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SENATOR JENSEN: (Exhibits 1 and 2) Ladies and gentlemen, we do have a quorum present, and so if the participants would take their seats, we'll begin. It's been quite awhile since we have been together, so it's so good to see faces again. And we do have a lot on our agenda today, and so I'm going to ask that really, if there are questions that you write those down, and there are 3x5 cards in front of you, and then at the end we'll address those. But like I said, we do have a very, very full agenda before us, and it's been awhile since we've also been together, and so I think there will be some comments that will be made along the way. So with that, you do have the agenda before you. Are there any additions that need to be made to that, that anyone sees at this time? Okay, the agenda will stand approved as presented. And the approval of the minutes from last May 11--any additions, corrections? They also will stand approved as presented. And so we're ready for Item 4, the report of the Division of Behavioral Health, Department of Health and Human Services. Ron, are you going to start off, or... []

RON SORENSEN: Yes.

SENATOR JENSEN: Very good.

RON SORENSEN: We actually have our clicker today. I'm a little...I didn't quite understand why you put Chief Mizner right next to the table where we're sitting. Was there a purpose in that?

BILL MIZNER: Keep it calm. (Laughter)

RON SORENSEN: I guess we'll have to watch ourselves today.

_____: Since you (inaudible).

RON SORENSEN: (Exhibit 3) Yeah, that's amazing, isn't it? I've progressed. I've been trained in clickers. That's for out here; these are for the Policy Cabinet. Okay, I think you saw most of this already. We sent it out. It does take us awhile to rethink things and pull things back together where we think we need to improve on it, so it's a little bit different. Hopefully,...has everybody got a copy of it yet? The table of contents is pretty much the same. We cover where we are on services, some of the data, management system, finances, and some of our accomplishments and challenges as we move along here, and talk a little bit about recovery. Okay, everybody got it? Okay. So in services we'll talk about these...we do have 56 slides, which I think is a record. We didn't get paid any more, but we had 56, and so I'm going to really kind of fly through these, because...since you've seen them. And if we could wait until the end to get questions, I'd appreciate it, since I think most of you are familiar with the stuff. I think this one is a key one. We talked before about how many more people are served now, and if you look at that you'll see there's a substantial growth. And I'll do a little math for you here real quick. What you'll see is we are serving 9,791 more people than we did in fiscal year '04. That's a 29.6 percent increase. In mental health we're actually serving more than 12,000 more people. And understand, the first number up there, the 33,000 to the 42,000 is unduplicated; the other counts are duplicated, and that's why you can't really add things together to get to those numbers. And in substance abuse you see that we've actually increased almost 6,700 more people served, and people who are served in both services, mental health and substance abuse, have actually gone up 7,800 people. That's a 295 percent increase in three years--substantially more people served now than were served before with the money we've got. These are the individual services. I'm not going to go through these individually. (Inaudible) to say the total is 45 percent increase in most services. We still have an upward trend. In those that are more capacity based, in the sense there's actually beds where people are; for instance, psych res rehab, they're pretty much topped out in terms of where...the number of people that are going to be served each month. The variances you'll see will be a matter of recordkeeping--admissions, discharges that occur during the month will change that, just depending on the timing involved. Okay, before I get to that one, any questions

about that? Okay, we'll move along then. The next section...we need to think about the next poet laureate of the state of Nebraska, and one of his comments that I think needs to be kept in mind as we look at the next section of statistics--Larry, the Cable Guy said 42.7 percent of all statistics are made up on the spot. (Laughter) In honor of Carole Boye, I put that in front of the next few slides, because I know she really enjoys these. But these are about the wait lists. And we have talked about in the past the issues with collecting wait list data--inconsistent collection, duplication of people across the wait list, people actually being on a wait list but actually being in some other service. But it might provide a little bit of information, nothing that we want to go out and change a bunch of stuff about, but it tells us something. You see an increase in nonresidential services totals for substance abuse wait lists. These are...I'm really...these are kind of hard to read, particularly in your handouts. But again, you see somewhat of a downward trend in the residential waiting lists for mental health, and then increase in nonresidential, consistent with last time. We can't say they're necessarily accurate, but we can say they are consistent, okay? All right? That's about all we can say.

CAROLE BOYE: Garbage to garbage comparisons (inaudible) validity. Yeah.

RON SORENSEN: Yeah, there you go.

CAROLE BOYE: No problem.

RON SORENSEN: Consistent in validity. Although I guess that does (inaudible) reliability maybe, just not validity. Conclusions, real quickly: Wait list data is collected in order to meed Federal Block Grant requirements. We have to do it--we thought we'd report it. Inconsistent reporting by providers--some providers take it seriously, some don't. They're not rewarded either way, or disciplined in any way, I guess, so it doesn't make a whole lot of difference with some providers. And again, we said we don't have any way to check across wait lists. They are duplicated, and the one thing that can come out of this is it appears that nonresidential service appears to be increasing in

mental health. That's about it. Okay. We also wanted to talk about, again, protective custody. We're not calling it emergency protective custody, because we're going to talk about both emergency protective custody and civil protective custody real quickly. This is a bar chart for those of you who like charts, and you can see, if you look at the last number in each region, you'll see a significant decline in numbers, except for Region I, which has gone up slightly, and we're taking a look at why that's happening. This shows the EPC admissions per thousand--pretty consistent with what we've had in the past. These are the numbers. I think the most valuable on this slide, on Slide 22, is probably the percentage. If you look at that you'll see some significant changes in some regions. Again, Region I is an issue that, well, we are looking into with Sharon, who is the CPA up there. Civil protective custody: We actually have only two places that report civil protective custody information, and we only provide it because we have it. And what we want to do is track this over time. It's one-year data, so I'm hesitant to draw any trends from this at this point in time. What we...one of the reasons we brought it up is because when we were in Region VI and talking to law enforcement there, there were a number of issues about people being taken to EPCs when they probably should have been civil protective custody, just because of access to beds. And so we're going to start reporting this and try to look at that whole situation. That will be one of the things Region VI looks at closely when they start redesigning their system and Lasting Hope Recovery Center comes up, and so on. Okay, just some real brief conclusions about that data. I think we talked about most of those--emergency protective custody. Go down...that's a number we have to be careful with, though. I'm not sure what the right number is, and I'm not sure going down is always the right thing. What you want to make sure of is that people are appropriately EPC'd. And that's what we need to continue to work with law enforcement on, is find alternatives for people who don't need to be EPC'd, so that they don't have to do that, and at the same time help with EPC process to improve that as we go forward. So I don't know what the right number. I do know it's declining, but at some point it has to level off or become somewhat constant, until we bring in other services that might also help improve those numbers. Commitments to Regional Centers: That is just the mental health reform units at the regional center, and that is the

two units at Norfolk and the units at Lincoln. And these are pretty consistent--what you've seen in the past. You see the commitment rates per thousand people. That's the number of commitments there, for each region. You see it dropped over time, as you would expect, and here again shows the decline or the percentage of the previous year, and I think it's really important to look back to 2002 and see how the system has changed over time. In 2002 we began to see some impact of LB692 and the funding provided through the Nebraska Health Care Cash Fund, or as some people know it, the Tobacco Fund. That began the changes, and now with LB1083, we continue to see this number drop. Wait List Data: We've got to find a way to make this chart work a little better. It's so up and down and fragmented that we'll work on making this look better by showing, maybe, periods of time. I think the important thing here is, we had a great variance, for those of you who like control charts and those sorts of things, if you look at the first couple years, up through April of this year, you'll see an enormous variance from different time frames, going up as high as 41, being down as low as 5 or 6. In April we instituted the allocation plan. What we've seen since then is a lower average and a lower variance. Now the numbers are climbing up again for a couple of facts, because of a couple of reasons. One is we've got a higher number of patients at Lincoln Regional Center that are occupying an entire room, and what that means is we typically have two people in a room. But because of issues of, oh, violence or whatever it may be, we've had to take ten people and have them in their own rooms, which means we've reduced our capacity by ten people. So we have had a little bit of growth in that wait list here in the last couple weeks. Regional center census: I think this is pretty consistent with what you've seen in the past. This is a new chart that's in here this time, and this would just give a summary of where we are with beds. If you look at the time frame from 2004 to now, you'll see that we have actually closed 112 beds at Hastings. If you look back to October of 2003, you'll see that actually that number would be even bigger. But for the purposes of tracking reform, we used the early part of 2004, not 2003; 112 beds reduced at Hastings; Norfolk, we have reduced 120 beds; we still have 60 beds there that are behavioral health reform, and if you'll look at the bottom row you'll see that there are 60 beds there for sex offenders. I think as of yesterday there were 46 sex

offenders there and about the same number of mental health patients there, so 46 and 46--92 people total. Lincoln Regional Center, we had 83 beds in 2004. As part of trying to help with the EPC situation, access to...improving access to hospitals for law enforcement when they needed to EPC a person, we have added 17 beds there over the last year to help with that. And as I said before, unfortunately there are ten people there that are taking a whole room. So the capacity (inaudible) says 100; actually, right now it's about 90. Okay, this is an important slide, because it's a cost that is showing up in the program that funds community-based services. Our reference is Program 38, if you look at our budget. That's what we pay the regions out of for services. So when we contract with the region to provide community support or psych res rehab, it's in Program 38. Another source or expense from Program 38 is what is shown as LB95, and I think most of you are familiar with that. That is a program where we pay for the drugs, prescriptions related to mental health, for people who are indigent, can't afford the drugs, basically, and who need these medications and who have been committed by a Mental Health Board to either in-patient or out-patient services. That make sense to everybody? Okay. The issue for us is this cost keeps going up, so over the last four years it's gone up an average of 12 percent a year. Last year it went up 9 percent. So assuming appropriations stay level and there's not an appropriation for that amount, what it will begin to do over time is begin to impact what's available in the community. So here you see it in a table form. It shows the growth to 2007, and I don't know how clear I was in making up this chart, but you can see the change in those three years and the percentage each year in the fourth column to the right. And we have used last year's growth to predict what this year's cost will be, so it will be $193,000 more this year. Yes, Carole?

CAROLE BOYE: And the fact that it's coming out of community behavioral health, not the regional centers, the function is prescriptions goes to the pharmacy at the regional centers, correct? And the medications are mailed back.

RON SORENSEN: Um-hum. Yes.

CAROLE BOYE: Is that a--what pot this comes out of--is that a function of the appropriations process, or is that an internal decision as to where you assign that cost to be charged back? How does that (inaudible)?

RON SORENSEN: Well, originally it came out of regional center funds, which is a separate program from Program 38.

CAROLE BOYE: Right. Right.

RON SORENSEN: A few years ago it was changed. I'm not sure who made the change. It was moved to Program 38. In actuality, although we manage Program 38, we have no control over this...LB95, because it's a function of the doctor prescribing medication. The regional center then fills it. There's a determination made in our financial responsibility unit that the person is indigent and can't pay for that, and so they then will pay...excuse me. They do send out bills, and they do have to authorize that a person is indigent and so on. But the cost comes directly back to us, so when the cost comes in for the drugs, it's separated out from the regional center budget and put in Program 38.

CAROLE BOYE: But I guess the purpose of my question is if this is a legislative thing, it would be nice to know how, from the Legislature's perspective, how these dollars are appropriated and if the senators are even aware that it's included in here or not in here, or should this be separately funded with some kind of cap put on it. I just think we need some clarity at some point, to be able to pretend to talk intelligently to people like Senator Johnson, for instance, of how do you clean this up (inaudible).

RON SORENSEN: Yeah, and I think quite frankly the senators...I don't know that they would even know, because we have not, as a part of our appropriation process in the past, identified this as a cost that is increasing.

CAROLE BOYE: Identified it. It is absolutely critical for the people that we serve. There's no question about it. It's a lifeline, but...

RON SORENSEN: Right. And we do have a study internally now going on to look at the...LB95 and how we might look at how that's written and how it might be used, and so on.

SENATOR JOHNSON: Just one thing for clarification: Do we actually have an increase in the cost, or is it an increase of usage?

RON SORENSEN: Well, let me get to the next slide. We were unable to obtain, without a lot of data research going on over time, but we took two points in time--this is our financial responsibility unit that does this--and so what they did was, they took December of '06 and they said, how many people? And that's the fourth...well, the row that says "total," so in December of 2006, 305 individuals requested medication through LB95. And then in the next column to the right, in June of '07, 329 did. So there's a small growth there, or you can expect a growth, because we're having more people committed for in-patient/out-patient services. The number that's called the "other eligible consumers" is an estimation, because there are actually about 355 in the program, but during December, they estimated about 50 people didn't seek to have their prescription refilled. So they're estimating about 355 people in the program in December, and 379 in June.

SCOT ADAMS: And at the risk of delaying the presentation and upsetting the flow, I just want to take another moment or two, if I could, on this. There are a number of sort of different dynamics associated with LB95. Carole, you've been good to identify that. The distribution method through the regional centers are (inaudible) to come through pharmacies, for instance. Is there a means by which that makes better sense? And so we have, as Ron mentioned, sort of formed a small internal task force and are in communication with the Governor and the Policy Research Office on possible legislation

to amend this bill. So it's an area that needs attention, if for no other reason because of growth (inaudible), and especially the impact on budget that is sort of hidden in a way that catches us a little bit. And so...but I want to be real clear. At some point this is going to be a healthcare issue, that is to say, does everybody get it? What kind of rationing goes on, and what are the limits of the program? And so there are a lot of dynamics, and this is probably an issue that will get hairy down the road.

