiatrist. He helps me stay out of trouble. (Laughter) []

J. ROCK JOHNSON: But I do have a question. []

DAVID CYGAN: Yes, ma'am. []

J. ROCK JOHNSON: Like Seraquil, for example, that will be an off-label use. Is that what you mean by inappropriate? []

DAVID CYGAN: Well, it's not just...we recognize that there are some off-label uses out there. What we've looked at is from a Texas study and a couple of other studies is that it's completely inappropriate to use these drugs on children four years of age or younger. []

J. ROCK JOHNSON: Is that TMAP or is... []

DAVID CYGAN: TMAP. That is correct. []

J. ROCK JOHNSON: Okay. []

DAVID CYGAN: So we're looking at the results from TMAP. We're looking at best

practices. We're looking at four and younger for psychodepressants, psychoactives and one other category I can't think of off the top of my head. We're also looking at...and I think the letters on the five or more just went out here just this week, so NMA just sent them out and they'll be hitting doctor's offices. We discovered with the five or more behavioral health drugs and what we discovered also with three or more atypical psychotropics is that sometimes they're being prescribed by one or more physician. And sometimes the physicians didn't know the other physician was out there prescribing, so we're encouraging those physicians to get together and talk to each other and to work on sort of a joint plan taking care of the client. One of the other areas we're going to be looking at with the study is, like I said, we can tell how many pills were issued on such and such a date. So if an individual got 30 pills of a given type, we can go into our system and find out when that prescription was refilled. So if somebody is appropriately on a maintenance level drug, but they're not refilling it, and we're finding some that are going out 40 days, 70 days past when that prescription should expire. We're sending letters out to the physician to let them know and go hey, we've got someone out here that you've prescribed this drug for. It sounds like it's an appropriate application, but do you know that they're not refilling this drug regularly? And that may be an indication they're not using it regularly. So it's something you need to take a look at and reach out to the family. Maybe refer them to some community resources if they need transportation or something. Put some more services around them. So that's what we're doing with the drug study. []

RON KLUTMAN: Could I just make...are you looking at who's prescribing...Mr. Bigelow brought up about...see, my greatest fear is we have some family physicians prescribing a lot of potent medicines that I believe they shouldn't. But I've also seen a lot of nurse practitioner physician assistants (inaudible). Are you looking at who's prescribing these things? []

DAVID CYGAN: Yes, sir. We're reaching the nurse practitioners and everyone else and we're keeping a database on who's doing what. The other thing I should mention about

this is that we're using an NMA panel to provide then professional technical assistance back to the family physician, back to the PA that would say okay, here is somebody, here's an expert in this area. Here's a psychiatrist or someone similar that's got familiar with the appropriate prescribing practices for the issue you're facing. Here's a resource. They will call you. They will contact you or you can contact them. So we're trying to make those linkages there so that the family practitioner out west isn't out there by themselves. Yes, sir. []

SUSAN BOUST: I think it's...I happen to sit on the NMA panel that did the discussion on this and I think it's very important in the wording that those initial letters that are going out are not going out to identify inappropriate practices. They're going out to alert the physician to a potential problem and that then it would come back to that expert panel to say yeah, this is an inappropriate practice or not. []

DAVID CYGAN: That is correct. We were very, very careful to not interfere with the physician/client relationship to alert them, because there could be, you know what? They're on three or more psychoactives or psychotropics and I told them to flush that other down the toilet and they're not using that anymore. It just showed up that way. So there are bona fide reasons to why that occurs. So I'm rushing so I'm tripping over some of the niceties. (Laughter) But we try to be very, very politically correct as we were reaching out to the doctors on this. []

DAN WILSON: You're doing a very good job. []

RON KLUTMAN: I'll find out I imagine in September when I get a bunch of letters from rural physicians saying who is this person now, you know? []

DAVID CYGAN: Yeah, and we're also finding that some of them no longer have a client/physician relationship anymore. So it's kind of interesting to find that out too and if the prescription was refilled. So...let me go into a couple of other things we're doing.

Working with evidence-based practices and we're trying to figure out the best way to bring data and information on evidence-based practices to the state. I don't want to be in a position where some of the states have sort of legislatively imposed practices. I just don't feel comfortable making a recommendation along those lines because I think there would be, as experienced by the other states that have done this, some provider pushback. To, I think evidence-based practices right now is kind of like light ice cream or light hamburgers or something like that. It seems to be one of those buzz words that's being sort of overused. So we're working with a team of...with Mark and some other academics to actually sit down and review what are bona fide evidence-based practices out there. What are ones that have good history behind them? What are ones that have significant results to them? So we're working in that area. []

RON KLUTMAN: Senator Jensen is really sneaky. (Laughter) []

DAVID CYGAN: I saw Jeff dialing. (Laughter) (Inaudible) So we're working with evidence-based practices. The other problem I think we face administratively from evidence-based practices is if we go out there and we put incentives for adopting evidence-based practice or we mandate the usage of evidence-based practices. I simply don't have personnel to go sit down in every counseling session or to pour through every chart to make sure that evidence-based practices are being consistently followed. So I'd like to figure out a way so that sort of a consumer and a provider driven movement to access evidence-based practices, to understand evidence-based practices, and to bring the information forward in a way that's usable for the provider and the consumer community. Pilot projects. We're looking at a couple of pilot projects based on some promising practices we've observed in some other states and have experienced in this state. One of them is going to be premised slightly on what we have had in the state here for a number of years, what we call the CCAA. We had historically within the child welfare, child protective services area...yes, ma'am? []

MARY ANGUS: Excuse me. What's CCAA? []

DAVID CYGAN: I'll get there. []

MARY ANGUS: Okay. I never...when I don't know what you're talking about I don't hear what you're saying then. []

DAVID CYGAN: It stands for the Comprehensive Child and Adolescent Assessment and it's comprehensive because we used to have two evaluations going forward on every child that came in through the OJS, the Office of Juvenile Services system. And we would have what was called an OJS evaluation and in Medicaid we would have what was called a pretreatment assessment. And they were staffed by different people and they were different type of people like one would be...OJS would be looking at safety and would be looking at some social work issues, and the pretreatment assessment would be done by looking at what further treatment needs were needed by the child. And sometimes they were talking two different languages and sometimes they were reaching different results. And maybe both results were correct or not, but what we decided to do is to go out and partner with OJS and come up with a single uniform assessment that would be comprehensive and cover all needs. We adopted the CASI so we would be looking at substance abuse issues. We also adopted in there, because the judges just kept ordering it after we get the child into custody, a medication assessment by a psychiatrist, whether the child's medication is appropriate or whether the child would benefit from medication. So we adopted that into a single, very quickly paced recommendation back to the courts, a multidisciplinary approach to it so that we're pulling in substance abuse, we're pulling in mental health, we're pulling in medicine. We're pulling all those components together into a single evaluation. That was for our Office of Juvenile Services population. So the children come to us because of some sort of law violation or status offense or something along those lines. We're starting to move over into an area where we're dealing with abuse and neglect. We're looking at how we can model in cooperation with protection and safety, a process that will be very similar to that, but could also be used in abuse and neglect cases.

Multidisciplinary approach and expanding beyond just the child, but looking at the entire family dynamic. We're going to be looking at modeling what we're calling the CFA, which is going to stand for the Comprehensive Family Assessment, and looking at a way to leverage some Medicaid dollars for that. So that's one of the products we're going to be looking at. We're going to incorporate some of the evidence-based practice provisions so that we have some accountability behind it and so that we have some outcomes that we can measure and demonstrate back to you all. The other pilot we're looking at it is going to be a bit more tougher to get our arms around. We've looked at some very promising projects from Tennessee and up wraparound Milwaukee on mobile crisis treatment intervention. These are basically teams that when a call goes out to the police or the call goes out because there's some sort of crisis or breakdown in the home. This is a team of therapists that come in and actually provides...they assess the safety situation. They identify what any immediate therapy needs might be needed by the family and may even be something as simple as respite, just getting everyone apart for a little bit. They work on a short-term care management plan that they can...what the immediate needs are of the family in the future going forward over the next couple of weeks and any additional services that are going to be needed by the family. The model that's up in Milwaukee and the model that's in Tennessee right now are operating under what's called capitated arrangements. And we used to have a capitated arrangement here. It was operated by value options and (inaudible) can go boo hiss now. (Laughter) But we don't have that anymore here. We have reverted to sort of the default Medicaid funding stream, which is called fee for service. Within capitation you had quite a bit more flexibility. You could pay for sneakers. You could pay for gym memberships. You could pay for all these things, because there was a third party involved in making payments from value options or from the capitated entity to the providers. And CMS thinks that's enough stewardship or watching their funds that they will permit more latitude with those sorts of organizations. So many of the organizations that you hear across the country that are talking about blended funding, wraparound funding, those sort of things are operating in a capitated environment. We have a fee for service environment here. We have to pay for a specific service for a specific identifiable client.

One of the reasons this grant right now is housed out of Medicaid, but in partnership with our other agencies is that Medicaid spends approximately $110 million a year on children's services--children's mental health and substance abuse services. Protection and safety is paying approximately $5 million and behavioral health is paying approximately $5 million. It makes sense, from my perspective at least, to keep a lot of that funding over on the Medicaid side. With Medicaid we do pick up the 60 percent federal match. So out of that $110 million, only 40 percent of that is federal funds. We're drawing in 60 percent dollars, but we do get our hands tied a little bit more with the rules and regulations from the feds that we have to follow. So we're trying to figure out a way to take this mobile crisis treatment that's operating fairly successfully in capitated models and bring it here to operate in a fee for service (inaudible) environment. So that's one of the things we're going to be looking at here going forward. Am I out of my 10 minutes yet, Jeff? (Laughter) []

_____: Senator Jensen said oh yeah. (Laughter) []

DAVID CYGAN: Okay. I'll open up to any questions at this point. []

SENATOR JENSEN: Any questions? Thank you very much for your presentation. Think of a (inaudible) step that we have them. We look for the outcomes... []

DAVID CYGAN: Outcomes? Yes, sir. []

SENATOR JENSEN: ...of this study. Thank you. []

DAVID CYGAN: Okay. []

SENATOR JENSEN: Next consumer inclusion. Joel? Where are you? []

JOEL MCCLEARY: (Exhibit 5) Right here. I'm going to give you one useful handout and

one that's not. I'll be honest. I'm Joel McCleary. I'm the administrator at the Office of Consumer Affairs. This is the useful document. I'll start the one that's not useful on the other side. []