TOPHER HANSEN: If I might, well, I think we're probably already there. I think it's probably one of, if not the most critical piece of, a whole bunch of welfare of individuals, and we've seen in Medicaid budget reports that it's sky high. It's like the number one cost by exponential amounts and that we see here. The other question I have is the...sort of the...and I don't know if the proposed legislation would go to the issue, but the idea of LB1083 was to transfer what's going on and take that money and move it into the community. But what I just heard was the dollars for medication came from the regional center and didn't get transferred in. They just got reassigned to where it's coming from.

RON SORENSEN: No. Well, let me correct that. The movement of LB95 from regional centers to Program 38 was not a part of LB1083. It predated LB1083, but I'm not sure how many years. But it was a separate decision,...

TOPHER HANSEN: Okay.

RON SORENSEN: ...made at a previous point in time. It was not a function of LB1083 or a function of the transfer of regional center funds. It was, I think, a decision made because LB95 funds are in the community and not, you know, at the regional center. So therefore they ought to be a part of the community system rather than the regional center system. But it wasn't...there...it had nothing to do with transfer of regional center funds or LB1083.

TOPHER HANSEN: But in flavor, what it did was it reduced the regional center budget and increased the burden on the community budget, and that's what we've been trying to do, is take the resources that we're already spending and move them into the community, and we didn't do that on this, on what is a major item within the behavioral health system--medications. And so I guess in the legislation one of the issues, I say, is have we not followed the tenor or what we've been trying to set, of moving from someplace we're already spending money and moving it into the community, rather than just adding to the burden of the community system?

RON SORENSEN: Well, yeah. I think really it's been a function of...about $2 million was moved into the program. It really hadn't been an issue until it grew to this point, and that's...and it hadn't been an appropriations issue identified by the agency up to this point. And we're saying now, with all the regional center money being moved out here eventually, and so on, now we have to pay attention to it. One way or the other, it's going to impact our system. It's to the point of expense now that it has a big impact if it continues to grow. It wasn't before; we had unspent money before. If you recall we've never spent all our appropriations in the past three years, because it took some time to bring services up, to build the capacity to where we are now. We're to the point now where we're probably going to spend all of our appropriations, and so now it becomes an issue. Okay.

LINDA JENSEN: Ron?

RON SORENSEN: Yeah.

LINDA JENSEN: How long does it take when, like the consumer has to get their medication filled, how long does it take for the regional center to get that (inaudible) to wherever they live? Are they mailed to them, or how to they get them?

RON SORENSEN: Yes. We've had a couple of issues here a month or so ago,

with...what happened was, Hastings Regional Center lost their pharmacist, and so we had to change some processes there. And there was a little lag time in getting it worked out, because we had to split the populations--who was going to be served by the Norfolk pharmacy, who was going to be served by the Lincoln pharmacy, and that took a little ironing out. I think it's, from all reports I know of, and (inaudible), it's pretty well fixed. So I think it gets there pretty quickly, within a day or two.

LINDA JENSEN: Within a day or two? From the time they...(inaudible)?

RON SORENSEN: Yeah. We were having some problems getting it there. We are going to continue to look at other alternatives for that. I mean, there may be a better way to do that. You know, do you contract with a local pharmacy, for instance? Well, the issue then becomes, okay, you're talking about this...

_____: How much more expensive is it?

RON SORENSEN: ...much money, and we save a lot of money because of a, I guess it's called a consortium of some kind, that us and other states go into to save money on drugs. So if we actually look at other contracting methods, we've got to make sure we're not, you know, getting ourselves into a pickle, so to speak.

TOPHER HANSEN: The other piece, too, that's important to understand is, this is just behavioral health that we're looking at. We've seen the Medicaid dollars that are off the charts, but also within all the counties, I would imagine. I know Lancaster County information, but within Lancaster County the General Assistance dollars going to medications has skyrocketed and is off the charts, as well. And the other thing that providers are using is patient assistance programs, and in Lancaster County, the Lancaster County Medical Society is invaluable assistance to us in helping to get consumers medications they need that they can't afford, and so on and so forth. So this is just one piece of the medication pie, but on all fronts it's going through the roof.

RON SORENSEN: Yeah, it's an issue, with other issues we've got to face. Okay, I'm going to move through...we've talked about them. The next few slides relate to Medicaid. They are pretty much the same as what we've had in the past, and I know we wanted to move this presentation along, so that's pretty much what you've seen in the past few months, or past years in terms of growth in Medicaid, in both mental health and substance abuse. Slide 37, wanted to present for you where we are financially right now, in terms of money going to the regions to contract with providers, and this reflects the contracts in 2004 in the first column there, the contracts we have today for this fiscal year. Shows the increase over time and then the percentage of increase on the right-hand side. One thing to keep in mind about Region V, as you look at that calculation, that it's a low percentage, but remember, in that region we did not provide funding for acute/subacute beds. That's being provided for by the regional center, Lincoln Regional Center, so in fact there's...you could argue that that's part of the cost to Region V. You'll see the Lasting Hope Recovery Center there, at $2.5 million. That will eventually roll into the Region VI budget. What is now funding Telecare in Region VI will not fund Telecare, and the Lasting Hope Recovery Center will replace that funding. But they're going to come up in, we believe now, in April, and so we have estimated an expense--it's actually going to be less than $2.5 million now, at that date. So that's in there for a short period only. Our Homes is a Region V facility that had some financial issues, and they were actually providing services that weren't being paid for at that point in time. And in the interest of keeping capacity in the community we have funded them temporarily for this year, so that those consumers continue to get their services. So that's a quick rundown of where money is at this year. You see a total of $23.7 million coming out. The next slide--this slide...I know there's been some questions asked of me about where's the money in regional centers. If you look at this slide what you'll see is at the top, the proposed funding transfers. (Inaudible) July 1 of 2004 showed $25.9 million coming out of the regional centers--not a specific regional center, but the regional center total budget. (Cell phone ringing) That's not you, Mike. (Laugh) I recognize the music, but it's not you.

_____: Mesmerized by the tune. (Laughter)

_____: Thanks for that intermission; we needed it.

RON SORENSEN: Did you ever see the Disney cartoon about that?

_____: Yeah, I did--pretty good.

RON SORENSEN: Okay, so $25.9 million coming out, and then the transfers that have been made to date, and that is this column. And as you see, in 2005 we took out over $5 million, part of it going to community-based services, part of it going to administration within the agency, and that really paid for the director of the behavioral health division, it made by the psychiatrist position, and some other stuff for the division, as well as Joel's position. Office of Consumer Affairs is part of that, and there is some other things.

_____: Yeah, most of that is mine. (Laughter)

RON SORENSEN: No, I think yours is the 674. (Laughter) So in '06 we took out another amount of money, again split between the regional budgets and the administration, and so the total coming out, as it came out in '08 in the budget, is $14 million. So that total that's come out is the $22 million here. Now you have to take off the two administrative budgets, so if you do that what you have is $21,105,252 have gone to the regions; $987,000 went to the Department of Health and Human Services. Okay. Yes, Carole?

CAROLE BOYE: First of all, thank you very, very much for this slide. I mean, we've been asking for this for some time, and I know it's been really difficult to get to the $3.7 million, and I appreciate the clarity of this. I do have, with the Chair's indulgence here, a series of questions that I need to ask on this, because a number of us have been also trying to get to these numbers in some ways. And let me just...

RON SORENSEN: Well, and I didn't get to the last line there, and I did want to make it clear to everybody, and I think you picked it up, but I'm not sure if you saw the last line and said that, you know...that leaves $3.7 million out of that $25.9 million to move out. And so that's been identified.

CAROLE BOYE: Right, and that's a number that I know any number of us around the table have been trying to say, what's left and what needs to come? But I need to ask a couple of questions on those numbers. The $25.9 million--is it correct that that $25.9 million is the initial planning? That's been consistent throughout--it's the initial planning from the FY '04 budget of in-patient dollars that were being spent at Norfolk and Hastings?

RON SORENSEN: Yes, and it has showed up in the Governor's report of July 1, 2004, on the implementation of behavioral health reform.

CAROLE BOYE: Yes, and I have a copy of that with me, and yeah,...

RON SORENSEN: All right.

CAROLE BOYE: ...that number is tied throughout these documents. What I want to clarify is that that number was derived from FY '04, General Funds, state funds, in-patient services only.

RON SORENSEN: The regional centers' budget appropriations.

CAROLE BOYE: Okay. It did not include and has never included the ACT services that were at Hastings at that point in time, FY '04, of approximately a million dollars, nor did it include the out-patient services at Norfolk or at Hastings at that point in time, which together, approximately another million dollars.

RON SORENSEN: Yeah, I don't have the chart, but in that plan it shows money coming specifically out of Norfolk and Hastings equaling the $25.9 million.

CAROLE BOYE: Right.

RON SORENSEN: It's only in-patient; there's not any other services listed.

CAROLE BOYE: In-patient only. Okay. I also want to verify that it is my understanding, our understanding, based upon the reports that have come to this commission, that all the out-patient services from Hastings and from Norfolk have been moved into the community; is that correct?

RON SORENSEN: They have been closed; service has been closed at those two facilities.

CAROLE BOYE: Okay, and that the ACT services at Hastings, as of July 1, was moved into Region III,...

RON SORENSEN: Yes.

CAROLE BOYE: ...correct? Okay. I guess my question is to you, to Scot, and to this commission is, that while I appreciate the accounting for the $25.9 million, which was a planning document, the statute--LB1083--states that all funding derived from savings and reallocation of services from regional centers moved into the community--all funding is to be moved into the community and utilized for the development and maintenance of community-based services, okay? There seems to be a contradiction between the $25.9 million, which is an FY '04 figure, and the mandate of the statute, which I think this commission is responsible for overseeing the statute, that all funding be moved. And I guess I would like to ask someone to comment on...I'm a numbers person. We're tying

very nicely into $25.9 million. What we aren't tying into is the statutory language that says all funding, starting with out-patient services being moved into the community and ACT services being moved into the community. I actually have more questions than that, but how do we synchronize those two numbers?

RON SORENSEN: Okay. Well, what I can tell you is that the $3.7 million will be moved, and we're looking at the regional center budgets to see what else is appropriately moved as a result of this.

CAROLE BOYE: With your permission, I put a little spreadsheet together to try to track this through. May I share that with the commission?

SCOT ADAMS: How about after the presentation? I mean, we can come back to it,...

CAROLE BOYE: Okay. I see this as a vital...

SCOT ADAMS: ...but this is sort of a report that we've asked to give.

CAROLE BOYE: And that's fine, whatever...sure.

SENATOR JENSEN: Okay, we'll wait till after the presentation, and then, please...

CAROLE BOYE: Okay. Thank you.

RON SORENSEN: Okay. All right. I think we'll have time for that, too. This is...put this chart in here just to show you how things stand in terms of fundings of the region. The first column here is the estimated census of 2005, reflecting how many people live within each region. The next column is the percentage of people living in each region. The next column, called "allocation formula,"...in 1999-2000, the regions together with what is now the Department of Health and Human Services met to work out a formula

for how funds should be distributed. That formula consists of 75 percent of this column and 25 percent of income...a three-year income average in the regions. So typically, if you look at the income average in the state, what you'll see is lower incomes on the west side of the state, higher incomes on the east side of the state. The effect of that is that it changes these percentages from this column to this column. Now I need to say we never...our plan was we would hold everybody harmless, and we would only try to get to that formula as new money was added. LB1083 kind of made a step back from that, because we had to first deal with Hastings being closed as a result of losing psychiatrists. So money was put first out into Regions I, II, and III. And our plan, our strategy, was to move money into the east. So what you have then today, as a result of those moves, is this column, totaling that $72 million (inaudible), and this is the distribution currently of funding. And this is per capita funding by region. So, put that in there, just so you have some knowledge of where the money is at and to think about that as we move forward with the additional $3.8 million we've identified. Okay. What I want to do...I did...you know, we don't want to answer these questions now. I don't want to spend time on this, because we want to get through this. But we thought...we do have some funds that have not been spent over time that are one-time funds. That means we can spend them on something, but they will be gone when they're gone. Unlike my daughter's allowance, when they're gone, they're gone. (Laughter) So we could spend it on something that will build the system. So I want you to do is, rather than just discuss this, is if you have ideas, spend some time now, and as we go through the meeting today, develop ideas about how we might spend that money on a one-time basis. Some of the more obvious possibilities related to data systems, training, long-term care recovery--and all those things are tied together, in one sense or another. So if you would do that today, hand them to me and we'll sort of pull those together and summarize them. I'd appreciate that.

TOPHER HANSEN: What are we talking about, in terms of dollars?

RON SORENSEN: I don't want to talk about dollars. I just want your ideas at this point.

If I could say today, I can buy what I want to buy, this is my top priority, it would be training, or whatever it is. And this kind of training, but some specificity; not just training, but training in best practices of a certain kind, or whatever it might be. I don't want to limit or get this confused with dollars.

TOPHER HANSEN: Right. Okay.

SHANNON ENGLER: Ron, is the long-term care component related to the incoming problems with the senior population?

RON SORENSEN: Yes. I would put...

SHANNON ENGLER: Okay, because I think that's important to identify.

RON SORENSEN: Yeah, and I would think of it, really, in two terms, I think, Shannon. I think of it in terms of the population that typically goes to nursing homes, but also maybe assisted living homes, as well. So how do we find places for people that need those kind of services, and how do we support them in those services? Okay? I'm going to fly along here, and (inaudible). So the Governor's challenges--they give some on July 10, 2007--want us to complete the final steps of behavioral health reform. That includes reducing the number of mental health consumers at regional centers. In particular, we still have a number of individuals that we think could be placed in the community. We have some that maybe can't, at least in the current availability of services. We have the complete infusion, that $3.8 million we were talking about, moved in the system. We looked at our data system. That's an important one, as you've been watching our statistics and commenting about them over the past couple of years. That's an issue for us. Continuing the fuller integration of mental health and substance abuse into sort of a more common sense of understandings of what we have now between those two pretty diverse kind of systems for delivering services. Consumer involvement in all levels of system, expanding work force development, increasing the quality of services and

conducting research, integration of multiple funding streams, including children, Medicaid, whatever else we might include there. Briefly, accomplishments: We have seen, as we said earlier, a significant increase in number of persons served in community-based services. We've increased the persons served in community hospitals. I know Shannon may not want to hear that, but in fact people now are, instead of regional centers, getting their services more directly in community hospitals, which I think to a large degree, is a very good thing for consumers, because now they don't go to regional center; they go back to their communities more than they ever did in the past, and so that's a good thing. And we're still working with hospitals on how we improve access to emergency beds. Reduction in number of persons served in regional centers: We've showed that. We've closed those beds. We talked about it earlier. We have transferred regional center dollars, and we're going to transfer the rest of those (inaudible). We...the codification of behavioral health is the term of choice. Greater consumer input into all aspects of the system. LB95 meds--that's largely some stuff that we're going to be getting done here as the next legislative session is done. But the system has worked as we have moved from no longer having a pharmacist at Hastings, and hopefully continue to improve the process of getting those out. And LB40--housing, which has been, I think, one of those things that we hold up as...I think we hold up across the country as a success. And so, with that, oh, I guess that's not this...sorry, it's later. We want to talk about that in more detail in a little bit. The EPC road show: We have been traveling across the state visiting the regions. We've been to Regions III, IV, V, and VI talking to...the intention of that is to talk to law enforcement officials--Chief Mizner (inaudible) Region IV, and we're dealing with the issue of law enforcement officials taking a significant amount of time driving people around, looking for beds. How do you access a hospital bed without having to travel across the state or wait for a couple hours to find out even where there is a bed. So we spent some times in Regions III, IV, V, and VI talking about that. We had people--probably about 50 persons on average--in attendance at those meetings, mostly law enforcement officers, some providers; hospitals were in attendance, I think in all those regions. And as you...what we really picked up was that there's great variance in how people do the emergency

system, first of all, and a great variance in where we're successful. I think a great contrast to me was in Region V, if you attended that meeting and you attended some of the other meetings, what you really saw was a much greater satisfaction with how the system is working, great relationships between the local crisis response team and the police officials in this area, and success in managing that emergency system, so that...and you know, by no means not perfect, but boy, it was just a different sort of attitude about working together and what we managed to accomplish. Our purpose here, of course, is to bring some of those successes to other places and spread sort of the knowledge we've learned across the state. The issues we identified were access to the hospital beds; the transportation, moving people from Norfolk to maybe Kearney or someplace else; repeaters, and a couple reasons, we had discussed a lot of that--people who keep coming back into the system. Some of that we think we can deal with, with more attention at the local level to people who do come through the system, and making specialized kind of plans and support services that deal with that. The utilization of mobile crisis teams--vary from basically not even being (inaudible) in existence in one region, to being very successful in another region; and the training we need to do with law enforcement, hospitals, providers, local crisis response teams, and so on. Another issue that we're looking for, and Shannon brought this up earlier, is that we see a number of individuals that are...come out of nursing homes and end up in hospitals--the same in assisted living. So that's one of the things we are tapping now with the group within the division and across the Regulation and Licensure and Medicaid, and we'll be expanding that into the community as we develop ideas for how to support people in nursing homes. How do we provide services? Or do we need a different kind of service, whatever the answer might be? Assisted living--same sort of issue. Assisted living you've got to look at things like rates, you've got to look at support for people with behavioral health issues. We have a task force that's already moving along pretty quickly in that area, and we'll be going out more to the community as we sort of get some idea of the issues there. And of course, assistance for affordable housing, which is also a continuing issue. This is what...I actually (inaudible) we're going through this, skilled nursing facilities. We have some fear of behavioral health patients

within nursing facilities. We don't always communicate with the regions and the nursing facilities and providers. Reimbursement is an issue. They don't get paid more for people who have behavioral health issues. Training and back-up/crisis plans for how to manage that population when they need a higher level of care. I talked about these. We have the collaborative efforts going on in assisted living, and I think this is the cue for Jim. Jim is...I'll introduce Jim. Jim is in charge of the housing assistance program and is largely responsible for putting this thing in place. I know (inaudible) a lot of help, and you did.

JIM HARVEY: I had a lot of help.

RON SORENSEN: But Jim has pushed this thing from the start, has worked with the regions very closely. It's gotten going, and Jim, just to say this for the purpose of your acknowledging this, Jim picks up every job that comes down the pike within the division. And a lot of them nobody else wants, and Jim does them all with 100 percent energy and ability, and that's why (inaudible).

JIM HARVEY: Thank you very much for saying those things, Ron. If you'd use that clicker for me.

RON SORENSEN: Oh, you want to use it, or...

JIM HARVEY: No, you're good with it. You know what button to push. But let's start with this slide right here. I think everybody in this room is aware of the fact that LB40 in 2005 authorized housing-related assistance for adults with serious mental illness. And 2006 was our first full year of implementation, and of course it took a little bit of time to get the guidelines in place and the contracts signed and program plans running and staff hiring, and all that kind of stuff. And at the end of 2006, we did serve 127 people, and when I say "persons served" in this particular case, what I mean is that somebody was found eligible for housing-related assistance, then actually found housing, and money was

flowing from the region to the landlord or (inaudible) kinds of people. So money was being expended on behalf of that individual. So we had 127 people statewide who did benefit from the program. In 2007, that number rose to 557. And the other thing I'd like you to notice on this slide is, at the bottom there, it says 418 people, active consumers in the program on June 30. And what that's telling you is that people come in the program. Some can stay for an extended period of time, because we really have no cutoff. If you meet eligibility criteria, you can stay in the program for as long as you meet eligibility. But we did have 418 on the last day of service, which meant 139 people left the program. And some of those people left because they got on Section 8. Some people left because they got jobs and their lives stabilized, and they were earning money and off they went. And in a little bit we're going to be sharing some stories with you about those people.

RON KLUTMAN: In 2005, where were these people being housed at?

JIM HARVEY: They were being housed at the regional center, they were being housed in assisted living, they were homeless, they were living in substandard housing--places like that. In fact, we've got in our stories we'll be sharing with you some of that information. Now here's another slide that I find very interesting. This is number of persons per household. Statewide you can see that 557 number once again, persons served, and you can see that 77.7 percent of these individuals lived by themselves. But what that also tells you is that 22.3 percent had others in the household. So if you add together everybody who was served by household, we could say that there was at least 768 people. And the reason why you see that plus sign after 768 is that in our data collection, we asked for five or more people, and I don't know how four more breaks out, okay? So it's at least 768 people benefited from this program in one form or another. Now this particular slide, what this is telling you is, one of our criteria for receiving services is that you have authorized DHHS behavioral health services, and when we say that, we mean both the services funded by the division as well as behavioral health services funded by Medicaid. Those are the things that count. And part of this is

because we had an agreement with the housing people that DHHS would provide the support services, they would provide the housing. Eventually we also had the housing money itself. You can see here at the average amount of services is 1.7 services per consumer. This is a duplicated count, by the way. Next slide then,...oh, you missed a slide. Somehow we were supposed to have something about housing quality standards, and maybe it just got dropped out. Let me just tell you about that content, though. One of the expectations is that consumers live in suitable housing, not substandard housing. And in order to assure that, what we have is, we expect our regional housing coordinators to do housing quality inspections. And in 2007, we completed 438 housing inspections--83 percent of them passed; 12 percent of them actually failed, and then there was no conclusion on about 5 percent of those. What that tells me is that our housing...regional housing coordinators are getting out, looking at the properties are living in. By the way, a second reason for doing that is to facilitate the process of moving people from our program onto Section 8 rental assistance wherever it's available. So...and that brings us to the very last slide here, which is going to tell you about who our regional housing coordinators are, and two of these housing coordinators are in the room with us right now, Denise Anderson and John Turner. Would you guys stand for a moment? You're going to be hearing stories from them here in a minute or two, but I just wanted you to be aware of the people who are actually making this thing work. It's one thing to come up with the statutes and come up with the guidelines and the contracts, but you've really got to take all those ideas and put them into action, and these are the people, these are the people who are putting it into action. So anyway, as we were preparing for today, I shared a story with Scot about...from Region I, which I thought provided a good illustration as to where were these people before. And so Region I shared the following with me: Bonnie Lockhart sent me the e-mail that basically I'm going to share with you now. She wrote the following: This person was referred to me with emergency community support, as the result of being placed under emergency protective custody in the behavioral health unit at Regional West Medical Center in Scottsbluff. She became known as a frequent flyer because she had a recurring history over a two-year period. She would receive assistance from different agencies with

utilities, and she was still working at that particular point. However, health issues caught up with her, and her health generally declined, which led to her not being able to work, creating instability in her life resulting in her not being able to pay her bills, which meant that the utilities in her house were cut off. So suddenly this is a person who had no electricity, no gas, no water, no sewer. And she would decompensate--people would say, oh, hey, go check out this lady, law enforcement would her up and take her back to the emergency room. They kept doing this over and over again for about two years, okay? Well, somewhere around that time, then, our housing-related systems program started and the community support worker (inaudible) to sign this lady up. And what happened was, she was a homeowner, and because she was a homeowner, of course, we said no. I'm assuming if you're a homeowner you have access to some equity you can tap into, and you can go pay for some stuff like utilities. But this lady inherited her home, and she was not in that kind of position. Financially, she wasn't in a position to act on anything, either. So she kept decompensating. Anyway, finally Region I appealed to us and said, hey look, this is what the situation is, and once it finally got through to my head, then I turned to Ron, I said, what do you think? And we said, okay, and we approved her. It was the first assistance she got, and then once we started paying utilities, her situation stabilized. And once she stabilized, then she started receiving other services from Region I and that led to a whole bunch of additional stability, and she stopped being EPC'd. And today she's living in a very stable situation in Scottsbluff. So that's our first success story. Now I'd like to introduce Denise Anderson from Region III, and she's going to share two more stories with you. Denise?

DENISE ANDERSON: Well, last year the housing assistance program was able to provide assistance for 85 households in Region III, and this is a story about two of those households. Andrea began working with emergency community support after her last hospitalization. Andrea is 56 years old, and her only income she is receiving is from death benefits from a daughter who had died. She is taking care of that daughter's two children. Her monthly income is only $646 a month, but the rent was $475, plus utilities. At time of the referral into the program, she was living in a two-bedroom trailer with her

other daughter, Anna, and Anna's four children. That's eight,--two adults, six children--all in a two-bedroom trailer. The trailer was also not up to housing quality standards. Once approved to the housing assistance program, we began looking at her options. She applied through the housing choice voucher program and the scattered site housing program in her local housing agency. The wait list for the housing choice voucher in our communities can be anywhere from six to twelve months. Kearney and Grand Island average about a year on their wait list (inaudible) start the background process. Hastings is in a unique situation, where they do not have a wait list. Andrea found a three-bedroom apartment in Kearney and was able to move into that apartment September 1, 2006. Andrea continued working with the emergency community support program before being transitioned over to the community support program. Once she started working with community support she also started looking for employment. She felt she was in a stable enough situation that she move on to that next step. She has found a full-time job; in fact, she just started this past Monday, September 10. She's very, very excited. And she's been in the housing assistance program for 13 months. She did exceed the $5,000 cap by $3,000. She has also received notification about the scattered site housing, Promise (inaudible) site housing program there in Kearney, and they're starting to do background checks, so she should be able to transition out of the Housing Choice, the housing assistance program. The emergency community support program also began working with Anna, Andrea's daughter. Anna is 26 years old and has four children from the ages of 18 months to 6 years. Anna had moved in with her mother when she had lost her job. They were living in the trailer, and there was concern that she may need to be hospitalized due to that instable housing environment and all the problems that kind of arose from too many people on the same spot. Anna was approved for services from the housing assistance program. She applied to the scattered site housing at the local housing agency; however, she's not eligible for Housing Choice voucher program at this time, due to damages that she had at the last place that she lived in. She was in the Housing Choice voucher (inaudible) program. We found a three-bedroom apartment for Anna. She also moved in September 1, 2006. At that time her only income was from ADC. However, in February she found a full-time job

at a local manufacturing company. Unfortunately, that company had to lay off a lot of their employees. She was able to find another job about two weeks later, though, at a little less pay. So she's now a manager at a gas station. She's been in the program for 13 months and will continue. She did exceed the $5,000 cap by $3,000 for the last 12 months and will probably exceed that $5,000 again. She'll continue receiving assistance until she's eligible to apply for the Housing Choice voucher in Kearney or until she finds employment that constant and stable enough and can pay for her housing on her own.