J. ROCK JOHNSON: I hope it's just blank. []

JOEL MCCLEARY: I wish it was. The non-useful one, the one I'm referring to, is actually a list of what we've been doing over the last 2006-2007. I say it's not useful because it's primarily things that only we will know a lot about, but I wanted you to know what happens in our office on a day to day basis. That's what this is. It may or may not interest you, but...let's see. Jeff, am I doing this right? I'm going to go ahead and keep talking as I go. It would be foolish, I think, of me to sit here and tell you what's going on without asking you what you think we should be having going on and I would like to have all of you, whether you're in the commission or in the audience, to tell us what's on your mind if that's okay with Senator Jensen. The useful document is a list of the seven consumer specialists who have been hired over the last four months. One was hired in Region 4 just three weeks ago. And these are folks that you've heard about before. $50,000 was allocated to each region out of the money that the state had to send out that way. We earmarked it for a regional consumer specialist to do much of what I do at the state level in their region. And the reason that it was made a region position was because we wanted to have local control and well, that's what the consumers told us to do when we did our surveys. The other document that you have in your hands is, like I say, it comes from what we thought might be the need for this position as it was described in 2004. And so it says OCA, the Office of Consumer Affairs' strategic plan and we anticipated, in 2004 and in the first meeting that I had with the administrators, that probably our work would fall under four basic categories and they are these. The rationale for believing this was we knew that we were going to have to gather some information from consumers all the time. What we do with that is start planning processes. Out of that, relationships would be built, and of course these are not a linear process, but criss-crosses every which way. And something that we anticipated was

that--what we call--peer support at that time was also used in other words. You know, how do people help each other? And by and large, the kind of phone calls and the kind of work that I get asked to do do fall into these four areas. A couple of areas that probably don't fit nice is we work with grant management. We probably are called upon to contribute to grant development processes and it doesn't fit into this very well. Another areas that was specifically called for in the early job description was to describe the grievance procedures for a consumer in any area, and so those I haven't spent as much time on. Those are different depending on your age and where you come from, where they're in assisted living and so forth. But by and large, these are the things that we find that we would do. So I listed a few of the things that we literally bullet so we know whether we've accomplished anything in the year or not. That's what that page is. To me, far and away the most important thing that has happened in the past year is that we have had the regional consumer specialist come on board and I think that's going to change completely what the office even does. I think what's going on in there offices is what informs me as to what I ought to do to support them. And where they are is they're working with consumers much more directly than I probably can and in a much more relevant way, because they're right there. They're their neighbors. So I'd be distant and I think it's better to have that neighbor's neighbor contact and they'll be able to learn from that experience and feed back to us. But I am called upon about five or six times a week to meet in a group like this and...by consumer groups or consumer support families and so forth and what they want me to do is tell them what the state or the nation is going to do to solve their problem. And then there's a little gap in time while I take a deep breath and say well, you know...and I try not to mention Katrina and have you been to New Orleans recently. The thing is that the state can't solve people's problems directly. We can do what we can, but most of the meaningful, long-term recovery comes from...and people who have that inner drive who take personal responsibility for much of their health care and are willing to beat the bushes to find what the need. That's a cruel reality but it is true that those who seek, find. And I try to help them find what they need. I receive e-mails every 10 or 15 minutes. We take phone calls on an 800 line. I meet people in person, do presentations and so forth. A couple of the types of presentations

that I work on, and this gets more at consumer inclusion...every time a person calls the office we try to capture their name, number and put them on a database so that they are looped into the system. I now connect them to their regional consumer specialist, but because of HIPAA I can't describe the person in great detail. I can give them the regional, because they don't work for the state. Now we have to work that out so that if a person, say, is coming out of the regional center and they want to know who their contact person is in Region 3, I would really like it if they could talk to each other before they just jump out the door, but we'll work it out. But a lot of times what I'm called to do is to train in (inaudible), so we're doing individualized plans for recovery everywhere we can get a chance to do those at all the regional centers. We'd like to have everybody have a plan before they get out the door. Other things I'm called to do are these prepackaged kinds of presentations. This one is called "Meth 360". This is a situation where the Lincoln Police Department asked me to come there and be trained as a "Meth 360" presenter so that...well, this is set up by the folks who did the old this is your brain, this is your brain on drugs fried in the pan. These are the folks. And it has the effect of scaring the hell out of people, because it shows all these horrible pictures of people on meth, but what I find is consumers don't like this program because it doesn't show that recovery is possible. They want to see more pictures. You know, this is when I was healthy. This is when I wasn't and then my life was ripped in half. They want a third picture--consumers do--and that's where I think the value of consumer is in this kind of program. They want a third picture that says and this is what happened when I got clean, and this is what happened blah, blah, blah...on down the road. My reality is that I don't have enough hours in the day to do this kind of stuff and already our regional consumer specialists are finding that their time is constrained as well. So we need more consumers involved at every level. So a person comes into the office, they ask me...well, we ask them if they're willing to be involved, particular if they are complaining about something. I'm big on asking what are they going to do about it. Would they help us to get that done elsewhere? If they haven't signed up to be on a committee for the Governor's selection to be put on one of the advisory committees I ask them to complete one of those forms and we send it in. Most of the people who say anything

about it talk about consumer inclusion differently from what J. Rock and I talk about consumer inclusion. We know we don't have enough consumers included. I can't count them very well and I can't describe how deeply, richly they are involved very well and that is why I don't have a piece of paper to show you exactly how consumers are being involved. So I'd like your advice on that point. I would answer your questions and I could tell you more things about what we're up to, but do you have any questions so far? []

ANDREA BELGAU: I do. You were talking about the difficulty between the consumer who's about to be released and getting then in touch with the regional coordinator. HIPAA's protections can be waived. It's just a simple release form. Can't you employ something like that? []

JOEL MCCLEARY: Yeah. It seems simple doesn't it? Sign this form. I don't think everybody along the way knows how easy it is. []

RON KLUTMAN: I'll second that, because, you know, our EPCs come out of any place. I have no information back. It's always they invoke the HIPAA or the child can release it or the adult and they won't release it. So there is a...I mean, I absolutely...of all my EPCs, I have never gotten a note in almost 20 years back from the treating psychiatrist and I'm supposed to take the responsibility for it. []

MARY ANGUS: But that's not HIPAA. Twenty years ago wasn't HIPAA. []

RON KLUTMAN: Yeah, I don't know who it is. []

MARY ANGUS: And I think we're invoking HIPAA when it's not appropriate to. []

JOEL MCCLEARY: It seems like there's a lot of fear in (inaudible). []

MARY ANGUS: If I call the regional specialist or whatever they're calling themselves in

each region, there is no HIPAA violation for me to tell them anything. I could tell them whatever I... []

JOEL MCCLEARY: Right. You can call him and... []

MARY ANGUS: But there are some assumptions on the part of the public that I can't even... []

JOEL MCCLEARY: But I can't call them and give them your name. []

MARY ANGUS: Right. Right. []

JOEL MCCLEARY: So we work it out. []

MARY ANGUS: Unless I tell you to. []

JOEL MCCLEARY: I've been told not to. []

SUSAN BOUST: I think that Andrea's point is well-taken. Health care information is to be protected, but I don't think you're in a relationship of a health care provider. You are not a health care provider. []

JOEL MCCLEARY: See, well, there's an opportunity for training and all of our consumer specialists need to go through it. []

SUSAN BOUST: Yeah. []

JOEL MCCLEARY: On Monday we had our first meeting together face to face and I was a little surprised, but I was asked to actually write out on the board what is the relationship between us and everything else. So I started. Here's the Governor. Here's

the Legislature. Here's where the money flows. Here's the regional authorities. And the group did not know how those were connected even though they have been hired to positions. So we need a lot of education. Speaking of education, complete sidebar, Cheryl Krause (phonetic) asked me to tell you, J. Rock, that the support you're giving the people who are going onto the Advisory Committee meetings is working and it's something that J. Rock's been telling me forever is that the people who serve...consumers that are serving on advisory committees don't know how to do that confidently enough so that they can speak up in meetings. If you're only meeting quarterly it takes awhile to get in the swing of it. []

DAN WILSON: You're creating a whole raft of J. Rock clones? (Laughter) []

JOEL MCCLEARY: I know. Look at her ride. She's riding over here. She's riding. []

MARY ANGUS: J. Rock is solely unique. If we could create a whole group of J. Rocks we'd be in better shape, but she's pretty unique. []

J. ROCK JOHNSON: I'm actually a pod person. (Laughter) []

MARY ANGUS: That's what it is. []

JOEL MCCLEARY: Something else that I talk about being in our silo, I was an agronomy major once. I can talk about silos right? Sort of volunteered to be the cultural--what do you call it--cultural competency guy reporting guy within behavioral health, because I think we're close to the consumers and it makes a lot of sense. But if you look at me, I'm not the kind of person who's going to fit well with a lot of the different kinds of cultures that need to talk to us. So we're trying to look again for consumers that can bridge that gap and search out the information that the (inaudible) need. We fund...we only have...we spend about $140,000 a year on--and this is not office money, it's within the group--that we fund generally to advocacy organization and projects

through advocacy organizations that help consumers be, well, advocated for I suppose. But my hope is that we can continue to move toward getting the money closer to the consumer than to fund other things. I would really like it if we could see consumers making decisions about how money gets used. Putting that in practical terms is something we probably could all use advice on, because if you give it to one person that means you're taking it from somebody else and somebody's not going to like that. []

JIM JENSEN: J. Rock. []

J. ROCK JOHNSON: Yes, at our last meeting--and I do appreciate very much--I had asked that you present to us a written annual report. It is somewhat disconcerting to have that--and I didn't even ask that it be in English, so I really appreciate that--to have that presented... []

JOEL MCCLEARY: I tried to accommodate your... []

J. ROCK JOHNSON: ...that this would be not useful or not helpful and I apologize for, perhaps, not giving you some of the kinds of outlines of things I would be looking for. For example, in LB1083, 71-803, Number 3, Item D, consumer involvement is a priority in all aspects of service, delivery, and planning. How's that playing out? What is that? How's it working? Also, in the planning advisory council, which is the federal oversight and recommendation making body that's underneath our advisory committee for the mental health block grant, has three responsibilities. One is to provide advice and assistance to the division and this was added by state law, including but not limited to the development, implementation, provision, and funding of organized peer supports. So that would be another domain, if you will, that I think would be helpful to be addressed in a formal report. And the third item under the planning council and I've never seen this implemented within the planning council, which is now the advisory committee, promote the interests of consumers and families including but not limited to their inclusion and involvement in all aspects of services, design, planning,

implementation, provision, education, evaluation, and research. We have had this in our federal law for 20 years. There's one, given my excellent organizational skills here that doesn't seem to be on my paper, but that is that this body is to have an allocation to look at the use of monies and services across the whole system to do an assessment on a yearly basis. Now you spoke about Cheryl Krouse (phonetic). She's one of the new members along with Jo Hall from Region 1 and Pat Talbot from here in Region 5 on this planning and advisory committee planning council. And I really appreciate knowing that our working together is being helpful. It's my believe, however, that this kind of work needs to be done as well by the state. There should be modules. We should be bringing in the federal people, which we have done thanks to Ron Sorensen. For the first time, we were able to bring those people in to provide education to the council, because it was necessary that the state actually do the inviting and that had never been done before. So I really appreciate that, Ron, but I think we need to work together more on that and I think we will have achieved some success. When that block grant funds, which is only about $2 million--it's less than 2 percent of our overall budget--is used for peer support, is used for consumer run services. Let's see. I think one of your responsibilities though may or may not be written somewhere is to get dollars for consumers into the community, whether that's general fund dollars, whether that's private dollars, whether that's federal grant dollars, and involve consumers in that. You mentioned the log. I know that there's been this toll free number for quite a long time, but I don't know that you're logging...what are the kinds of problems? I'd like to see that as data. We've got so many calls in the area of. By the same token, I know that Phyllis McCaul (phonetic) who has really done an excellent job with this, goes out, does site visits and generates reports, but I've never seen one of those reports. I've never seen a listing of one of those reports. I've never seen a listing of the sites or what some of the concerns were. This is incorporated in what I said previously, but specifically, consumers and families are to be involved in the development of materials and would include implementation of the mental health commitment laws. And to the best of my knowledge, that hasn't happened. So those are just...and I'd be glad to, as I told you before any number of times, be glad to visit with you and work with you on developing

these kind of things. But that's kind of an overview of what I think would be important. We've got I know work being done with the hospitals around the emergency rooms. Oh, and as the grievances. I would like to know what the rights are. What rights do people have? The only rights I really know about that I can remember is you get one stamp a week if you're in a regional center or something like that. It's in the regulations. But we don't have a human rights structure within our system and I think that this whole rights area is one that needs to be researched and developed. []