JIM HARVEY: Thank you, Denise. And now I'd like to introduce John Turner, with Region V.

JOHN TURNER: Hello. Here are my two success stories. I actually chose to change their names to protect some of their confidentiality, so the gentleman in the yellow standing in front of the apartment complex we'll call Dave, and then the gentleman in the red is Lance. Dave called me one day to tell me that (inaudible) housing authority Section 8 program. He wanted to talk about the process that he'd just gone through, and he wanted to thank me for helping him. As he discussed some of his accomplishments and challenges through that process, he was also educating me on what it was like to be one of the consumers I'd been serving. In Region V, bridging to permanent housing is a reality. Thirty-eight percent of the consumers that received the state rental assistance program voucher are bridged to Section 8 throughout Region V service area. Dave's explanation that day helped me realize that we had some work to do to perfect the process so that it is seamless and doesn't create a stressful situation for the person being served. I asked Dave if he wanted to be on the housing steering program so the rest of the committee could have some more insight into the workings of the program. You see, Dave's perspective is what this entire program is about. He was on an in--patient commitment at the Lincoln Regional Center. He was transferred to a site res rehab program in the community. He then began working with the Assertive Community Treatment zone. As he was getting ready for independent living, he was referred to the rental assistance program at Region V. Dave already had a place in mind where he

wanted to live when I first met him. I worked with the support staff and the landlord to do a housing quality standard inspection of his future apartment. The apartment passed the inspection, contracts were signed with the landlord, and Dave moved into his new place. I see Dave every month now at my housing steering committee. How else can we really know if we're making a difference? He can share his personal experience of living at the City Mission years ago, or what it was like to apply and get approved for SSI. I feel like we both benefited from the state rental assistance program. And then Lance. Region V receives many priority one referrals from the Lincoln Regional Center. On this particular occasion, I went to meet on an issue about Lance at the regional center. Lance came from rural Nebraska and was having a difficult time trying to decide where he wanted to live. The rental assistance program is all about housing choice, and Lance chose what town he wanted to live in. He was working with an emergency community support worker. That worker and the regional center social worker helped Lance with those decisions and assessed his ability to live independently. He rented a small house in the rural community he chose. At the time, Lance had no income and was appealing his denial from Social Security. He was concerned about housing expenses and not having any resources to purchase appliances and furniture to live independently. With the flexibility that we have, the program was able to furnish his home with those necessities. Lance was also nervous about living alone. For some, independent living is exciting, intimidating, or both. That is why support services are essential. The landlord wasn't familiar with housing subsidy programs. He agreed to work with the rental assistance program because he knew that his rent would be paid, and he had someone to call if there was a problem. When I approved Lance, I recognized that we'd be helping him for a long time because there were no Section 8 programs in the area that he could bridge to. Since he had no income, I also realized that his expenses would exceed the allotted $5,000 cap on (inaudible). Today Lance's ten year old son has moved in with him. Lance is integrated into his neighborhood and community. He was transferred to long-term community support. He was approved for Social Security disability, and he can now begin to pay for some of his housing expenses. Now I can assure that he stays under the $5,000 cap, because he's contributing to those expenses. To think back to

that day when I first met him and compared to now, I recognize the impact that safe, decent, and affordable housing can have on a consumer's recovery. Thanks.

JIM HARVEY: So that's our report.

_____: Joel?

JOEL McCLEARY: Joel McCleary. I think I'll present from here. Here are three quotes that come from the substance abuse recovery consumers. Some of these folks I know, and anyway, they have special issues as they move into housing. But one of the quotes is: I do know if a person wants to change that they can. For me it took several treatments and staying in a halfway house. I have a career in a field that I only dreamt about before. Life is okay today. I'm going to add to this. I asked John to come out and check my own house to see if it would qualify for somebody to live there. (Laughter) Not without a whole bunch of work. I have an adjoining (inaudible) bedroom apartment. I thought, well, that will be cool if I can get somebody in, you know--put your money where your mouth is. And it won't work yet, but we're working on that. Here's another quote: My life is great, with a future ahead. Sounds funny, but I have keys and they go to things! God still loves me and together, we're okay with today--one day at a time. A third: I was helpless and hopeless. I just wished I wouldn't wake up in the morning. Alcohol was in my life and it was a life of death. Living in the halfway house was an incredible support system. And this person is teaching at the college today. One of the things that I talk about with some of the men that I am sponsoring, who are moving to halfway houses right now, this housing thing is tough when you're going from a house with many people in it, moving to your own house. They're scared to death they're going to screw up. But what I've found, at least in Region V, is that they have choices about where they live. John has identified maybe, you know, a number of houses they could cross into, and because of that they're able to choose one that you get close to family or away from family--close to the old playgrounds or not. And some of the guys are making some good choices about that. In the next slide, here's a...takes a little bit of a turn.

We're talking about the value of peer specialists, about people helping people, and it takes so many different forms. But here are some quotes, stories. Maggie had had frequent hospitalizations and police were often called. She is currently experiencing fewer issues with her peers in her apartment, and that's in Lincoln. No police contact for a long time. She is still learning and growing and developing new strategies to connect to people around her. She has asked her peer specialist from the Intensive Case Management program to help her systematically plan for that move, instead of impulsively getting on a bus and moving there overnight. Oh, how many people have done that! I've got to get out of here, they hop on the bus, across town they go and into the next one. Her peer specialist will take her on trips to the new city so she can be well-connected in the community before she makes the big move. Part of that connection involves wellness recovery action plans, connection to some of the other programs that you see, even just having somebody from the AA or another substance abuse community. Having (inaudible) numbers makes a lot of difference. Jeri, who is 48 years old, has been institutionalized most of her adult life, either in places, rehab, or under mental health commitments. She's had over 20 admissions to LRC. But now she is living successfully in her own apartment. For many years she was afraid of public transportation. Her peer specialist rode the buses with her and showed her how to use the bus route maps, and now she's regularly using the bus to go downtown. She is enjoying art classes that she had earlier been afraid to try. The third one on leadership. The quote: Our lives are not defined by what happens to us but our reaction to what happens. It is not what life brings to us but the attitude we bring to life. It is the catalyst, the spark that creates extraordinary results. We, my fellow peer specialists, we are that catalyst. We will trigger and accelerate the change and reaction in our state. Our abilities for change mixed with those in need provide a necessary bond and an extraordinary outcome. In the words of Carl Jung, (inaudible) consumer here, the meeting of two personalities is like two chemical substances. When a reaction occurs, both are transformed. And in the spirit of reaction, we will fuel our own recoveries and light a full-blown Bunsen burner under Nebraska. Aimee apparently has a chemistry class in her background. She is a graduate and commencement speaker at Community

Alliance. (Inaudible) that last one--last slide. This last slide I heard directly from a person that I just couldn't be prouder of. She is a college to master's degree, using her schizophrenia as a tool to understand the world and to do some art. And she was on her way into private housing as (inaudible), the transition. This short sentence caught it all to me: Sixty days ago I lived at the regional center; Monday, I'm going to college. She is. She is in the graduate program at UNL. Right now she's in class.

RON SORENSEN: Okay. That's it. I do want to acknowledge Sue. We don't ever give much attention to Sue, but Sue gets the joy of putting the slides together. Work, you know...either me or Scot or somebody changing everything at the last minute, and I just want to acknowledge. She goes through a lot of hard work and suffers a lot of grief and stress during the week leading up to this, and I appreciate the work, Sue. You're doing an excellent job. Thank you. Okay. Questions about any of what we had on here? Yes.

HOWARD OLSEN: Ron, that Slide 38, and then there was some mention of that $3.79 million that's on the verge of being accomplished. What are the conditions for the rest of that money to be released?

RON SORENSEN: We only have to move it; that is, we...I mean, our financial section has to simply make the money available to Program 38, move it. You know, it's a paper thing--move it into Program 38. Eventually, the Legislature in the appropriations, maybe in this next session, would show that being actually moved. That make sense?

HOWARD OLSEN: Is there any reason why it hasn't been moved prior to now?

RON SORENSEN: Well, because basically we just identified that money, said, here's where it's at. Here's where we take it.

HOWARD OLSEN: Okay.

SENATOR JENSEN: Yes, Dr. Klutman.

RON KLUTMAN: One quick question. One of the things the medical association was sold on is, as we close down the regional centers, we would bring more Medicaid dollars in. Has that happened, I guess is what I'm asking?

RON SORENSEN: Yeah, I went over that pretty quick. We're above...

RON KLUTMAN: I must have missed it. I...

RON SORENSEN: Yeah, that's going to be back there a ways. Okay, here's one of them--34. This shows the MRO, Medicaid Rehab Option--the growth from '04. We actually had MRO services prior to '04. I think back in 1995-1996 it started. And so at this point in time we had, oh, it looks like about $14 million total. We're up to $16 million now. I'm sorry, (inaudible). That would be $11-something million. Maybe it's on the next slide. Oh, we don't have the actual numbers, I guess. But it's grown from that total in '04 to about $16 million in '07.

RON KLUTMAN: And that's the federal government matching it?

RON SORENSEN: Yes, we're basically paying 40 percent of that, whatever 40 percent of $16 million--$6.4 million. Is that right? Something like that. That's what we pay, and then the rest is the federal government.

RON KLUTMAN: And that's above what we used to have; is that what you're saying to me?

RON SORENSEN: Oh yeah, yeah. That's a growth of...I don't have the exact number as I said, but you're talking about $11-something million to $16 million, so $4 or $5 million, something like that. And then you've got on the substance abuse side, actually goes

from nothing up to this, what looks like $1.6 million.

TOPHER HANSEN: I don't know if it's coming later, but on this point there's legislation at the federal level about MRO services, so are you going to address that at some point?

RON SORENSEN: Well, we're just kind of tracking that. You know, I guess it's no secret the federal government is looking for ways to save money, and one of those is to tighten up on MRO and even removing MRO services. So what that would do to us is to rethink how we do this. Maybe we would find an alternative, or maybe we fund part of what we've got. But you know, if they tighten down it presents an issue for availability of services in the community.

SCOT ADAMS: You know, that's one of the great opportunities with regard to the money to be infused, the $3.8 million, roughly. That's one of the key questions, how best to use the money, and that's one of the dynamics that's vibrating out there. Should some of that go away at the federal level, would that be a means of sustaining those services with certain funds versus what other options and important priorities are there for those funds. Your input to those kinds of questions would be very useful to us.

RON SORENSEN: Carole.

CAROLE BOYE: Are you suggesting by that, Scot, what you just said, that the $3.7 million that you just referenced that's going to moved out, that there's some thought of holding that back until you see what some of the implications are of that?

SCOT ADAMS: You know, we'd like to move it out as rapidly as possible, and Plan A would be through the regions, of course. It makes the best sense. There are a number of sort of interesting dynamics at play, in terms of folks stuck in regional centers and this and that. And so some of that may include conversations with regions.

CAROLE BOYE: So what is the plan of the department, in terms of when that money will actually be made available?

SCOT ADAMS: Today our suggestion was to ask you for your thoughts and ideas with regard to priority populations.

CAROLE BOYE: On the $3.7 million that's been identified?

SCOT ADAMS: Yeah.

CAROLE BOYE: I want to go back to that. I don't know when...if this is the appropriate time, or if there's another time.

SENATOR JENSEN: I think what you're talking about results...or refers to what he presented, so I think this is the proper time.

CAROLE BOYE: (Exhibit 4) Okay. May I...I like spreadsheets. It's the only way I can keep the numbers straight. I believe...and again, this is not an attempt in any way to take something away from regional centers and give it to community. It's not an attempt to put heat on HHS, you know, or promote. I believe that in reviewing the statute and our responsibility as an oversight commission in terms of the fulfillment of overseeing the full implementation of LB1083, as well as our roles as advocates, as people who need services within the community, as people who provide services within the community, that it is extremely that we ask some questions and identify some numbers. I would call your attention to the front part of this page that's being handed out--this is LB1083. Section 10, paragraph 3 says, and emphasis has been added here, all funding related to the provision of regional center services that are reduced or discontinued under this section shall be reallocated. We have utilized throughout this process a $25.9 million figure, and it was based on FY '04 dollars going into in-patient services. I totally

support using that figure. I again applaud and thank the division for tying back to that figure so we could see where we are at. The fact of the matter is, at least in my analysis, is that was a planning figure. It was a FY '04 figure; we've tied to that figure time and time again. A planning figure is one thing. The statute that says all dollars need to be moved out into community services is a different thing. And so what a number of us have attempted to do utilizing the data that was available to us, is to figure out what all services have been moved out and what that dollar amount was, taking into account the initial estimates of $25.9 million. The front simply recaps different documents that we have seen, coming from the legislative Fiscal Office, what the general appropriations have been for the regional centers over the five-year period when we started it, all the way out into next fiscal year, less the transfer in of LB1083, which was provided to us in this month's report, and identifies the $22 million that has already been transferred, plus again, from the legislative Fiscal Office, the sex offender treatment, so that we've got some apples to apples, oranges to oranges kinds of numbers. It also gives us, from the behavioral health report, the number of regional center beds. The only purpose for trying to summarize this information is to see if we could tie to the numbers, to start with, that everybody has been talking about. What it tells us is, from FY '04, when the $25.9 million was identified as a planning target, through the current fiscal year there has actually been a net increase, after you subtract the transfers and all of those types of things, that the Legislature has approved a net increase of 13.3 percent in regional center appropriations. That makes sense--2 to 3 percent a year over four or five years--cost of living. That makes sense. At the same time there's been a 31 percent decrease in actual number of beds. The bottom line on here, the dollar change per bed--just trying to do an average cost--the only reason that we looked at that was because from FY '04 to FY '07, the average bed cost--just number of beds divided by appropriations left at the regional centers--has jumped from $100,000 to $156,000. If you add the additional 60 beds for sex offenders that are planned at Norfolk, it jumps by 33 percent to $133,000. The only purpose for that is to say, yes, there has been an increase in appropriations from FY '04 to the regional centers. By inference, then, that same increase should have been applied, should be

applied to the $25.9 million in FY '04 that is being transferred from the regional centers to the community. The $25.9 million was not a static dollar amount. It was a point-in-time amount. Over time that $25.9 million has increased by 13.3 percent by legislative action over time, and so at minimum that $25.9 million planning figure should have grown by the same proportion of legislative increases--13.3 percent over time. I'm trying to keep this as simple as possible by apply some basic math here. If you flip up...I'm sorry.

RON SORENSEN: Could I ask...before you switch pages, can I...when you say "plus 60 future beds at NRC," is that related to the $13 million you show up above, or is that something else? The $13 million above is the 16 beds.

CAROLE BOYE: Right. All I was trying to...the plus 60 at NRC, I couldn't figure out if the 348 beds that your report reflected...we know that eventually we want 60 more beds, that the Legislature has approved up to 120 beds under LB1199.

RON SORENSEN: Right.

CAROLE BOYE: I was just trying to not skew the data here, because...and look at it both ways. What it tells me, and I think what it tells this commission, is that there has been a 56 percent increase in cost per bed over these four to five years within the regional centers, or at minimum 33 percent. Again, that's not my point. My point is, if there has been a 33 percent cost for increase, that adds validity to...there's been at least...13.3 percent should be assigned to services. There should be no...it is not right under the statute, in my opinion, that there is 0 percent increase over five years on the $25.9 million, and a 35 to 50 percent on regional center costs. That money should be following into the community. On the back side, taking those numbers and just trying to do, again, just a straight-line analysis here, under the provisions of the statute, which says all dollars should be transferred to the community, on the left-hand side what we have is the $25.9 million that we've all tied through, throughout this planning and

implementation stage. We have the $22 million that has been transferred into the community, according to the documents that we have seen today, and ties to the $3.7-$3.8 million yet to be going into the community. On the right side, what we have is the $25.9 million. In addition to that, what was confirmed earlier in our discussion is that out-patient services from Hastings and out-patient services from Norfolk have been transferred to the community, and those dollars have not transferred to the community. They were never included in the $25.9 million, and yet they have been transferred to the community. And again, as I read the statute, that money now should be moving into the community. The same as of July 1, the ACT team services was moved from Hastings Regional Center to the community under the auspices of Region III. My understanding of the statute is, it was not included in the $25.9. That, too, should then move into the community and be put on the community ledger. Then we get to the 13.3 percent. What has occurred from the initial planning dollars of FY 2004 to today, and at minimum, according to the legislative Fiscal Office, there has been a 13.3 percent legislative increase off that $25.9 million. So if you apply it to the $25.9 million, you apply it to the FY '04 figures of the out-patients, and if you apply to the FY '04 ACT services, we come up with $31 million worth of services have been moved into the community, and the actual balance per the statute that is still available and should be moved into the community is actually $9.7 million. I would suggest to this commission that if we go back to our responsibility under the statute and our responsibility to consumers being served in the community, that we need to look at these figures and look at whether or not we are fulfilling the statute. Thank you.

RON SORENSEN: Thanks, Carole. Well, all...I can say what we'll do. We'll go back and take a look at your numbers and maybe talk to you about some of your assumptions and look at also what we've got going at the regional centers, and figure out where we need to go.

CAROLE BOYE: But with all due respect, my comments here are directed to the commission and to our responsibility to oversee the statute. I have had numerous

conversations over time, as you all well know, trying to track these dollars. And what is of concern to me, and I will express to the commission here, is the typical response has been you, the community, the consumers being served in the community, were promised $25.9 million. You will get $25.9 million. We have somehow transposed--and that's not said adversarily; I think sometimes we've lost the forest for the trees--we have somehow transposed an initial target, an initial planning number, with the guidelines...with the law of the state, as passed by the Legislature. And that...I'm not...I think this is an issue worthy of this commission's discussion and direction.

SENATOR JENSEN: Yes, Susan, and then Linda.

SUSAN BOUST: I also thank the division for this slide and getting these numbers in front of us and thank Carole for putting together a spreadsheet which, of course, gives me blurred vision and a headache. (Laughter) Numbers are not my thing, but I believe that statutes are, and I certainly thank you again for bringing this forward, that the role of this commission, in going back to the statute and following through with the legislative mandate. So I guess that's my basic comment. I think this is one of the most vital roles of this commission, is to deal with this question.

LINDA JENSEN: I also want to thank Carole for putting this information together, and I would move that it be part of the minutes for this meeting, if she would be agreeable to that.

SENATOR JENSEN: I don't think that's necessary for a motion. It will be part of the minutes.

LINDA JENSEN: It would be part of the minutes? Not just the transcript, but the minutes?

JEFF SANTEMA: At the Chair's direction, I'll (inaudible).

LINDA JENSEN: Okay.

SENATOR JENSEN: Yes. Dr. Klutman?

RON KLUTMAN: Well, I've this viewpoint and this viewpoint. Do we have an independent auditor that can help the...I mean, does the Fiscal Office have to come in here? I don't know. I can't say one...I don't understand any of this. So I depend, you know, when I need to have my heart taken care of, I go to a cardiologist. You know, this is figures of here and figures of there, and I don't know how reliable the figures are, and I would like somebody, some state organization or the Legislature or somebody, to come in and try to this side here, talk to this side here, and come back to me and try to make some sense out of this. Do I need to make a motion like that, or...do you understand where I'm driving at, Senator? I...

SENATOR JENSEN: Yes, I do, and...

RON KLUTMAN: And I can't decide here at this meeting.

SENATOR JENSEN: Okay. And I'll also tell you that that is always one of the tasks of part-time legislators, is to determine what is right and what is wrong, or what is actual and what is not. We do, however, rely upon the statute, what the statute says.

RON KLUTMAN: Right.

SENATOR JENSEN: And I think all of us probably have somewhere in our file LB1083, that we can take and look back at. Now I...and I will be the first to admit, I had used that $25.9 million that Carole says is a static figure, and that that was the dollars that would go into the community. I also did know, however, that there was an increase annually to the regional funds, or to the regions, and how that's all to be addressed.

RON KLUTMAN: I guess one of my concerns is, our costs per bed went from $100,000 to $130,000, possibility $150,000? Is that what you were saying?

CAROLE BOYE: That's what the numbers show. I don't suggest that...that's what the numbers show. I very much appreciate your idea of what isn't known here. What I don't have access to, that the legislative Fiscal Office may have access to, is what have been the actual expenditures of the regional centers over these same four years, and is there dollars...are there dollars there that should be transferred? Is there more than $3.7 million in program whatever-it-is you said, Ron...

_____: Thirty-eight.

RON SORENSEN: Thirty-eight.

CAROLE BOYE: In 38, that should have been...I don't...and the legislative Fiscal Office is probably the perfect place to go for a few more pieces of this puzzle.

SENATOR JENSEN: Okay. Howard?

RON KLUTMAN: Is that fair to the department?

SENATOR JENSEN: Oh, excuse me.

HOWARD OLSEN: I'm sorry.

RON KLUTMAN: Is that fair to the department for me to ask, that you at least sit and talk to the...I'm confused. I don't know what is going on, and I'm trying to look for help.

SCOT ADAMS: Yeah. I think...appreciate the information. We've got a range to talk

about now. I think your suggestion is a good suggestion, and to each and every reasonable, rational perspective, political electricity surrounds it. So we have a range of $3 million to $9 million, and we can get additional data, and others will settle the question.

CAROLE BOYE: And Scot, for the record, you know, you too have been one that I have talked to about this. Understanding that this is a political arena that we're dealing with, that is why I went back to the statute. This is...as I read this, and in my respect for the rule of law and the statute, the statute is actually very, very clear. And so I don't...I was shocked at the way the numbers turned out. I did not expect that, but applying as I read the statute and the numbers, I don't see this as a negotiation at some point. It's a matter of gaining clarity as to exactly what has happened, what dollars apply under the statute, and then assuring that the statute is followed. I don't see it as a range for negotiation, not with my hat on here right now, as an oversight commissioner of LB1083.

SCOT ADAMS: And I appreciate and applaud that perspective.

SENATOR JENSEN: Howard?

HOWARD OLSEN: Well, Carole, thanks for bringing the issue to the table. I guess I'm not as convinced that the statute is so clear, and I wonder while this process is going on, if Jeff at some point could give us some guidance. I look at the little blurb that you have here on LB1083, and I guess there's not much question in my mind that maybe it applies to the out-patient services and to the ACT services. What I wonder is whether it also applies to the straight CPI increases that have been taking place on a yearly basis, and I think we ought to have some guidance maybe, with regard to that part of that issue.

JEFF SANTEMA: And I think one thing that might be helpful to the commission is if I can provide you a copy of the entire Section 71-810 in the statute so you can see

context, as well. And if the Chair chooses, Sandy Sostad from the Fiscal Office is here in the room today and could be called on to comment to the commission, if the Chair would like, as well.

SENATOR JENSEN: And I think that would be good. Sandy, could you come up and...

CAROLE BOYE: Could you clarify this for us?

_____: Aren't you glad you're here? (Laughter)

SANDY SOSTAD: Do not do that. (Laughter) We would be more than willing to sit down and look at Carole's numbers. I haven't seen these before today. I understand the philosophy. I understand what you're saying, and I don't disagree with what you're saying, in terms of...it would just be a matter of looking at that 13 percent and how you got it.

CAROLE BOYE: Yeah. You are a much more objective source and have access to more information.

_____: (Inaudible.)

CAROLE BOYE: Yeah, I'm just simply trying to raise the issue.

SANDY SOSTAD: So we can sit down and look through those numbers and (inaudible) adjustment, so.

JEFF SANTEMA: Well, it seems like the commission is asking for a response, though, and some kind of considered response, and I don't know if that can be forthcoming today, Mr. Chair.

SENATOR JENSEN: Well, probably not today, but certainly I would think it could be forthcoming in the next two weeks.

_____: Sure.

SENATOR JENSEN: Is that adequate time? Susan?

SUSAN BOUST: I just want to say that as a commissioner, one of my special interests will be in looking at the actual cost per bed of the regional center over this period of time, because I think that is a good kind of benchmark for us to use and not get completely lost in some of the other numbers.

SENATOR JENSEN: I think that's well.

RON KLUTMAN: Yeah, we understand cost per bed. I mean, doctors do, you know.

SENATOR JENSEN: Right, okay. The only...we're in a period of transition, which sometimes changes that a little bit, that we need to recognize. But anyway, without a doubt that's something that should be considered. Hopefully that will come out within the next two weeks also. Yes, Topher?

TOPHER HANSEN: Also, thank you for throwing the rock in the pond, as it were. (Laughter) The...and I think it's important, but there are two issues in here. One is growth of dollars, and so why is one stagnant and the other grow? But the other is, what about the transfer of out-patient and ACT funds? And we have to make sure we're accounting for...if the statute thinks of all of it and two pieces come over at a different time, then are we accounting for those, as well? And I think those...I don't want the out-patient/ACT dollars transferred to get lost in the growth-of-the-dollars analysis. I think we have to really address both those questions. So I would very much like to hear an answer to that, as well.

SENATOR JENSEN: Any other comments? What I'd like to do is, within the next two weeks, between the department and Sandy and some members of this commission, sit down and come up with a report and have that then to you upon its completion, if that is agreeable to all. There isn't any question that we can't sit here today and come up with a conclusion, I believe. But I think it's certainly worthwhile to spend the time and effort to do that. Any other comments? Scot, I think...are you next on the...excuse me. Howard?

HOWARD OLSEN: Senator, I have something that was unrelated to this that I'd like to ask Ron while we're still on that report, if it's all right.

SENATOR JENSEN: Sure.