JOEL MCCLEARY: Okay. Those are helpful that as we go forward...I do think that because the new consumer specialists are in each region it's going to clean up a little time for me so I can actually plan in advance instead of catching pianos. And... []

J. ROCK JOHNSON: Your office now has three full-time people as well as Iliana whom I met who we're so fortunate with her being a person who speaks Spanish, but you got three people so you got about 480 hours in a month. So in a sense, it's kind of within all of these areas is how are you spending your time? Because where you put your money and you put your time those are the priorities. []

JOEL MCCLEARY: Um-hum. It's true. Something that I want to mention is Leo here. I talked a little bit about peer support, but this is where consumers are getting involved and this is also where I get my buddy Lee to talk about some of the things that are going on in peer support world. []

LEE TYSON: Thank you. First of all, I need to express my heartfelt gratitude to Sue Adams who kindly informed me a little while ago that I returned to the room with my skirt tucked up in a rather indiscreet manner. (Laughter) []

_____: Now that we know your secrets... []

LEE TYSON: Yeah. Had she not done that I would be standing before you now

self-disclosing a lot more than I intended to. So thanks, Sue. []

_____: The rest of us didn't know how to do it. (Laughter) []

LEE TYSON: But you were talking about it. Well, what we did, I mean referring to the project that Joel is talking about is we knew that there were a lot of, kind of a confluence of a number of different issues, a lot of the things that have been discussed here in the meeting today. We knew that there's the mandate from LB1083 that we include consumers and that we promote the cause of recovery. Part of promoting recovery is instituting peer-run and peer-managed services as J. Rock was just talking about. We also need to continually improve our community-based services so that when folks do come out of the hospital or do come out of higher levels of care that there are people out there who can work with them to transition in a meaningful way back into the community of their choice. So we got to thinking, you know, what kinds of services...where would that work the best? And we thought well, community support and peer services--peer-run services. We thought how can we do this? How can we capitalize and build on some of the great efforts that are already going on around Nebraska in regard to peer services and how can we look at our existing community support services and see if there is a way to make them more receptive to the current needs of the consumers in Nebraska. Look at the service definitions and maybe even find a way to blend those two so that they could leverage each other and create a synergy that would produce even better results. So that being said, we had a group and it just kind of started out as a idea group, you know? Just a way for folks to get together and start brainstorming around this issue a little bit. Mary Angus was there and she almost single-handedly transported half the participants. J. Rock and Cindy were both there too. And at the end of the day we decided that we were going to form two groups. One group has to do with community support. The other has to do with peer-managed services, peer specialist services. And then, you know, at some point we'll come back together and integrate that. These groups are intended...I think it's one of those processes where the process is almost as important as the outcome, because what we

hope is that folks in these groups will go out, we're going to educate ourselves about the different paradigms, the models other states are using, what the experts have to say, and what our own folks here in Nebraska need and want. We're going to become savvy as to, you know, how we can make this work in Nebraska. We're going to develop relationships with different kinds of groups so that we can adapt ourselves in the best way possible. And at the end of the day, we can provide recommendations to those in a position to make decisions about such things and hopefully influence them to give us the money to start some of these projects. I left out grants. You were talking about funding before and definitely something that we will be looking at are grants, you know? How can we get some money for ourselves? How can we get some grants? How can we bring some money to this project? So we've got the two groups. We just got them formed and we will be meeting again in the first of June sometime and, you know, we encourage involvement. We have representatives from traditional community support, emergency community support, substance abuse community support, co-occurring community support, as well as complementary cadre of consumers. We do need more consumers on our community support committee. I'll just put...I think Cindy Scott is the lone ranger right now. So we do need some volunteers for that one, but you know, we have just begun the process of putting our tentacles out and finding all of the people who would be, you know, best used in this kind of a project, you know? So if you know of somebody or you want to be involved just give us a call. Yeah. []

CAROLE BOYE: Lee, first of all, congratulations for doing this. This isn't a criticism as much as (inaudible), which is that there is a lot of enthusiasm and actually there's been a lot work and trying to figure out how to do this for some time within, I know among the community support folks. There was a very short kind of announcement time on this thing and I think that precluded folks. So I would just encourage you to not interpret a lack of interest or a lack of enthusiasm, but give some front time, because community support workers, peer support workers, all of those have full case loads, full job duties, and to turn it around on a dime is really hard. So please get us that information. Go through the regions or whatever and give us information, who's doing what, and I think

we can generate an awful lot of enthusiasm across the state for this initiative. So... []

LEE TYSON: I think so too and I do apologize for the short notice. []

CAROLE BOYE: It happens. Stuff happens. Like I said, don't take it as a criticism. I was talking (inaudible). []

LEE TYSON: It was an odd situation. So yeah. Next time, they told me loud and clear that they need at least a three week lead time so that's what we're doing from now on. So... []

JIM JENSEN: Anything else? []

MARY ANGUS: Lee, I'm going to kind of reiterate what Carole is saying. I have known you since you came to Lincoln and I so appreciate your enthusiasm, your energy, and your basically a wonderful cheerleader and all of that stuff. []

LEE TYSON: I was a cheerleader. (Laughter) []

MARY ANGUS: So now I can understand that. I don't believe this was intentional and it is very difficult to see consumer involvement as a priority when it's a last minute affair. When...I think you approached me on Thursday and the following Thursday was the day that we met, and as Carole said, it was very difficult. I was amazed at how people could get there. I really, really was. []

CAROLE BOYE: But I think that does speak to the enthusiasm (inaudible) and the fact that the time has come for this kind of initiatives and these kinds of discussions. []

LINDA JENSEN: And Mary did a good job of e-mailing. (Laughter) []

LEE TYSON: Yes, she did. Well again, it was a... []

MARY ANGUS: Well, the other thing is that it wasn't until Monday or Tuesday when the thing was Thursday that we got the news that we could have some reimbursement for mileage. That's an extremely important thing for folks that many of us cannot get gainful employment at this point. I would also say that many...it was at least, as I recall it was the provider who mentioned the time turnaround and I would put forth that those of us who are consumers, who are maybe not in a program that can allow us the flexibility to become involved with that group, because the time that we've allotted to some class or something can be put to that, that we have schedules too, and we have the obligations too, and that we can't...you know, it's a rare event for me to be able to say I can do that tomorrow or I can do that next week and like Carole says, I don't mean to be critical, however those are things to keep in mind and they really are kind of critical. []

LEE TYSON: Yeah. This was something that kind of came together...an opportunity presented itself and we just seized on it. So... []

MARY ANGUS: Yeah. I know it. Well and it was successful in getting a lot of people involved and the enthusiasm and the energy and the dedication to doing something was there. []

LEE TYSON: And next time we won't do that again. So... []

MARY ANGUS: Well and I'm hoping that we can be effective in altering regulations and service definitions in order to change the infrastructure, because previous attempts to change infrastructure to be less medical model more community services and recovery philosophy as well as self-directed, consumer-directed rather than professionally-directed has not been successful. And so I think that's something that we really need. That's got to be...that is critical. []

LEE TYSON: I really believe that the best way to create change that is substantive and permanent is to include and promote the ownership by the people who actually provide and use the services, and so that's what we want to do here. We want to start from the ground up and develop our program that way rather than the other way around. []

MARY ANGUS: However, there need to be changes in the regulations in the regulations, the rules, the way those are applied, and the service definitions. This is kind of out of the realm of this particular group, but we just got the Money Follows the Person Demonstration project, which provides $27.5 million to the state to rebalance the system from institutional care to community-based services. The job tital is medical services unit director or... []

_____: The director of (inaudible). []

MARY ANGUS: ...the director...and this is supposed to be the program director for Money Follows the Person, not a medical services unit director. []

LEE TYSON: Sounds like we have a lot of work to do. []

MARY ANGUS: But another indication of how the service definitions--and I can have all the personal responsibility I want--the service definitions and regulations get in my way. []

J. ROCK JOHNSON: And I'm going to just jump right in myself, because I find out that when you have white lettering on a black background the third of the three responsibilities of the planning council relevant to the block grant is to monitor, review, and evaluate not less than once each year, the allocation and adequacy of mental health services within the state. That is the duty that I have never seen even remotely addressed and we've talked some about not having a needs assessment. And I think that if there could be some funding devoted to accomplishing this purpose or beginning

to look at how we do do that. I think that fits in very well with the development of the peer services. It's an opportunity, a mechanism, for looking at that. So I'm not disorganized and I'm not color blind. I'm not sure what to call it, but not too often are things really black and white to me so maybe that was it. []

MARY ANGUS: That's true. []

LEE TYSON: Well, perhaps this is one small way to begin to demonstrate the power of consumers and that if we become educated and we learn about what's going on, what the experts are saying, we develop models that make sense, then might be a chance to actually change some of those rules and regs and convince folks that those service definitions need to be altered and that new ones need to be drawn up and that sort of thing. So... []

JIM JENSEN: Okay. Anything else? Thanks. Oh, Joel? []

JOEL MCCLEARY: Thank you. I asked each of the regional consumer specialists to write a section about what they would like you all to know about their operation and it ended up being 30 pages. So I didn't copy it to you directly, but I will e-mail you that because it's important to them that I not mess with their work and send it directly to you. So I'm going to honor that, but I"ll send it electronically. Thanks for the chance. Hey, thanks for spending the day and much of your careers saving folks like us. Appreciate it, thanks. []

JIM JENSEN: Ron, you're next. []

RON SORENSEN: Yeah, I want to back...not going to take more time than I have to, but I was supposed to talk about sex offender a little bit earlier and I skipped over that. I think we were hurrying along too quickly. Just wanted to show you this slide which gives you an idea of the current census at Norfolk and Lincoln of sex offenders. That's in the

FY07 YTD, or year to date, column. We now have 124 individuals in sex offender programs. We project by the end of the fiscal year we'll have about 135 total. You can read those notes there for yourself as to what some of the assumptions are about those projections, but that's one of the things I think when we talk about the budget issue earlier with Sandy Sostad when she talked about we funded 120 beds at Norfolk for sex offenders. We only have at this point a total of 44. So what they chose to do was to use the funding there to fund the behavioral health people, but that won't last forever. And so as you can see by the growth in the census, we need those beds, so we still have to move to get people out of Norfolk. Okay? []

BRAD BIGELOW: Ron, clarification. []

RON SORENSEN: I'm sorry? []

BRAD BIGELOW: Point of clarification. Now the sex offender program in NRC, is that going to be under corrections or is that going to be under behavioral oversight or under regionals? []

RON SORENSEN: It's all administered under one program through the Lincoln Regional Center. We actually have this is (inaudible) a little bit, but now the three regional centers are actually administered by one individual. Bill Gibson is now in charge of the three regional centers. This program also has a program manager out of Lincoln and Norfolk and Lincoln have been working together to make sure the program follows three steps and they're all worked out together and that is when you begin in Norfolk is step one, you go to Lincoln in step two and step three. So it's one program run by us. In that regard, though, we've been meeting monthly with corrections, probation, the Attorney General's Office, and others to talk about the sex offender treatment program and just develop a pretty good working relationship with us in corrections with the (inaudible). They're actually working with us now on our program to sort of make what they have and what we have very similar in nature to the (inaudible) can make it similar. We do

have--there's a notice here in the notes--we do have corrections' individuals that have come into the sex offender treatment program in Lincoln. So there's two accesses to the Lincoln program. One is through corrections, one is through (inaudible). So make sense? []

BRAD BIGELOW: So the budgetary impact...the regional center...they all have monies for the regional center, will encompass the monies for the sex offender program? []

RON SORENSEN: Yes. []

BRAD BIGELOW: So the savings...we're not actualizing any real difference in spending between now and what we're projected with the 120 beds? Will there be, technically, a savings at all or is it about the same? []

RON SORENSEN: Oh yeah, the charge we had from Sammy? Yeah, the money in LB365 for sex offenders and the money in LB870 for sex offenders--I know this is confusing--but that's not impacted at all. It does not impact the behavioral health program at all. Okay. Then I was supposed to talk about medicare. Excuse me, Medicaid. It's all the same to some of us. (Laughter) []

_____: Some of us it's not. (Laughter) []

RON SORENSEN: Yes, I know. I don't have to worry about it though. []

MARIO SCALORA: While you're searching for that, I recognize looking through the report that your staff went through a lot of extra effort to parcel out some of the data and show the unduplicated pieces and recognize that takes a lot of effort. I want to express my gratitude. I realize it took extra effort and thank you for laying some of that out a little differently. That made it a little easier to review some of that information. []

RON SORENSEN: Yeah, thank you. I appreciate that. Sue Adams, sitting back here, fixed the major (inaudible) in putting the report together and other people in our office like Betty (inaudible) and others helping her. It does take time and effort and I do appreciate it. I want to run through the Medicaid slide real quickly here. Some of you, I think, last time asked about medicare part D and its impact on Medicaid spending on the state level. This about as graphically as anything demonstrates the implementation of medicare part D and you can see that what we were paying for medicare eligibles out of the state budget was over $4.5 million at one time. Implementation of part D brought it down to a much smaller amount. But before you start thinking we've got a lot of money left over in the state, there is what they call the claw back provision of medicare part D, which means basically the state has to make up the savings that we save when we went to medicare part B. So we didn't really save anything as taxpayers (inaudible). []

RON KLUTMAN: So they just...what you're paying for, that's what you pay for now huh? []

RON SORENSEN: Pretty much it. It's just that we pay it...rather than pay it on an individual basis to providers, we have to pay it to the federal government. []

RON KLUTMAN: Okay. So even if we start having cost savings with our review of psychotropic drugs and things, we go... []

RON SORENSEN: Well, I'd rather not answer that, because I'm not an expert on what happens when you experience cost savings as part of medicare part D. []

RON KLUTMAN: Okay, okay. []

RON SORENSEN: I'd just rather not... []

MARY ANGUS: Ron, I would put forth that there are no experts on what would happen

in any case with part D. It is so complicated. []

RON SORENSEN: That may be. This whole thing is gone by the time I get (inaudible). Okay. This is the chart we show each time. It shows the increase in Medicaid match and it's changed each month based on the actual expenditures to that point in time. You can see, I think, in the total (inaudible) it's about $3.5 million in Medicaid rehab option and $2.5 million in substance abuse. So we're up to the $6 million, $7.5 million dollar range in terms of increasing Medicaid matching funds as a result of increasing our involvement. And basically, what's being used is matched (inaudible) is the program 38 or community-based program, which is (inaudible). All right. Skip along here. I think that reflects...that's basically the chart you just saw earlier for those of you who like numbers rather than charts. This is an interesting chart. I haven't had a chance to analyze it yet. I just saw it when they sent it to us yesterday. It shows the Nebraska Medicaid payments for emergency room recipients. It's interesting because if you look at the growth in both children and age 21 and older, you'll see that the number of individuals paid for by Medicaid, eligible persons entering a hospital has gone up from the fiscal year '03 to '06. What's interesting is that at the same period of time our EPCs have actually gone down. I'm not sure what to say about yet but it's something we'll take a look at. That, in fact, these may be individuals who aren't being EPCed, but are being brought to the hospital on some other basis and we're going to (inaudible). []

MARIO SCALORA: Now this is if they have a mental health diagnosis, but they could be going into get their arm set. Would this...or is this strictly for psychiatric care? []

RON SORENSEN: I'm going to have to ask about it. They set it down and unfortunately Mary Steiner is sick today and I'm supposed to explain it. So... []

SHANNON ENGLER: That's psych care because of the diagnostic codes. []

_____: They wouldn't code it otherwise. []

MARIO SCALORA: Okay. So it would be split (inaudible) treatment code. []

MARY ANGUS: Yeah, those are treatment codes in psych. []

RON SORENSEN: Okay, got you. []

TOPHER HANSEN: Did you say it's grown? []

RON SORENSEN: Yes. []

TOPHER HANSEN: It's going down, right? []

RON SORENSEN: No, it's going up. Recipients of this (inaudible). It's an interesting chart that may explain of what's going on in terms of your (inaudible) hospitals? (Inaudible) talk to Medicaid about that. Get some understanding of exactly what they think is going on. That's it for that. So I think that covered Medicaid. I apologize. I can't explain it. I could explain it, but... []

_____: We don't want you to make up things. (Laughter) []

RON SORENSEN: Okay. Senator Jensen, do you want to just go ahead and go into the next thing? []

JIM JENSEN: Yes, please. []

RON SORENSEN: (Exhibit 6) Okay. We could be handing out this handout if two of you could help me. Okay. Some of you were in attendance of the third (inaudible) a few weeks ago. We talked about data and what you need as a commission to understand the providence being made and (inaudible) form. So after that meeting we took our

notes and first of all, let me say I appreciate you coming in talking about that and giving us a little more insight into what it is you need to see or want to see. So as a result of that we came back to our office. Scott and (inaudible) staff members all went through what happened at that meeting and decided we would come up with four measures that we thought would help to understand what's going on in the system. One of them we technically already do, but we will be expanding this as we go forward. And hopefully, what I've given you explains some of that. But the first one is the person served in the community-based services and you have extensive discussion about duplicated and unduplicated. And if you have the old reports, if you look at...if you recall those bar charts we showed the numbers going up over time, each service is an unduplicated account, but the grant total is a duplicated account. So when you look at those and the handouts you already have, you can take a look at that. But when we had our handy dandy data person take a closer look at what's going on in the system, we've gotten to the point where we've been able to pull information out of what's provided to us through the UNMC (inaudible) that you heard about earlier. Some of our data, because of the person we have helping us, that we are better able to look at whole system in terms of the number of people being served and this is 2004, this would be the year before reform starts. And just to take a closer look at these numbers, although there are 61,000 records in the Magellan system, there are 33,124 individuals; 13,567 of those individuals access mental health services; 19,557 access substance abuse; and actually 2,661 of that total have access both mental health and substance abuse services. Make sense? Okay. That's an unduplicated account. In 2005, we saw the total grow to 43,719 individuals and I won't go through reading all those numbers. You can see those, but you can see there's a broken system. In 2006, we're up to 47,664 persons being served in the system. So that growth over (inaudible) two years. It's interesting to note the growth in the people getting (inaudible). And then up to date, at this point in time we have 44,642. I think Sue laid out a chart here that puts the numbers in perspective (inaudible) take a look at them--'06 is the tan, the pink is '05 and the blue is '04. So you can see the kind of consumers in the three year comparison there clearly expanded the number of individuals paying (inaudible) by even more than I think we

originally made...well, I guess it's about $4,000 []

CAROLE BOYE: Really? []

RON SORENSEN: Yeah. []

CAROLE BOYE: The records...is that that duplicative services or... []

RON SORENSEN: No a record...anytime you go in to authorize somebody for services different than they had before it's going to be (inaudible). []

CAROLE BOYE: Going to be (inaudible). Okay, so that's how I would... []

RON SORENSEN: And they may not even get served, but they have (inaudible). []

CAROLE BOYE: Okay, all right. []

RON SORENSEN: Okay, move along to the next one. Here you see that the consumer is served in both mental health and substance abuse services just in community-based services. We took...we had trouble with the regional center numbers so it's best that we take them out. So this is strictly community-based services. Okay? (Inaudible) questions about those? []

CAROLE BOYE: So there's been growth in the number of persons served between 2004 and 2006 in the community-based services. []

MARIO SCALORA: And potentially the numbers of services those people are getting. []

CAROLE BOYE: Right. But the percentage growth of just people served is fairly phenomenal. []

MARIO SCALORA: Yeah. []

CAROLE BOYE: Am I reading that right? Okay, thank you. []

RON SORENSEN: Okay. All right. No questions about (inaudible). I hope that answers some of your questions about unduplicated accounts. Next was the waiting list for community services and I think it's important as you look at this one to really take a look at the handout, because as you look at these numbers you'd have to keep in mind that these are pretty the best way to explain it. It shows some trends that are very interesting, but they're soft and (inaudible) and the way that we collect these. We have inconsistent reporting, (inaudible) providers. We don't really know that the person on the waiting list is in fact going to be eligible for the services. (Inaudible), number one. Number two, I know the personal examples where people can (inaudible) three different lists. And so the numbers may be a little bit skewed, but let's assume that they're skewed on a consistent basis, (laughter), so we can at least take a look at them and see what's happening. The number of individuals or persons on residential waiting lists per region is shown on that first chart and it's interesting to know that that chart basically has a downward trend. Yes, Carole? []