HOWARD OLSEN: Ron, you commented about the EPC slides and the slight increase that it shows in Region I and that the department is looking into that, and I don't know whether this has any relationship or not, but it leads me to the question that I want to ask. But you know, I'm extremely disappointed that the Crisis Respite Center in Region I is closed.

RON SORENSEN: Yes.

HOWARD OLSEN: And I understand that it has closed because of staffing problems, because of control issues, because of mixed admissions issues--it was a homeless shelter at some point--wrongful admissions, the cost was twice as much as they projected, and a number of different reasons. And so that leads me to the question. You know we get these regions working to bring these services up. Does the department give them any help or any consultation on the bumps in the road here?

RON SORENSEN: Well, maybe we need to talk to you more about that, because what I have personally been told was, it was an issue of the hospital wanting the space back.

HOWARD OLSEN: Well, I...

RON SORENSEN: So...

HOWARD OLSEN: I think that's one small piece of it, but...

RON SORENSEN: Yeah, okay. Well, maybe we can talk, maybe, afterwards about that? And we'll investigate some of those other ideas, because what we had been told was the hospital wanted the space back, and we didn't have any other place to put it, and we looked for space but didn't find it. And so if you can give us some ways as to follow up on some things that may have gone on there, we can do a better investigation of it.

HOWARD OLSEN: Well, what I'm particularly interested in also is, you know, does the department work in consultation with these regions on finding alternatives to those community services who just...that don't work?

RON SORENSEN: Yeah, I agree. And to be totally up-front here, one of the issues in this whole reform project is Region I has been, I guess, so successful in working with the hospital and so on that you don't hear about them a lot. And so we've spent a lot of our attention in the places where we get more red flags. And so for that (inaudible), we probably haven't paid the attention, quite frankly, that maybe we need to now, with this issue coming up. So I'll be up-front about that.

HOWARD OLSEN: I think what it points up is, is that they got some of these community services up quickly and maybe first among all the regions, but obviously, then, they're the first to run into the problems. And we've got to have some mechanism for follow up to assist these regions, I think, in the event that happens.

RON SORENSEN: Yeah, I agree, and we are working with them. We do have a new field rep, so they'll be getting some help from other field reps in our office to work with them. But we can talk more about that.

SENATOR JENSEN: J. Rock, you had a comment, and then Topher.

J.ROCK JOHNSON: Yes. I should like to see the regional administrators at these meetings, just so questions such as this could be addressed to them. This request has been made, I believe, at virtually every meeting that we've had, and also Director Montanez, prior to her departure. It appears that there is a real need for technical assistance. To the best of my knowledge this is, notwithstanding the warmline going down at Telecare because those funds are being transferred to the Lasting Hope Recovery Center, this Crisis Respite was the only innovative and creative service that we've put into place with any of these dollars. You know, and to hear, well, we couldn't find a place for it; (inaudible) we're shutting down, is very difficult to hear. This is something that people should have really pulled together. This is an incredibly important service. We brought in an expert, Steve Mishio (phonetic) from New York, who talked with Director Adams and also the Lieutenant Governor. There are people who are doing this. This is kind of the first step of having a respite as a voluntary service, to keep people out of the subsequent. It's critically important and yet...it isn't that we're treating it in a cavalier way. I don't mean that. There's so much that has to be done. But this is the biggest red flag that I could possibly wave, that attention needs to be paid to. The second would be the warmlines. I thank you for the time, Senator.

SENATOR JENSEN: You bet. Thank you. Topher?

TOPHER HANSEN: I need to go back and revisit my comment about MRO, just so I feel confident that you all understand the gravity of this. One of the premises of LB1083 was to access dollars through providing community-based services that would then access or leverage those behavioral health dollars and use Medicaid. What the Secretary of

Health and Human Services has presented to Congress is a bill that says if behavioral health service is offered by a county or a state, other than through Medicaid services...so if Medicaid or MRO pays for a portion of it, like community support, for instance, but behavioral health dollars also pay for a portion of that and don't get Medicaid reimbursement, if there is a service like that, then that service would no longer be funded by Medicaid. So if the county or the state provides funding for non-Medicaid recipients, then that Medicaid would go away. And you can see that we're up to $16 million in MRO services, so community support, day rehabilitation, psych res rehab, and ACT teams would all lose funding under that scheme. That is a major impact to our system. I am curious, then, as I guess a guardian of LB1083, I'm curious, then, what our state response is. What is the Governor up to around this? I think this really threatens our budget as a state, because if all that MRO disappears, that's many, many millions of dollars we have to pour in to get back up to that, or we have to eliminate the non-MRO services to then continue MRO services. But then all those consumers who aren't Medicaid qualified would not be able to receive that service. Now I don't know what the wisdom is in Washington about, this bill is dead--this isn't going to go anywhere, or this is a major threat to Medicaid funding, or, I just don't know the status of it.

SENATOR JENSEN: You are assuming there's wisdom in Washington. (Laughter)

TOPHER HANSEN: I did leap out on that one.

CAROLE BOYE: Topher, and I was going to ask you to tell us what the status is, but the couple of e-mails that I've read, this is actually a proposed Medicaid rule change. I don't know that it's a bill, is it? Are we in public comment period time? It's important for us to know what our time frames are to respond to this.

TOPHER HANSEN: Leavitt submitted it as legislation.

CAROLE BOYE: Oh, as legislation, okay.

TOPHER HANSEN: And that's as much as I know about it. I don't know if the pulse says that's never going anywhere, or if it will go somewhere. I just don't know any of that information. I just read what he had submitted, in paraphrasing it, and it's just what I told you. And I think that is a giant threat to our state system.

SENATOR JENSEN: Yes, Mary?

MARY ANGUS: Well, we were just told that we don't hear anything from Region I because, I presume...I think what I heard you say is that they're doing a good job. I would suggest that 116 percent from FY '02 to '07 in EPC admissions would be a red flag.

RON SORENSEN: Well, my comment was that Region I, from the start, as you look at the numbers...I don't have them back up there now. But initially they did a good job, and their relations with their hospitals have been excellent, and working with them to develop new programs and services. So in the whole, yes, I'd characterize them as doing an excellent job. Is there a blip on the screen now? That's...yes, there is a blip on the screen, and that's what we've got to get to is what...is it the Crisis Respite or is it something else? I don't...but I wouldn't say, because this blip is on the screen, (inaudible). That's...

MARY ANGUS: Oh, no. That wasn't...I'm sorry. That wasn't my suggestion. My suggestion was that that is a red flag.

RON SORENSEN: Yes. Absolutely.

MARY ANGUS: And I know you mentioned earlier that you're looking into it. Frankly, I'm going to be...again, I'm going to be self-disclosing. I'm tired of hearing the words "looking into" and "considering." And I'd like to see a report on exactly what that means,

rather than...

RON SORENSEN: We can talk to you about it.

MARY ANGUS: Thank you. I appreciate that.

SENATOR JENSEN: Thank you, Mary. Yes, Topher?

TOPHER HANSEN: I guess I had posed the question and then we kind of went back to the previous question, too, but I'm still interested in what we're going to do, what is our administrative response to this looming legislation? And as a commissioner, I am very interested in hearing what the plan is to protect our behavioral health system, number one, and our state budget, number two. And if there is some information or if we can get update on it, I think we've got to be more aggressive about this because it's such a large step. And you know, again, it may be dead in the water. I don't know. But until I hear that, I guess I'm perked up.

SENATOR JENSEN: Perhaps we can link that with this other situation, that within two weeks, we'll get a response back, if that's soon enough, anyway.

TOPHER HANSEN: In Congress I would guess that two weeks would be soon enough. (Laughter)

SENATOR JENSEN: Okay, any other comments? Yes, J.Rock.

J.ROCK JOHNSON: Yeah, and I think included in that is...I'm not familiar with that as legislation. But I believe that CMS has out for comment a proposed definition of rehabilitation, which of course could change everything. And so that, I think, gets rolled into this activity. I think that it's another 30 days (inaudible) those responses are due.

SENATOR JENSEN: Okay, anything else. Scot, you want to go ahead with your portion? And we might eat a little bit into the 12 o'clock hour, but...

SCOT ADAMS: It's really...it's sort of daunting being the last thing before...standing between you and lunch. (Laughter) But we'll give it a shot. And I intend to go rather rapidly through this, but I had been asked to provide sort of a...some thoughts and reflections about maybe what's next with regard to behavioral health, and especially at the point where we're in the final unit of the oversight commission and the original planning and those kinds of things--sort of a time to take stock about things. And so this...I want to very clear at the front end, this is not a plan etched in stone. Obviously, we've talked about a number of dynamics today that can affect and alter plans, so I wanted to provide, though, sort of a general sense of overview. And I tried to organize these within the framework of four major goals, if you will. The first two of these are the Governor's directives with regard to sort of the revised structure of the Department of Health and Human Services, and his sort of criteria for successful change and transformation of the department overall. Two of those are related to completion of behavioral health reform, implementing children's behavioral health within the Department of Health and Human Services. Currently, there's not a single department or division or section in state government that sort of attends to children's behavioral health. A third goal that I've talked about is really nurturing the behavioral health system, and whether that's called maintenance or modification, evolution, those kinds of things, that's (inaudible) of what I mean by that. And then the idea of a sort of "reach" goal, if you will, for Nebraska becoming a top-five state. With regard to completing behavioral health reform, I think we have a number of issues. We have a number of special populations. Ron spoke briefly about the emergency protective custody issue. Sex offenders were an unintended group of people that have come on the scene since LB1083. Long-term secure is something that we need, as we see the inability to, in recent times, in the last year or so, to move significant numbers out of Norfolk Regional Center into communities. Providers have not been equipped or able to take some folks, and so we sort of have been a bit stuck, and so some attention to that is an important

element. Also, well, we've got that middle one. (Laughter)

_____: Got a typo there.

SCOT ADAMS: It may be a typo, subject to change--modifications. Fascinating how soon these things go out of style (inaudible), isn't it? A third issue there, I think, that's important is in light of the changes to community-based services, in light of the successes of this, the role and function of regional centers, their particular place in the system overall, is an important element to consider. With regard to the second goal, implementing children's behavioral health, we have the LB542 task force that has assembled, has been meeting with regard to describing and defining the children's behavioral health system as it ought to be. It is anticipated that we'll issue a plan. The department is charged with developing an implementation plan within a month of that report and then providing that to the Legislature, which will make, I presume, legislative...take legislative action with regard to all of that. In anticipation of that, but not wanting to go too far beyond LB542--we didn't want to be presumptuous of the work of that commission and that task force, but we wanted to sort of get ready--we are establishing the office, if you will, the section of behavioral health within the Division of Behavioral Health Services. We are in the process of hiring an administrator, a peer to Ron on the community-based side, and to Bill at the regional centers. So that person has high visibility within state government. This is apparently in the top 20 percent, apparently, of states across the nation in terms of where they rank, position wise within the state government. And then we also have the state infrastructure grant. It's a five year grant. We're about halfway through that, and we hope to have the learnings from that also (inaudible) LB542, LB542 (inaudible), and to be able to use all that together. Now here I mean no rub; in fact, I hope everybody appreciates the pun, but we want to institutionalize consumers--if you stop there, that's a dangerous phrase, right--in all aspects of prevention, recovery, and evaluation of our system. We have inserted them, we have involved them, but we want to make sure it's permanent, and so that's my intent. Secondly, further to nurture the system, to keep it moving forward, we have a

pretty serious work force issue here. Senator Johnson is leading the way with regard to LR203, taking at look at that particular issue, but this really is head-to-toes--peer specialists to physicians, and everything in-between, and across the state. It involves also, I believe, telehealth and other kinds of issues that are very important to the state, in terms of work force and training. Quality improvements are always an important dimension. One of the things that's sort of interesting to me is, in a system like we have, where you have sort of a state authority that really doesn't get to do much, other than run regional centers and then work through others, our ability to provide control on things like quality and provide control and implement, is really very limited. And so we have something of an uneven system, on any given topic, from region to region, provider to provider. And so focusing in on quality and trying to help standardize that and to increase quality across the board, is an important improvement. In the last several weeks we have all witnessed or been made aware of the tragic assault on Dr. Martin. As a result of that I have formed a group of people with Bill Gibson to help us take a look at the (inaudible) of our regional centers, especially Norfolk and Lincoln, to make sure that we are safe and operating as well as we can, given the constraints of the facility budgets, staffing, and those kinds of things. We want to make sure that we do that. This will involve people from outside of the state of Nebraska, outside of state government, to help provide input and recommendations to us. This last one is probably, I suppose, among the more lightning rod kinds of items, but at present--and I don't think of this as a long-term goal, but I do just want to recognize the reality--we haven't been able to get about 46 people out for a long time. I think we are able to develop and reduce that below a 30-bed unit, and a unit is 30 beds at (inaudible) Norfolk Regional Center. Those are sort of the clumps of numbers we have to work with. And I think that's going to be with us for some time in a secure setting for those folks. Fourth goal: With regard to helping Nebraska become a top-five state, really rests with regard to one of the Governor's important elements, which is that we have kind of a greater accountability within the state of Nebraska. But there's a lot of talk about a couple different things--best practices. Most all of the research identified in the Sampson materials as best practices is without a theoretical orientation; thus, it's all