CAROLE BOYE: I looked at this one earlier. What's the definition of residential services? What all is this capturing? []

RON SORENSEN: It would be, well basically, (inaudible) rehab, short-term (inaudible). []

CAROLE BOYE: Okay, but not hospital care? Not subacute care? []

RON SORENSEN: No, no. Subacute care would not be on this. []

CAROLE BOYE: Okay. I got to say just knowing something about residential services in Region 6 that on its face it's ridiculous. There is no way that there was ever 1,250 people taking 25 agencies and being...would ever have 1,250 people nor would they now have 850. So we've got to go back to data sources and... []

RON SORENSEN: Well, I said it's very soft, Carole. []

CAROLE BOYE: Well, it's more than soft. It's... []

MARIO SCOLARA: It's wrong. []

CAROLE BOYE: It's wrong. []

_____: That's a good way to put it, Mario. []

CAROLE BOYE: Without even getting into the specifics, it's just on its face just more than wrong. []

RON SORENSEN: And Community Alliance does turn their's in, right? []

CAROLE BOYE: Oh god yes. (Laughter) They harass us constantly. []

RON SORENSEN: Okay. Well, this is what the data we had shows. It does not reflect Carole's experience or anybody else's, but this is what the data shows. Non-residential waiting lists and this one, interestingly, goes the other direction. Now I don't even try to explain April '04. I don't remember April '04 and so to say why that spiked like that I don't know, except you can look at this and say on July '04 is when we started reform and did that have an impact here? Possibly. I mean, you could...there's certainly enough here to say that you might want to look at that (inaudible). But I think overall the trend is clearly in opposition to what we saw for residential care. Are there any non-residential

providers here who disagree with this? []

MARIO SCALORA: You're more likely to get overlap and duplication here, because you've got more people getting referred for multiple types of services. So even if they're like being referred for let's say residential, they could also be getting case management referrals. They could be getting...so and looking out at Lincoln, people are more likely to get referred to multiple types of service as we're finding people with higher needs coming in and out. So part of this just may be the nature of how we're tracking that. I'm not suggesting these aren't the numbers you have. It just may be an artifact of patterns of how people are being referred with some of that. []

RON SORENSEN: Right. Yeah, there's so many variables in this. That's why I said you've got to be careful with it and some people would choose not to believe it and (inaudible). []

TOPHER HANSEN: As a trend line, that's consistent with our experience. []

_____: On the non-residential side. []

TOPHER HANSEN: On the non-residential. []

CAROLE BOYE: That it's going up? []

TOPHER HANSEN: Yes. Our basic services are getting stacked and they haven't in the past been as stacked. []

CAROLE BOYE: Well, and one of the things that happens with non-residential service is that many folks choose not to keep a waiting list for nonresidential services. So, you know, I take that piece of information and see the trend line going up and I'm going boy, that doesn't match kind of my perception either. And so I hate to infer anything, you

know? The one's going up, one's going down or...you know, what does it mean? Even if it's a trend line, even if the raw numbers are bad? Because it goes counter to some intuitive stuff and then certainly some just basic (inaudible). I think it's really important. Going back to what you talked to real early about, Topher, the whole capacity issue. This is critically important that we figure out what it is we're measuring and what it's really telling us. So it may merit looking at something other than the past year's reports if we have that much divergence and who's filling it out and what it means and all of that. []

TOPHER HANSEN: And is this inconsistent with your agency experience? []

CAROLE BOYE: Our agency does not maintain a waiting list for nonresidential services. []

TOPHER HANSEN: Oh. []

CAROLE BOYE: We just figure out a way to get them in, you know? And I can't talk about all Region 6 agencies, but generally speaking, we in Region 6 do not go towards waiting lists for services. We may have delayed admission, you know? It may be that well, we're not doing intake now for three or four weeks instead of, you know, a week, but we don't put them on a waiting list. They're admitted and their first appointment is out there. []

RON SORENSEN: So they're waiting, but not waiting? See, that's one of the issues we... []

CAROLE BOYE: But it depends on how you define a waiting list. Is the admission to see if you've made before or after you put them on a waiting list? []

RON SORENSEN: And that's one of the issues we ran into when we started working

with the numbers... []

CAROLE BOYE: That's a huge issue. []

RON SORENSEN: ...is some providers say well, I have an appointment for them. It's six weeks away. So they're not waiting. []

CAROLE BOYE: That's right. That's one interpretation of a waiting list. I think this is an important piece of data. I think what we have to do if we're going to try to track this down is use something other than capacity reports. We need to systemically...and I would imagine every region and every provider would be real willing to do that, because capacity reports are kind of subject to interpretation under the best circumstances. Then we have a look at what exactly is it that we need to know and let's track that specifically so that we can infer appropriately on what we're seeing. I hope this is true. []

SCOT ADAMS: Carole and others, what I would like to add to this conversation is we have a lot of really brilliant and (inaudible)...general characterization and... []

MARY ANGUS: Scot, could you speak a little louder please? []

SCOT ADAMS: Thank you. At the commission meeting, the last one where we talked about this, we had a great deal of input as to what measures might be. And so we took that and today we're sort of presenting what we can present that we think is meaningful. We don't present this as done (inaudible) final. It may not even be in the best shape, but more than anything we'd like to have your reaction as to conceptually is this a good measure of outcome. That's what the conversation is about that I (inaudible) that day anyway. How will the commission know that LB1083 is on the right track? This seems to be a measure of that overall system squish is what we sort of called it that day, and you see the complexity involved in measurement. And so with this lots of...I know that, but why don't we get through the whole thing and then tell us if we're generally on the right

track. And your points are all right. I'm not arguing any of them and I appreciate the comments that you hear, because it shows some complexity. What's a wait list? Sounds like a simple idea until you start (inaudible). []

SHANNON ENGLER: And if I could just add, I was at that meeting. There was a lot of... []

SCOT ADAMS: A huge amount of input, thank you very much. Creative energy. []

SHANNON ENGLER: ...input, and Ron and you all have come forth with a lot of the data. To look at any one of these pieces by themselves that there's some danger to that, but if you look at the bar charts for people entering services, which are now unduplicated, between January and May '06 there's been a little growth in any of those specific services except for the first two and I don't even remember what they were. If you take that and say okay, we're not seeing more people there, more people are on waiting lists. And if you look back at the residential one, the bump started up about the same time there and take into account the consideration of the graph for the increased number of emergency room visits for behavioral health clients, you're starting to get a true picture of what's going on not using just one data element, but trying to correlate all the different pieces. So that's...thanks for the info. It's helpful. []

RON SORENSEN: Okay. I'll move along here in the interest of time. This just puts the numbers together. This residential/nonresidential shows the differing trend lines for those two. Don't need to say more about that. I think we covered it. And I don't know what that one is. We know it's not Carole, though. (Laughter) []

MARY ANGUS: You've got a reputation now, Carole. []

CAROLE BOYE: I am...all kidding aside, I absolutely support what you folks (inaudible). I think that a very, very critical measure and I always think about when we leave to go to

the Legislature, because I believe that's where we're going eventually in terms of this additional capacity issue that's coming up and that's where I would challenge all of us to make sure we could hang our hats on this. And that's really...I'm not arguing with the measure. Please don't misunderstand me. I'm saying let's find something that on its face can't be blown up, because I don't want to go talk to some senator and have it blow up. []

RON SORENSEN: Yeah. And as Scot said, you know, this is what we've got and if there's ways to find something that's better or to improve this that's what we'd look at next, or if there's ways of corroborating through other measurements. But this is...where we're starting we have to look at some of these issues around demand versus capacity that we talked about and this is one way to start taking a look at it. So with that, we go to emergency protective custody. We expanded this chart just a little bit to show how each region is doing through the third quarter. EPCs continue to be down. I know we've had a number of discussions about EPCs. As I mentioned earlier, we are going to continue to work in this area of access of EPCs and it may take looking at other measures, maybe fix (inaudible) in front of the actual EPC like the number of law enforcement conversions, the number of law enforcement contacts. All those things are linked to diverting or finding other solutions for people and places. So...yes? Do you have a question? []

RON KLUTMAN: So the EPCs are going down. I think I read that from there. Is the facilities they handle them going way down? []

RON SORENSEN: No. That's the...I think...I was looking for Shannon. He's standing right there. We talked... []

RON KLUTMAN: Although I admit our's used to always go to Norfolk. Now we're all going to Lincoln. []

RON SORENSEN: Well, that's... []

RON KLUTMAN: Andrea is that correct? []

ANDREA BELGAU: No, we still have people going to Norfolk. []

RON KLUTMAN: Right. []

ANDREA BELGAU: The EPCs? []

RON KLUTMAN: Yeah. []

ANDREA BELGAU: First they go up to Faith Regional. []

RON KLUTMAN: But we seem to be having trouble getting them someplace. []

ANDREA BELGAU: We've had a lot of trouble with that. []

RON KLUTMAN: See, that was my question is... []

RON SORENSEN: That's the issue is although EPCs have gone down, access has...I don't know if it's any worse than it ever was to be very frank about it, but it's not good and I think part of--and Shannon can argue with me--but part of this is I think what's going on and the health business in general is that we've got people accessing hospitals more than they used to, correct? And what we're going to be looking for is some way to improve the access. I don't know what it is yet, but that's why we're meeting with the consumers, county attorneys, the regions, and law enforcement to say what are we missing here that we need to find solutions for? I don't know if it's people who we don't pay for or if there's some way to deal differently with EPCs. I don't know that we have the answer to that. We try to budget things, as I went through earlier, but it's a

(inaudible). We've got to keep working till we get (inaudible). So in terms of EPCs, the reason I brought up that Medicaid slide earlier is we're showing increase in number of people who are Medicaid eligible accessing emergency rooms. At the same time, we're seeing EPCs drop. So it's an interesting sort of...kind of two different lines crossing in different directions, but we have to take a look at why that's happening. Okay, the other one we wanted to get to... []

SHANNON ENGLER: Ron, excuse me. []

RON SORENSEN: Yeah. []

SHANNON ENGLER: I really don't like to ask for additional stuff, but it just struck me, are those truly just EPCs by law enforcement or do they include--what do we call it--the warrants from the county attorney? []

ANDREA BELGAU: We do mental health warrants. []

SHANNON ENGLER: Yeah, the affidavit that comes affidavit that comes directly to the... []

ANDREA BELGAU: The affidavit give probable cause? []

SHANNON ENGLER: Yeah, versus an EPC, because those are two different things. Are we counting... []

RON SORENSEN: This is strictly for measure of the people who end up in a hospital in emergency protective custody. So if they have not been put into custody by a law enforcement officer (inaudible). []

ANDREA BELGAU: But what those numbers don't reflect or say, for our instance, if an

individual doesn't get admitted into Faith Regional, but goes to Kearney, Richard Young, or even North Platte or down to Bryan LGH, those are not reflected in that data and I've been keeping those numbers and e-mailing them to Ingrid in our jurisdiction, but that's similar to other jurisdictions too. []

RON SORENSEN: Yeah, if they are EPC they wouldn't be reflected. []

ANDREA BELGAU: It would be reflected in the receiving... []

RON SORENSEN: There would be some that would be showing up in the other hospitals. []

ANDREA BELGAU: Yeah, that would make sense. []

RON SORENSEN: And we have started tracking...try to track through Magellan where people...how many instances of people being taken from region to another region or some distance to be admitted. So we're trying to get some useful numbers out of that data too. As we said before about datas, first you pull it, then you've got to see what problems you created on the parameters you had for pulling it and then go back and sort it out. That's where we are now. []

SHANNON ENGLER: Well, why I ask that specific question because EPCs could be going down as a result of law enforcement being very tactful and talking individuals into presenting in a voluntary manner for the first 15 minutes and then all of a sudden they decide they don't want to be there and would be leaving. And then the practitioner has to step in and complete the affidavit, which is we're not counting those as well, and I bet we're not if those are strictly EPC. It would be nice to see if there has been a shift there, because then we could truly measure the effectiveness. Are involuntaries on the front end really going down or are we just shifting from law enforcement initiating an EPC to now the practitioner is having to work with the county attorneys. []

MARIO SCALORA: Is that something you're encountering, Shannon, in your facilities? []

SHANNON ENGLER: Yes. []

TOPHER HANSEN: And I've had conversation with the higher ups in the Lincoln Police Department. They have definitely changed their policy around EPCs and approach it in a whole different manner than they did three years ago. So we can look at the numbers being reduced, but drawing conclusions is a little more risky there. But it would... []

SHANNON ENGLER: If there would be a way to capture that, and I have no idea...I'm just... []

RON SORENSEN: I don't either. I don't either. We'll check and see what's in Magellan. If it shows coming in in some other method then some other...I suppose it would show up as a legal status of some kind or... []

ANDREA BELGAU: Well, I would think. I mean, the burden would still be on the county attorney to, if the evaluation showed cause, to file that petition. []

RON SORENSEN: So maybe... []

ANDREA BELGAU: And that would be available through the... []

RON SORENSEN: So maybe the access would be through the county attorneys then. []

ANDREA BELGAU: It might be. []

RON SORENSEN: Okay. []

DAN WILSON: We've discussed this before, Ron. We're not really measuring all the involuntary hospitalizations that are taking place, which is from a policy and planning point of view, more critical than the specific category of EPCs. []

RON SORENSEN: Yeah, and I think that's where that other discussion gets to talk about one of the regions. Why we have...don't we have access (inaudible) to get access. Okay, the last one is the length of stay in the community. This is one area that we want to take a look at, because the measure of success is people staying out of hospitals and the communities longer and we have one preliminary way to measure this. We hope to expand this into looking at private hospitals as well and seeing what other information might be available. What we're using as information out of that study (inaudible) and I don't know that (inaudible) got to this part. I think...did she (inaudible) get to the readmission of 180 days? []

RON KLUTMAN: Yes. []

RON SORENSEN: I think she did. So we're taking a look at this and if you look at the left percent rate, I think that's pretty much the national average at this point in terms of readmission in state hospitals. So this will be one method we have where we subtracted people out of the regional centers as to how long they stay in the community without having to come back. There (inaudible) as we move forward, we have to move to tracking people from the hospitals as well. That's a little more difficult now that we're getting information system inaccurate. Yes, J. Rock? []

J. ROCK JOHNSON: Yeah, as we're moving toward measuring employment, housing, income, recovery, other measures, community integration seems to be a better concept for measurement than recovery and some of the things I've been reading, but you definitely have to know this information in order to move toward the others. This is really good. []

RON SORENSEN: Yeah and I think we mentioned before, just so you know, we do have an extensive project now we just got started at HHS about our information system and looking at pulling together, ideally, Medicaid, protection safety and ourselves into the information system that we hope would help solve some of these questions that we have. At least answer the questions. Right now we have the Magellan system and probably will for at least a couple more years. Okay. The next slide was readmission status by behavioral health region among consumers in a follow-up system. It shows it by regions. Okay, any questions? That's it. []

JIM JENSEN: Okay. Any questions for Ron? Your new Medicaid director starts when? []

RON SORENSEN: Monday. []

JIM JENSEN: Monday. []

MARIO SCALORA: Ron, we talked about this at the last meeting. I'll make the pitch again and I don't know how easy it will be to get this. Again, I appreciate what you all did with this. This was a lot of effort and it took us a lot further from where we were, let's say from the last meeting, and tweaking data is a heck of a lot...you learn...we still know more even if we have to tweak the definitions. So this is wonderful. With Magellan reviewing cases, at some level they have to look at acuity or an intensity of presenting issues. And granted, we're going to have to pretty limited or incomplete measures there, but given the administrative services they provide can we tie in from (inaudible) or the Avatar system anything on acuity, so we can get a sense of how some of these are? Because we also may be seeing some shifts on how populations may be getting into the system or what's being used. Knowing a waiting list is important. Knowing how bad off people may be on the waiting list concerns me as much, if not more, because then it's not as much size, but intensity of issues there. I recognize that's not data you always have readily available. Is that something people have been exploring? []

RON SORENSEN: Well, quite frankly, we haven't to this point. We look at the Magellan system. All it can tell us at this point is you are authorized for acute services, subacute services. It doesn't...I think what you're asking is within that acute area are these people seeing different levels of (inaudible)? []

MARIO SCALORA: Yeah or...because they obviously have to be getting information on the nature of the presenting issues when they're saying yes or no, thumbs up or thumbs down or whatever level of care, presuming they're not pulling information out of body cavities somewhere. They're going to have to be approaching at a systematic level. Seems to me something like that...now whether it's electronically accessible is another question. []

RON SORENSEN: Well, I've got to tell you, we will go back and look and see what was in their system in terms of...you know, I don't know how much they record on each case. []

MARIO SCALORA: Right. []

RON SORENSEN: But we could take a look a look at that and see what they've entered in the record (inaudible). Getting it out may be an issue, but we can see what they've got. []

MARIO SCALORA: Understood. And I don't know what with HHS you would have other than Avatar that might come close to that right now. []

RON SORENSEN: I don't think anything. Magellan or Avatar is probably going to be it. []

MARIO SCALORA: Right. []

RON SORENSEN: And you probably know Avatar better than I do, so... []

MARIO SCALORA: Again, thank you. []

JIM JENSEN: Topher? []

RON SORENSEN: Thank you. []

TOPHER HANSEN: Side question that wasn't part of this. I've heard discussion of a proposal to expand the regional center beds by 23. Can you tell us more about that and what that is and how it fits and... []

RON SORENSEN: Yeah, actually it was very briefly discussed a couple years ago. Really what's happening is we are in a state of construction, renovation, whatever the right term is and basically those beds have just come back online. They haven't been online for awhile. So it's not technically an expansion of such...and it's down the road. It's '08, I think, sometime later in '08, and if that means that typical construction (inaudible) probably '09. So that's what I can tell you about it. We've had to, for instance, (inaudible) 14 come in here with that (inaudible) office used to be. They took it in thirds and closed it in thirds and people on one side and people on the other side. This assumes that all that renovation will be done in '08 and all the beds that are there and facilities over there for awhile (inaudible) operational. []

TOPHER HANSEN: But does that grow us beyond 100? []

RON SORENSEN: Yes. Assuming they're used for behavioral health (inaudible) goes beyond that. []

TOPHER HANSEN: But isn't 100 that...that's what I'm confused about. Isn't 100 the target and that we're trying to keep our budget at 100? But this would push our budget 23 beds higher? []

RON SORENSEN: Yeah, I think the other...there's two issues with it, Topher. One is we still have 50 some people at Norfolk--52 or 53... []

TOPHER HANSEN: Behavioral health. []

RON SORENSEN: Yes, yes. And as we talked about that budget that using LB870, sex offender money, to pay for behavioral health people is not going to continue over long-term. You're up to 120 sex offenders, if not before, those people have to be paid for by some other source. So the 23 beds provides an opportunity in which to move people if we can get down to it, you know, some reasonable number and of course (inaudible). So I think that's at best an important thing to look at. I think it's also important to keep in mind that because Lincoln has a 123 or 100 beds, you know, five years from now I don't know what it will be. If recovery and peer program become operational, I mean, our vision would be that you had best come out of Lincoln at some point. And you know, I don't know what that magic number is. Hopefully you get to it by all the things that have to get done and if it goes to, you know, we only need 90 (inaudible) as far as I'm concerned. You know, (inaudible) some point go to where regions pay for services, acute services directly from the regional center to contract any (inaudible) may have another impact on it. So I don't think you can ever assume that because there are 100 beds and there will be 123 beds (inaudible) 123 beds (inaudible). []

TOPHER HANSEN: Well, I would bet on anything five years from now. (Laughter) []

RON SORENSEN: The last three years (inaudible). []

TOPHER HANSEN: But no, my concern is more that the plan...is there a plan that's not coming forward? Is there a budget that's wrapped around it? Do we have things in place that are costing us money now that...I just don't know the details about it, but if

somebody's contemplating it what else is wrapped around that and...because we're trying to save money and grow as demand requires and operate off our current information and I haven't seen anything that says and we project that we're going to need 123 beds as opposed to 100. A hundred is the mark. And so I heard 23 more and I thought well where did that come from? I haven't heard anything about what that's about. And so then I have to question what's in place now that we're paying for that we don't necessarily need to pay for that we could put into community-based systems, you know? So it raises a lot of questions that I'm curious about. []

RON SORENSEN: Why don't we take some time and we can get more information back to you and the regions (inaudible)? []

TOPHER HANSEN: Yeah and we don't need to wait for the next commission, but e-mailing it would be great. Thanks. []

JIM JENSEN: I'd like to follow up on what Topher is saying, you know, and certainly it's so hard to pull out from data what is there, but it sure appears to me that we have--and maybe this was something that we never anticipated in LB1083--but we have somewhere, I think between 30 and 40 individuals that probably will never be in community-based services on the streets in the community. Well, not in the community, but I think that we should really look at at least two--and I think two might be sufficient--long-term care secured facilities, community-based, Medicaid eligible. Perhaps one in Region 5, one in Region 6. And I think it would be less costly than in a regional center. Now part of this regional center study might point that out, but I really think that we need to look at that somewhat. Those are individuals that are long-term, multi-year, but to keep them in a institutional setting, I think there might be a better facility to do that in. []

TOPHER HANSEN: I agree wholeheartedly and I...what that all says to me though is data-driven planning and being strategic about the whole thing, and my concern was

hearing that we're doing 23 beds when 100 is kind of what I''ve had, and so then it raises questions for me about why are we thinking about 23 beds? What's the data that says that, you know? []