over the board, and secondly, almost none of the research is done in rural and frontier areas. We're largely a rural and frontier state. And so I'm not dismissing those best practices; I'm simply saying we need to own those and to make them Nebraska's, and to modify them, perhaps, where necessary and where practical. Defining "recovery." I've had something of a bit of a rank, and I don't mean to burden you with that here. But I am absolutely thrilled that LB1083 codifies the idea of behavioral health, both as reform and as the focus of discussion. However, they come from very different camps. It comes from a camp of mental health services and substance abuse services traditionally, and there's a great deal of suspicion, mistrust, and on a bad day, anger and frustration and hatred between the two. Folks on the substance abuse side didn't trust the mental health side, because they were going to make me take those medications and screw up my sobriety. There's differences with regard to expectations around poor compensation work-related activities. Lots of good reasons for the differences. Well, I've started a list of our differences, and they exceed 30. And so our definition of what recovery is in this new world of behavioral health is sort of taken for granted. And I don't want us to take for granted what we mean by recovery. So I want to have a more specific and articulate and informed conversation about what we mean recovery might be. We want to, of course, integrate all the money we can, including Medicaid, but also our other resources of training, such as university involvement in the behavioral health system. What additional roles might they play? So other sources of infrastructure. Research is an important component, I think, to keeping any system fresh and alive, and I think in particular involvement with consumers focused on recovery, driven by outcomes and data, associated with universities and others, connected with our partners in a more close way, and most of all, a really anchored notion of hope. As the son of a mother who spent a lot of time in hospitals, went through a lot of electroshock therapy, she hated going into the hospitals; she hated coming out of the hospitals. She hated being there. She hated all aspect of her illness, and while she absolutely came out better--she was better--it was really symptom containment, and it wasn't living life. And she never got to living life. And we have, I think, at this moment the opportunity to help people live life more fully, and that's what I hope for. We talked about the stable living environment

through the housing kinds of things. I think that's another thing that will make us a top-five state. That's going to be different than many other states, and that's a huge infrastructure element, dynamic, variable, that we have on our side to help to grow this place. And finally, we really don't have a place in this data or time when we all come together and celebrate what we've done. Now some of that is just exchange of information, Region 1 talking about their successes to Region IV and III; Region 5 talking to Region 2; you know, across the board. WE don't do that very well. We don't sit down and get together. We used to do that, but in this world I think we have all become so sound-bite oriented and so cut-to-the-chase kind of thing that we don't have opportunity to sort of convene. And so I hope to increase our ability to convene, collaborate, and cooperate through, perhaps, an event such as an annual celebration. And we have much to celebrate. People do have a greater genuine sense of hope in their lives. Consumers are more involved than ever before in this state dramatically, in service delivery, in service participation. Are we done? Uh-uh, no. But the fact that we're not done does not negate the fact that there are successes, and I just wanted to take a moment to mark these. We're talking about the recovery model. We've closed regional center beds. Community services have expanded, and we've almost doubled access to services to folks in three years--pretty dramatic. So I wanted to end on a note of some sense of encouragement. We start this next period of growth from a period of some strength. We have some turmoil, we've got some arm wrestling to do--all that is to the good. I know we're all on the same page, and we're (inaudible) try to help people to live better lives. We are saddled with, sometimes, very vexing, frustrating, not-always-fully understand nor well-treated conditions. But we can get there. We can get from here to better, and with your help and support, we're going to go and do that. So thank you very much. Happy to respond to any questions you might have.

SENATOR JENSEN: Any questions in response to Scot. Topher?

TOPHER HANSEN: Just additional information, which is this Sunday at 1 o'clock there is the recovery rally, and that really is...and if you look at how many people struggle with

cocurring disorders, and then how many just have substance disorders, there's a huge number of folks there, and there is a recovery rally, and this is the fourth year, maybe, or something like that. And so that effort is going nationwide and building strength here locally and is a good opportunity. And the goal of that, I think, for a whole bunch of people that participate, is to get to the point where people aren't embarrassed to be in treatment or be in recovery. It's recognized as something we all have close to us in some way and that we can rally around.

SCOT ADAMS: Yep. Sunday at the Capitol, 1 o'clock.

SENATOR JENSEN: Any other questions? J.Rock.

J.ROCK JOHNSON: Do we have copies of your overheads?

SCOT ADAMS: You do not.

J.ROCK JOHNSON: Will we?

SCOT ADAMS: I'll get (inaudible).

J.ROCK JOHNSON: Okay, thank you. If you could do that, that would be helpful to me. I noticed, in terms of the recovery rally, that there hadn't been a focus on people with mental health issues historically, because that's come out of the federal government prevention...alcohol prevention and alcohol...it's T and the P. Help me, Topher. Treatment--treatment and prevention. And those within CMHS, those other two get significantly higher money than we do, so it will be interesting as that develops, the ways in which the possibilities of including people with mental health. And I think maybe the reason there haven't been a lot of celebrations in the past is possibly there hasn't been a lot of celebration to be done. But you know, change (inaudible)...

SCOT ADAMS: Could be, you know, and also the fragmentation. We've got three months that we're supposed to celebrate something of recovery--May, September, and October. What's that about? Let's pick one and go. (Laughter) And that's part of the conversation, you know? I mean it's...three!

J.ROCK JOHNSON: Yeah, it's just which season would you like?

SCOT ADAMS: It sort of almost feels like a divide-and-conquer kind of approach, and that's the beauty of LB1083. We brought it together. But we haven't fully had the full conversation of what divides us so we can come together and identify what unifies us. And that's my point.

J.ROCK JOHNSON: And to take a comment about...it's extremely fortunate what happened with Dr. Martin, and I would hope that...because sometimes we can characterize things as a safety task force. There may be other issues that need to be looked at, so you don't box it up. And by the same token, the comment about institutionalization. I'm involved with some activities about language sensitization, developing some various...(inaudible) water I do a lot better. (Laughter) But anyhow, mechanisms...and I'd like to see you develop a task force at the highest level to you with...and particularly with response, my response to that characterization that began with institutionalization, maybe beginning with the people who are sitting on this (laughter)--oh, bless your heart--who sit on this commission, because, you know, words have power to do other things using...

SCOT ADAMS: Try to put them in quotes, though.

J.ROCK JOHNSON: ...your pulp...well, the whole...using your presentation as my pulpit. There is a best practices document that the academic support group did in Nebraska. So of course, that's on-line.

SCOT ADAMS: Absolutely, and I'm aware of that, and my comments remain.

J.ROCK JOHNSON: And I'm sorry I can't give anybody this citation, and I don't have copies because I didn't think about it, but CMS has found peer support services to be a best practice and have sent letters to the Medicaid directors. And they use a...it's always good to have high authority. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life, despite a disability. For others, recovery implies the reduction or complete remission of symptoms. So this is just, you know, one place that it's coming from. I don't want us to get moribund in ways, but I'm interested in the actions that we can move forward with.

SCOT ADAMS: Thank you.

SENATOR JENSEN: Okay. Mary?

MARY ANGUS: Could I be so bold as to ask you to show us Slide 6 again? Something popped into my mind and popped out before...the other thing is, while I'm thinking about this, Topher, I'd like to comment a little bit. I think what you're talking about is absolutely incredible and necessary. We have to be at a point where we are not, whether we're substance abuse, whether we have mental illnesses or whatever, where we're absolutely not embarrassed to say that. And I think the flip side is, and this is vital, that we don't have that imposed on us, that when I say we need to have people who are willing and able to self identify as members of commissions, of committees, of task forces, as...when they are representing consumers. Until we...I had it said to me a couple of weeks ago that we want to make it safe for people to be on committees by not making them self disclose. To me that perpetuates the stigma, the discrimination, and the shame. And until...there's nobody forcing anybody to self disclose. If you choose to be on a committee and represent consumers, then I don't believe you can represent them without being willing and able, and I think it is shameful for us to say, you don't

have to because...you know, there's something wrong with telling that. Okay, that would be something that has been very, very much in my thinking for a long, long time, and I simply cannot remember the other comment that I had. But I appreciate your presentation. And I'd like to say that I think you've brought yourself up to speed pretty darn fast. (Laughter)

SCOT ADAMS: Yeah, I was able to shie away from the money. (Laughter)

MARY ANGUS: No, I mean entirely, since you've started.

SENATOR JENSEN: Any other comments?

SCOT ADAMS: Thank you.

SENATOR JENSEN: Thank you. We had a plan for a working lunch.

JEFF SANTEMA: We can still do it, if you'd like, on a modified way.

SENATOR JENSEN: Okay, well let's go ahead and do that, then. Jeff, why don't you go ahead and explain what we would be doing here.

JEFF SANTEMA: Under Senator Jensen's direction, we prepared a working session activity, dividing up the commission into four different groups. And we have different rooms for you to meet in. On the handout that I will be giving you there are five different questions or areas of questions. The purpose is to...and considering that this is the last year of the commission's statutory existence, the idea was to get a way to generate your ideas and consensus on some particular topics. In light of time and in light of the fact that the lunch rooms will only be available to you until 1 o'clock--so we do need to be out of those rooms by 1 o'clock--of the five things that are on the sheet that you'll be getting, would you only, then, just please focus on number two first, and then number

one, if you have a few minutes. And don't take a lot of time on each one. Don't get bogged down but keep on track. And think of making lists and statements rather than, you know, (inaudible) narrative. So it's just an idea generating session. So Senator Jensen, I think with that, number two first and then number one. Maybe the rest of the questions will be a basis for an additional working session, if you feel it's helpful for you and also would welcome your suggestions as to what other kind of feedback generating questions, etcetera, would be appropriate.

SENATOR JENSEN: Do they have the list before them?

JEFF SANTEMA: It's right here.

SENATOR JENSEN: Okay. And we'll then come back here all together at what time?

JEFF SANTEMA: And 1 o'clock...we need to be out of the rooms by 1 o'clock, so just if we could be back in here ready to reconvene at 1:15 or so.

SENATOR JENSEN: Okay. Yes, Dr. Klutman?

RON KLUTMAN: One minute, personal privilege. I really do want to thank the senator for coming out to Columbus and talking to our mental health consortium. The people were very impressed that we got the leader, and I hope you enjoyed it. It was a very good working session.

SENATOR JENSEN: Great. Thank you.

RECESS

SENATOR JENSEN: Let's go ahead and if we can, have short reports by the four groups that met, and so we'll go right down the list. Group 1, and I'll go ahead and

report on that. First of all, they did feel that we should continue, provided that we have focus and clarity of purpose, again with a termination date, whatever that might be out there. We also felt that because of term limits, that perhaps this commission is going to be very important. This next year, again, will be the last year for about, I think, 17 senators that will be rolling off. And just like we have some senators that were elected a year ago that still, I don't know if they really understand behavioral health issues, and so I think it does become very important that we have a continuity of what has been done and at least the direction that we're going. And so...and whether that commission would meet after June 30, 2008, on a quarterly basis--that's kind of where we have been this last year--to maybe even a semiannual basis, but at least that there be a continuation to go from that. We did look at a couple areas in answer to question one. LB1083, what has been general assessment, and there are some things that are kind of intangible that I think at least our group mentioned: one, that there has certainly been an emphasis on mental health, perhaps removing some of the stigma that we had out there before, that...also, the fact that it's all right to talk about it, even, where we didn't used to do that a lot; certainly, the inclusion that has resulted from that. Those are areas that I think our group felt was a success. Some areas that still needed to be addressed certainly is removing silos and also providing a continuing form of care. And also, on that list, that there be long-term secure care facilities throughout the state. However, when you say "long term," we don't ever want to say that that's where you go and you never get out, but that's a place that until you have progressed, that you can leave. So that kind of concludes the report on Group 1. Group 2, Susan Boust, are you the speaker thereto?

SUSAN BOUST: I am. We also felt that the oversight commission should continue, but we felt that it should end and reconstituted with the successes and actually thinking through what it is the next group should be. I think the strongest reason we felt that it should recontinue is, we talked about the mental health planning and evaluation council and the other statutory bodies, but those appear to be functioning really with the support of the Governor's Office, rather than the support of the Legislature, and that this body gives the Legislature an opportunity to ask questions and hear from the point of view of

the Legislature how things are going. And so we felt that that was very important to not just try and mold this into the already existing statutory bodies; again, along the same lines of all the HHS reorganization, term limits, that without a body like this at the request of the Legislature to be overseeing behavioral health, that we could lose a lot of focus on actually getting answers to questions that needed to be answered. And also that the makeup of this group is very important--the rural, law enforcement, consumers, providers--that this isn't just the usual points of view that you get around most tables with problem solving. It's much broader than that. We talked some about what the report, final report should be, and we did feel that there was one. And some of our discussion included suggesting that we actually have a group kind of compile where we started; have this be a big document, an archival book, so that everybody feels comfortable that, you know, you could throw away everything you've had once you get this book, that the history is there, the legislation is there, that some summary of the reporting that we've had is there. And it would be one of those places where you could say, okay, this is a fresh start, because it really does capture where we've been and how we got here.

SENATOR JENSEN: Thank you, Susan. Group 3, J.Rock.