JIM JENSEN: Right. []

TOPHER HANSEN: I agree. Let's sit down and look at what our needs are and try and present, well, solutions for the needs, but then also try and be flexible in our system where we're positioned for the future. []

JIM JENSEN: And then, you know, I was at a Region 6 meeting on Wednesday and I think the figure, Patty, was 85 percent of the people now are being diverted from a regional center that we used to send there? And so I'm just thinking, what...and the same thing is happened in all the other regions too. This diversion. []

TOPHER HANSEN: Right. []

JIM JENSEN: Where would we be if we hadn't begun this process? Now, you know, I don't know how that shows up in data, but my goodness. We would have had to add another regional center it would appear to me. []

TOPHER HANSEN: Might be a good model for prisons. []

MARY ANGUS: If I could, what we're finding across the country is that when the recovery philosophy is really implemented, we don't have a need for as much facility-based. I won't say we'll never have a need for someone to be in a lockup, if you will, but I think we are vastly underestimating the ability of people to recover and to be able to be out on the streets and I think Senator Jensen and I have had that discussion. It's...when we have an expectation that folks will not be able to be out in the community, when we have a mentality that says they need this or they need that, our expectations

for what they can do in recovery are dropped. And until we come to the conclusion that those expectations are too low we're going to continue that soft bias of low expectations. []

RON SORENSEN: Well, let me tell you we have the same discussion all the time. I mean, when we started this three years ago we had 179 people with Norfolk. People with Norfolk never get out. []

MARY ANGUS: Exactly. Exactly. []

RON SORENSEN: And then there was 100 people in Norfolk that could never get out. You know, now it's down to 50 and we'll prove them wrong again. []

MARY ANGUS: We're moving in that direction. We're moving in that direction. I just, you know...we can't keep that in the forefront enough as far as I'm concerned. []

RON SORENSEN: I have personally never said there will be X beds in Lincoln. (Inaudible) []

MARY ANGUS: No and I appreciate what you just finished saying. []

RON SORENSEN: Because I, you know, I think I share the same thoughts you do that I don't know that there's a right number until you have a community system that works well and works appropriately and, you know...so then you begin to tell what the number is if there is one at all. I think what we looked at the future is--and this is just me rambling here--but special populations will create some, you know, people with special needs that...for instance, people with traumatic brain injuries. How are we going to treat them? I mean, some of them may be so serious it will cost twice as much to serve in the community as it does in the regional center. []

MARY ANGUS: I would say that that's not accurate. []

RON SORENSEN: I don't know. I'm just saying that we don't know all the variables in this down the road as to what we're going to do with the people that come into the system or (inaudible). But I don't think we ever make an assumption there will be so many people in regional center (inaudible). []

MARY ANGUS: But I would just venture to say that other states are finding that if you take the average of what it costs to keep someone in an institution versus what it costs for someone with high needs, then you're going to find it costs more for them to be in the community. If you take what it costs for that person with a high need to be in an institution versus what it costs them to be in the community with the supports they need you're going to find a major cost and human savings. I think what oftentimes we look at is it costs an average of $125,000 to have somebody in regional center and maybe one of those, if you looked at the cost per person outside of what it costs no matter who's in there or how many people are in there, it's going to cost X number of dollars to keep that building open. If we take the cost of any one of those people...and say for me to be in there it would cost $100,000. For somebody else to be in there it would cost $180,000. If we take $125,000 and say it's going to cost $100,000 for that person to be in the community then we're really not--I guess the numbers I'm using are not right--it's going to look like it costs more for that person to be in the community. If I look at the amount of money it costs for that person to be in an institution...I have a dear friend who it would cost about $350,000 a year for him to be in a nursing home or in any institution because of his high physical needs. It costs approximately $125,000 with supports for him to live in the community. Now if you look at the average cost for somebody to be in an institution it may be $100,000. And so if I look at the $100,000 and I look at it's going to cost him $150,000 to be in the community, it looks like we're going to lose money by putting him in the community. It's not true. We need to look at the cost for that person. We're saving over half by having him in the community. He is an extremely productive man. I think we are missing the boat when we look at averages compared to that

individual. I mean, I have repeatedly heard that it costs more for a high needs person to be in the community versus an institutional setting and we're not looking at an average when we're talking about what it costs for him to be in the community. []

JIM JENSEN: Anything else, Ron? []

RON SORENSEN: No. Just how do you turn this thing off? []

JIM JENSEN: Any new business? Yes, J. Rock? []

J. ROCK JOHNSON: Yes, I'm wanting you to know that I am a person covered by the Americans with Disabilities Act and the state of Nebraska is subject to the Americans with Disabilities Act and I'm requesting reasonable accommodation under that Act. That means... []

DAN WILSON: Shorter meetings or...(laughter) []

J. ROCK JOHNSON: Well, I understand that the burden is not upon me to bring forward the solution, but that's a part of negotiations to discuss what those needs are and how they might be best met and how some of how meeting my needs may also meet other's needs. It's just when we had the curb cuts and the inclines we found it wasn't just people with wheelchairs. It was families. It was people with strollers. So a reasonable accommodation for me is quite likely to be helpful for all of us. It's just that at this point, after having said repeatedly and made suggestions of ways that our process and our materials could be approved, it has not happened. So I am officially... []

TOPHER HANSEN: What's the issue? []

J. ROCK JOHNSON: One issue... []

TOPHER HANSEN: Reasonably accommodate...no, no, no...reasonably accommodate what issue? I'm missing the underlying... []

J. ROCK JOHNSON: Well, the underlying is my ability to participate effectively in this meeting. More specifically would be receiving materials on the day of the meeting at the time of the meeting. That's one and that's probably the most significant one. []

TOPHER HANSEN: Okay. []

J. ROCK JOHNSON: And I don't have an attorney yet, but you know, if it's necessary I"ll see if I can't find one. Nobody laughed. I must be losing my touch. (Laughter) We took that otherwise. []

TOPHER HANSEN: I'm a lawyer. An attorney is a lawyer with a client. (Laughter) []

JIM JENSEN: Anything else? Probably comment? []

RACHEL PINKERTON: I'll be brief. I'm Rachel Pinkerton. I've spoken to you before. With Mother's Day here I'll put my mom hat on and say thank you very much to all of you collectively and probably well over half of you individually have given me support over this process. Well, my son, I'm happy to say, whose had extensive experience with the system is on the recovery track and he wants you to know he does appreciate living in an era and a place where recovery is the expectation. And he is taking some classes at Metro and recently one of his classes is Public Speaking and he gave a presentation on the correlation between illegal drug use and the onset of mental illness and is very passionate on that subject and I'd like to see him engage with us here, but he has his own journey. Anyway, thanks everybody. []

_____: Thank you. []

JIM JENSEN: Any other public comments? []

C.J. JOHNSON: Hi. C.J. Johnson, Region 5. I'm glad Sandy was here earlier today. I'm going to ask this commission...I'm going to throw some numbers at you real quick and I just, you know, want you to think about them, but...and I'm sure Sandy would be willing to come back and talk about them again. I'm going to throw three pots of numbers at you when behavioral health reform first started. The first one was the 26.8 million that was sitting at Hastings Regional Center, Norfolk Regional Center, okay? That was...what did I say? []

_____: 28.6. []

C.J. JOHNSON: Oh, I'm sorry. Let me start over. It was $28.5 million, okay, that was sitting at Hastings Regional Center and Norfolk Regional Center that were to come into community-based services when those closed down. There was another pot of general fund money going to Hastings Regional Center for outpatient services and a small pot of money going to outpatient services at Norfolk Regional Center. That was about $1.1 million. And there was also about $1 million--it was actually $1,039,000--going to the Hastings Regional Center out of general fund for the assertive community treatment team, okay? So we got three pots of money. I'm going to start backwards now. I would ask that this commission ask the question where's the money for the assertive community treatment team? Coming from general fund, because one of my concerns is--and I would want this addressed--is when that program gets moved out in the community, is that money for that having to be absorbed from the original $25.8 million? In other words, where did that million go if that's true? The next question I would ask is where's the $1.1 million for outpatient services coming out of both Norfolk and Hastings? If that's having to be absorbed in that $25.8 million where did that $1.1 million go? Okay? I really think that question needs to be asked. Has some of that money been diluted by almost $2.1 million in programs that are being moved into the community not having that money that was from general fund on a separate line item follow them into

the community. Okay? That's that one. Then the other piece that I would ask you to consider is number one, Sandy talked about approximately $4 million that still needs to be transferred. That's wonderful because right now--and Ron didn't say this earlier, I don't think, I might have stepped out--but that $21 million to $22 million that is already out there, everybody has to understand, is already committed to services. Okay? It's not just more money. So we already have that money committed, but my understanding is that $4 million that hasn't come out yet is not committed to services yet. Is that correct? []

RON SORENSEN: No, we're still identifying how much money that's going to (inaudible). []

C.J. JOHNSON: I know, but she said about four to six million. []

RON SORENSEN: Okay. []

C.J. JOHNSON: So...and the thing that concerns me, number one, is if that money is not out in the community and you saw 25 percent of people coming out of the regional center are Medicaid eligible, by not having that $4 million in the community doing services for Medicaid eligible people, we're missing about an additional $1.5 million in federal Medicaid match. So the longer it sits wherever it's sitting and not out in the community we're losing a lot of federal dollars that could be going for services. Now Topher brought up this 23 bed thing. A couple of weeks ago I was sitting in a meeting and heard Bill Gibson say that next year, at this time, there will be 23 additional beds at the Lincoln Regional Center. Now I'm going to be honest with you. I've gone to a lot of meetings with behavioral health reform over the last number of years and I have never heard the figure 123 beds at the Lincoln Regional Center. In fact, I think if you look at the original Governor's report there was going to be approximately 56 total state hospital beds. Okay? So you know, we could probably go back and look up numbers, but never was there a hundred beds and let alone 123 beds. And it's my understanding...oh, let

me go back. I have concerns...if you figure up what 23 beds costs that's about $4 million. I would ask this commission to get an assurance that the $4 million that Sandy talked about this morning is not the money being used to bring up those 23 beds. Okay? I would ask the commission to get an assurance of that. And then the second question, from the commission's standpoint, is I would ask the question if that money isn't being used for that then I would ask this commission to ask the following question is do we really need 23 additional beds at Lincoln Regional Center? And right now I would contest if you look at capacity needs at the Lincoln Regional Center you don't need 23 additional beds. So if that's the case then I would ask the next question. Gee, if there's already money to bring up 23 additional beds at the Lincoln Regional Center, but apparently we don't need them, why don't we take that extra money, so now we got maybe $4 million more that was never anticipated with behavioral health reform that could be taken from a state hospital and moved out into the community even more? And that again, as you look at the percentage, more match, another 1.5. So you're now you're talking about another $5.5 million. I would really ask this commission to ask those questions, because I don't know where a decision was made to have 23 more hospital beds at the Lincoln Regional Center. I don't know where that decision was made. I don't know why it was made. And I understand the concern there's people up in Norfolk, but you heard Sandy say there's money funded for 120 beds at Norfolk for the next biennium. There's 20 open beds there right now, so we can absorb 20 more sex offenders and I would encourage all the regions to continue to try and bring people out into the community. But again, we have $4 million sitting in the state that maybe we could be using for that. Maybe there's even an additional $4 million sitting there to bring up 23 beds that maybe we should dump that in the community. That's $8 million more. I'm just throwing numbers out, but I would really ask those commission to ask those questions as to where some of those decisions came from and why that money is sitting where it is and not where it should be. So with that, I don't know if any questions, but... []

DAN WILSON: C.J., I just appreciate your comments. I don't have a question, but just an observation that beyond asking questions I think it is the job of the commission to

advise the Legislature how mental health reform is perceiving. And you've, I think identified an area where there are opportunities for it to proceed more vigorously toward an extended community care system, including, I think, some changes that need to occur in Region 5 and this may be a sore spot. You're encouraging us to do our job. []

JIM JENSEN: Yes, C.J., I appreciate that an di think that's...you know, we don't go back and look at what we started from and what we were trying to achieve, and so I think what you're saying is absolutely right on and... []

C.J. JOHNSON: Well, I would just encourage you to look at the dollars. We're at crunch time and what I'm real concerned about...and this is why I came forward today. I wasn't planning on it. I always not plan on coming (laughter), but when I heard 23 additional beds and I have never heard that comment in any planning meeting, anything I've participated in. And the numbers starting rolling through my brain and I already know what the capacity is in the regional center. I've stood before this commission for two years talking about bed allocation and capacity and stuff like that. Nobody has convinced me right now that two years from now or even a year from now we need 23 additional beds at the Lincoln Regional Center. And I'm also concerned that maybe that $4 million that hasn't been thrown in is somehow going to kind of...as the horse is running out of the barn for 23 beds that money will follow that and we will never see that $4 million in the community. []

MARIO SCALORA: It may be worth...I appreciate C.J.'s question (inaudible). []

C.J. JOHNSON: Well, I don't know. I just... []

RON SORENSEN: Yeah, the questions I remember. (Inaudible) I only have (inaudible) memory (inaudible), but the act program money in Hastings is still there, okay? It's separate and it needs to be part of whatever is left there. That's what they're trying to figure out, exactly how much money is there. Whatever is left will not be used for the 23

beds at Lincoln. I can promise you that much. We're still trying to sort through what we have (inaudible), what's there. So...and yet we'll move out and Hastings' money will go with it. []

C.J. JOHNSON: Well, I understand that, but Ron, what I've heard is that it was $1,039,000 that's going out in the community. There is an assumption that a certain percentage of those will be Medicaid, therefore they will be matched already to pay for that. And so there will be a certain percent of general funds that won't follow that up. []

RON SORENSEN: And that's what we're trying to sort through, because in 2004 it was all behavioral health dollars, a million dollars in program 38. We got it Medicaid eligible and switched to $400,000 for program 38. So yes, that's what we're trying to sort out. Where did the $600,000 go and where should it be now? So that's the problem with saying how much will be out at Hastings next year. The problem with taking...when we did the lay-ups, part of the planning and the timing of lay-ups involved discussions of how far expenses would run in the future, and you know that unemployment insurance, you've got the cost of closing the facility, all that stuff. So our plan was that by the end of June all those expenses would be (inaudible) all the money at Hastings ready to move out. So I hope that answers some of that. When the Legislature moved the money out of Norfolk they moved everything out, including the money for (inaudible). So yeah, that's all included in that total (inaudible). We had held back $7 million this year ready to move and then they moved it. (Inaudible) []

C.J. JOHNSON: Again, well I was just asking the commission to ask... []

RON SORENSEN: I can't help you on the 23 beds much... []

C.J. JOHNSON: I know. []

RON SORENSEN: ...because you know I think we discussed that internally but it's been

like months or years ago and that was something that Bill just started talking about man, we just need to follow up. Find out what's going on here? []

C.J. JOHNSON: All I'm asking is... []

MARIO SCALORA: It comes off as new beds. The reality was we had beds come offline because they literally had to stop using certain beds to renovate buildings for code and related issues. It is an important question to ask do we still need those beds, but remember some of the folks who raise those issues also raised heck about the waiting lists and we need to sort out how to balance those issues. Bill is in a very awkward position and I'm not always in a position to defend Bill, but he's not here. He's getting pushed both ways. He was not told to cut 23 beds. He was told to renovate those beds and do it in a way that threw fewest people out of the regional center while they were renovating them so that care could be provided while cuts were being made elsewhere. He did that in a way that resulted at one level in a spike of the waiting list for a period of time. That's come down a bit. Now those beds will be renovated. And by the way, his budget didn't necessarily go down. Those staff were moved other places. They didn't hire as much while that construction was going on. There is not necessarily new money going to need to be drained from elsewhere to cover that. Now the bigger question I hear raised and a still very valid one, do we need those beds? And I think that has to be raised also in light of the waiting list and what else is out there. But I want to frame that a little differently because I think it's a very different issue than necessarily Bill building an empire, which is a way that could be framed, and all of a sudden we'll all be up 23 beds and we've got to find a check to cover them. We could raise the question well hell, we've done without them for so long, can we do without them even longer? And then that's a decision that has to be made. I do think we have to raise very carefully what we want Lincoln Regional Center to be and that's came up the last meeting between your region's needs or acute care and the long-term care issues and how much quote long-term care is needed. And I think if we're going to raise these issues I think we need to give Bill a consistent message to be frank about it, because he is doing what he was

told to do and did it in a way that tried to have the least impact on the system while people were juggling moving folks around. So let's keep that big picture in...I'm speaking to you. []

C.J. JOHNSON: Yeah. Well again, I just simply ask the commission to ask where the money is and do we need 23 additional beds at this point? And if not... []

MARIO SCALORA: You don't need those 23 beds for your region anymore? []

C.J. JOHNSON: I needed 40. I got 38 and that's all we need. []

MARIO SCALORA: So you've got your beds. Does anybody else need beds? Going once, going twice...(laughter) []

C.J. JOHNSON: Patty, would you want that money in your community or not? Thank you. Even Region 6 would want it in the community versus in the 23 additional beds, so... []

MARY ANGUS: Right. []

DAN WILSON: Well, and Region 5 needs to go the whole distance in the fullness of time on that same score. []

RON SORENSEN: Well, I don't know that we ever talked about 23 beds publicly, but it was in the discussion process early on (inaudible) beds and renovate them. And not it's come up because it's getting closer to the time frame and we're (inaudible). []

C.J. JOHNSON: I just asked you...okay. []

MARIO SCALORA: I don't know if there's other renovations coming in the pipeline

where are we done renovating out in Lincoln? []

_____: Well, you never know. (Inaudible). []

C.J. JOHNSON: For the hundred beds we are, Mario. I will say that. For a hundred beds we're done renovating. []

JIM JENSEN: Scot Adams, you had just a few words. []

SCOT ADAMS: Yeah, thank you. If I am the last one between you and the exit, I apologize for taking that time. It's been a fascinating meeting for me and I promise to be brief. I wanted to say a couple things though. One is I really appreciated this meeting. It's sort of my first official Oversight Commission meeting. I look forward to July when I'll focus my attention on the behavioral health. Couple things that I might encourage the--as C.J. did--encourage the commission to consider. In other words, in the vein of what can the commission do to be supportive to LB1083's implementation and behavioral health reform overall? Here are some thoughts for you to consider, maybe future agenda items. I think you ought to argue the parody bill, but I can't do that kind of thing out loud, but I think you ought to take that up and consider that issue. By the way, if I'm not here for the next Oversight Commission meeting (laughter) you at least will know why. Secondly, I would hope that you would cheerlead success. I don't know if there has been media here today, but we've talked about a couple of notable successes. Adult services at Hastings are closed. Like it or not, that was one of the goals of LB1083. That didn't get as much cheering as I thought we should and that ought to be in the media and you ought, in my opinion, to cheer that. Thirdly, I think part of the goal we started to talk about at the end is what are we going to do about these crazy special populations that are coming up--sex offenders, traumatic brain injury, that kind of stuff. And perhaps the study session will take some of that on, but that's getting another layer of the onion more deeply into this whole process. And so those would be some suggestions I might have and I realize that that's a fairly presumptuous thing for a

guy just coming into his first meeting to suggest perhaps a future agenda for you all. Finally, I guess I would just like to say that I hope that during the course of the next few years--in fact, the next six years--that Nebraska can become a top five state in behavioral health by completing its work with behavioral health reform through LB1083 and by developing the other elements of a comprehensive behavioral health system. I think we're at an extraordinary moment. We have a Unicameral through Health and Human Services Committee out loud still very supportive. During my confirmation hearing they said their top priority was to complete LB1083 implementation. Holy cow. We've got an executive branch still very interested in this and a judicial branch--for different reasons community corrections being the major reason--very interested in this topic moving forward. Talk to me about another issue where you've got all three sides on the same side. Holy "moly". Secondly, we're starting to see private money come into this system in significant ways. That's a big deal. Not only in Omaha with Lasting Hope Recovery Center, but in conversations in other regions--at least two other regions that I've been around--in this state. That's a big deal. Thirdly, we have universities sort of talking with each other. (Laughter) Sort of talking. I wish they would like talk more and better, but at least they're talking on the same side around training issues and other kind of things. I think that's not insignificant. Legislatively...I know, we can talk more later. I'm going to keep pushing. []

MARY ANGUS: Dan, you're turning red. []

SCOT ADAMS: I wouldn't necessarily blame Dan either. You got another counterpart, but they're talking. That's a good thing. We have LB1083, LB40, and LB296 is very important legislative kinds of activities that have positioned Nebraska very well. We haven't talked about LB40 and housing stuff much. That's a huge deal and a tremendous success that I think sets us apart from other states in the community in many, many ways. Recently, the feds came in to do our substance abuse block grant review and they were amazed at how well our language has come to the issue of integration of mental health and substance abuse to the point of causing some

confusion in accountability for the substance abuse block grant, because there's a mental health block grant and so sometimes we're so integrated on that conversation that the data sort of gets mixed up, because...that's a great problem to have in my opinion that we have come so far that the two are integrated. What a success. I think that's a great strength moving forward. So I think...and finally, the involvement of consumers at this level and at the regional level and in other ways, I think is another extraordinary moment. So I think we've got tremendous strengths on our side and I want to congratulate you. I want to thank you for your role and input to this whole system. I look forward to working with you. It's going to be a hell of a six years. It's going to fun. So thank you for your time. []

JIM JENSEN: Thank you. Anything else? []

MARIO SCALORA: Move to adjourn? []

JIM JENSEN: We're adjourned. []