J.ROCK JOHNSON: Yes. As well, we agreed that there should be continuity in many ways, and things that have already been said in terms of the unique role with the Legislature, as well as the unique composition of this group, that it's extremely important that there be continuity, in terms of the senators who have come aboard. So all of those comments we would endorse. On the shorter term, it was felt that there should be some working sessions or meetings or study groups--some way of...between now and the end of...now and June 30, around some specific issues. For example, and we're not suggesting that we should meet again to deal, but these are very, very important questions that we were asked here. And perhaps there could be study groups to contemplate some of this. We talked about a report and that one of the critical aspects that we would (inaudible) census was that that report has within it the ability to have

performance improvement, to be able to have some absolute assurance that whatever and however we move forward in the future, that these aspects that really haven't been in place, be given prominence. And I'll just point out the handout here--measuring outcomes for quality and accountability, which you know, fits right in here. We thought, too, the...I like archival, but I don't know about archival paper. That gets to be a little pricey, but maybe we could have one...

_____: Or it could be on CD-Rom.

J.ROCK JOHNSON: But I think that approach is excellent. That's what we talked about, too, the role and accomplishments of the state, the role and accomplishments of the commission, and we also suggest that there be a section authored by the consumer and family members of the commission. As far as the continuity, again, the importance of having mechanisms that will go forward, that will be able to assure accountability, and that will develop more transparency in not just the access of the commission, but citizen access to information. And part of that was an idea that when the report is done, that...have a major kickoff, perhaps a conference, press conference, to get it out to the public; and in moving forward with work for the future, that there be a focus and a job of how LB1083 is being translated into action, along the lines of like number four in our handout. So I would just ask my group if there's anything else that they'd like to add.

SENATOR JENSEN: Okay. Thank you, J.Rock. And Andrea, I think you're last but certainly not least.

ANDREA BELGAU: Thank you, Senator. Group four was much in consensus with the other three groups. We too believe that this commission should continue and by the continuation of the commission, we felt that would vitiate the need for a final report. However, we felt that it was very important to have a summation reporting the progress of the past four-year term. And if this group continued, we thought it should be beyond the scope of mere implementation. Hopefully, by June of '08, implementation will be

much further along than it is as of this date, but we thought that it should take up the banner of implementation, but also act in the role of monitoring and safeguarding our current progress, but also to be sensitive to the needs that will develop that at this point we have not yet even envisioned. Additionally, we recognized that this commission is a public body, and as a public body, it provides public input from folks whose voice may not otherwise be heard. So we thought that was another reason, definitely, for the continuation of this commission. Additionally, Chief Mizner brought to my attention a handout that we had placed at our desks while perhaps we were at lunch. It's from the Mental Health Association of Nebraska, and frankly it's pretty articulate as to that issue. So if you haven't had a chance to read that, you might want to. We also thought that implementation--and I think I might even be quoting you, Howard--implementation contemplates some measure of reasonable success with measurable outcomes. And that, again, is one of the roles of this commission, is to ensure that we not only progress and are successful in this endeavor, but that the outcomes have some degree of measurability. And if they can be measured, then that, too, ensures accountability. Then as to what we would like to see happen before this particular term ends in June '08, we sided with Dr. Boye, at least her philsophy, in the, you know, the show-me-the-money philosophy. (Laughter) We want to know: What progress have we really made in those areas? That being said, we are not at all equating progress with money. We want to focus on services and the consumers whose needs are being met. We want to verify that that actually has occurred. We want to see some sort of schemata or status report on the actual progress in community-based services, whether it's for out-patient treatment, intensive out-patient treatment, dual diagnosis--whatever it may be--we want to see some sort of a report that we can look at for each jurisdiction and each region. We did note that there may have been an overall 12 percent decrease in EPCs, and we want to make sure that continues. But that being said, we also made note of the fact that at least for law enforcement and the entry level, the emergency level of an individual who's in crisis, who has been taken into emergency protective custody, that situation, frankly, has deteriorated. And I know that Ron made reference to a road trip that HHS is doing right now, and that certainly is giving voice to (inaudible) law

enforcement officers in this area, but that particular...and it's not law enforcement saying, oh, this is so hard on us; this costs us so much money and time and officers off the street. It's for the individual--the subject who is actually...that EPC. They're being in an emergency situation, they're having the police power intervene, deprive them of their liberty, handcuff them, take them to one hospital. That hospital has to medically clear them before they're being taken somewhere else, and that somewhere else may be hours down the road. So it's not just law enforcement saying this is a burden--it's looking at what that consumer, that person in need and crisis, is undergoing. And they shouldn't be undergoing that in handcuffs and shackles. We also wanted to make sure that we are actually providing better services, not mere reallocation. Did I leave anything out?

SENATOR JENSEN: Good. Anything else? I'll just mention one other thing that was mentioned afterwards, and boy, I totally agree with. You know, through term limits, I think that through the three branches of government, the Legislature has perhaps diminished somewhat. And the Governor's Office, I think, has increased somewhat. And so I do believe that also, continuation of this body or another body is very, very important to ensure that the citizens and the consumers have a good representation always, and I appreciate what Andrea was saying about even the public airing at these meetings. I think it's very rewarding. Okay, thank you. The next thing on the agenda is other business, and if you'll permit me, I'll just relay a few things that I've been involved in. One, at our last meeting we did pass a resolution to look at the long-term regional hospital and their services. Met with some political opposition to that and so that will not be taken any further at this time, and we'll see where that goes from there. Also, with the passage of LB542, which is the children's behavioral health task force, and because I was chairman of this commission, I was...became chairman of that commission, without anybody contacting me. (Laughter) But anyway,...and the children's behavioral health is part of LB1083; it's mentioned right in there. I have attended...we've had three meetings. I've attended two of them. The last one I was out of town. The first one was somewhat organizational, here; the second one was out at Hastings; and then they've

had a subsequent one. Their report is to come back...or to have a report the first of December to the Legislature, and we'll see how that all progresses. I will just make mention I've made, of course, in my 12 years in the Legislature, several trips to Hastings, and I think we constantly need to be looking at our regional centers--Lincoln and all of them combined. Hastings...and I'll even mention that when LB1083 was passed,...I come from a construction background, as a developer of about a thousand acres in the city of Omaha, to building a half-million square foot of office and commercial space, and also as a taxpayer. And I lay out that last one, in that through the evaluation in Douglas County--re-evaluation--my home was increased and...I've got other buildings, but my home was increased 58 percent, and so I'm concerned about that as a taxpayer. But Hastings as 57 clients, if that's what...you want to put a number on those. Three are children suffering from mental illness in a program and seen by a psychiatrist in Lincoln that must travel that far, for at least one hour a month, sometimes more. There is the Bridges program, which are 14 DD patients that are currently housed in the old psychiatric hospital, 111,000 square foot building. They do have access to outside environment in a screened-in, solid screened-in area, which yes, you can be outside, but you can only look up. And then there are 40 substance abuse youth that are there that are from YRTC out at Kearney. By the way, that DD program is really not run by the mental health division but by Beatrice, and so it's 107 miles away. And again, you look at dollars, and as a taxpayer, over $10 million annual expense. I hope that we can look at that situation a little closer. They will issue a report, like I said, the first of December, and then it depends on what the Legislature does with that report. Any other business that anyone wants to bring up, commission members? Yes, J.Rock.

J.ROCK JOHNSON: I do not have the statute before me; I believe it's 71-919, and that has to do with the involvement of consumers and families in the training of the mental health wards. And to the best of my knowledge, no consumer family has been formally involved in that process historically, and I noted that there is activity of going out and making these visits. It was two years ago where Dr. Schaefer and Dan Power put together a booklet on the commitment statutes and put together substance abuse with

the mental health and the civil commitment. And there was a good reason that those were...statutes were separate, so I was just concerned about that. But I think there was any consumer family involvement in that, and I didn't hear any discussion of consumer and family involvement in this process of working with law enforcement. So without the statute in front of me, I cannot frame a specific question, but what I can say is that I think that that's part of the responsibilities of this body and its relationship to the work that the department does, is to continue to encourage particularly our statutory requirements. And this is one that I'd like to hear back on, if it would be possible.

SUSAN BOUST: Senator Jensen.

SENATOR JENSEN: Okay. Yes, Susan?

SUSAN BOUST: In the behavioral health legislative update there is an interim study, LR205. I don't know if you or Senator Johnson could speak to that. My understanding is that that is to look at kind of the same things that this commission looks at, and so I guess I just wondered if that...if we needed to hear anything about that.

SENATOR JENSEN: Senator Johnson, would you want to reply to that?

SENATOR JOHNSON: I'm not like Cudaback, I can't tell you what all the numbers are, and so on, so I'm looking for my thing (inaudible).

_____: Does that (inaudible) LB1083?

SUSAN BOUST: Well, that's what I was wondering. Does that have anything to do with LB1083? I guess that's really my only question.

SENATOR JOHNSON: You know, I don't specifically remember enough that I think I could make a comment that's worth putting (laugh) it in any record and so on, so I think

I'd better just get back to you about that. There's Jeff. Maybe...Jeff, can you help us any on LR205.

SUSAN BOUST: LR205.

JEFF SANTEMA: There have been some requests by different individuals and groups, asking for a public hearing on the resolution. Initially, Senator Johnson hadn't planned to have a public hearing. But Senator Johnson is open to that, and we talked about the possibility of November 2 as a tentative date for a public hearing. LR205?

CAROLE BOYE: Public hearing on what?

SUSAN BOUST: On what? Yeah, what is it about?

JEFF SANTEMA: Oh, I'm sorry. You're wondering what it's about. I'm sorry. (Laughter) I shouldn't go out of the room. (Laughter)

SENATOR JOHNSON: We have 29 different bills that were referred to us for this type of thing. That's why I'm reluctant to...

J.ROCK JOHNSON: It's in your materials.

JEFF SANTEMA: I'm sorry. It's a general resolution that just talks about the very things that you're talking about today: Implementation of LB1083 and what additional legislation or other recommendations need to follow the implementation of LB1083. So it's a very general resolution introduced to give the opportunity for the Legislature to look specifically at elements of LB1083 and its implementation.

SUSAN BOUST: So should be comment on it? I mean, should we be at the public hearing?

JEFF SANTEMA: Certainly, certainly. You will certainly receive notice of the public hearing, if it's scheduled. If it is November 2, it will likely be in the afternoon, starting at 1:30. So that's the tentative date and time, and it would be here in 1510, most likely.

_____: What about LR203. It seems somewhat similar there.

JEFF SANTEMA: Um-hum. That's specifically focused on behavioral health work force development, the need for peer specialists, psychiatric social workers, (inaudible) psychiatrists, etcetera; statewide strategies to address the need for behavioral health. So specifically, Dr. Boust from UNMC, and representatives from Creighton University and others have been meeting in Senator Johnson's office discussing the issue at this point. Senator Johnson?

_____: Would you be looking at having these both, say, on the same date, same afternoon?

JEFF SANTEMA: No, I don't believe there will be a hearing on LR203.

SENATOR JENSEN: Any other questions or other business? We're ready for public comment, should there be some. Yes, please come forward, John.

JEFF SANTEMA: You're free to sit down, John, if you like.

JOHN PINKERTON: Oh, I can stand. My wife has been called by Joel Johnson the "adjective lady," (laughter), and (inaudible) I'm not wordy here. I am going to use a four-letter word--EPC. Well, it's only got three letters, but I think that everybody here equates to a four-letter word--I know all the counties do. I equate it to a four-letter word, too--L-O-V-E. These are people that need the help the most, and I am afraid for dollar reasons they are being, not allowed to fall through cracks, they're being stomped

through the cracks. I think we...I think, Ron, I think we need another category up there that you're not showing, and that's the people who needed to be EPC'd that were not. I myself, I...we all know what cherry-picking is. Everybody wants to take care of the people that least need it. I think the people that most need the help need to get the services first. If nobody gets any other help, the people that need it the most need it now. It's a matter of life and death. And I really think we're overlooking...maybe it's only one-tenth of 1 percent of the people, but the people that really need the help do not get it, oftentimes. Now I hope we can maybe work on that. One other...two other things. At these meetings, I wish they weren't so structured. I've been to Region V meetings, Region VI meetings, and when somebody from the peanut gallery, as I term it, has a good point that's topical to the discussion, let them talk for two seconds. The moderator can...if you're not on point or whatever, the moderator can tell them to shut up and sit down. But a lot of times there are some people out here that have some good information that could really help communication. I wish we could do that somehow. The other thing is conflict of interest. Regions cannot be doling out the money and providing the services themselves. That is wrong, it's immoral, it's disastrous to the taxpayer and to the consumer who gets the poor quality of services. It's got to stop. There's...we tried to get LB616 passed this last year. Nobody was interested. Well, that is the heart of the whole problem in this state--money not being spent wisely. We need something more restrictive than LB616. We need a law that says no region provides any services. If they want to dole out the money, let...if they want to provide the services, let somebody else dole out the money. But it's not being done correctly, and it's hurting every one of us in this room, and all consumers. And that's all I have to say. Thank you.

SENATOR JENSEN: All right. Thank you, John. Anyone else? Yes. Mr. Green?

ALAN GREENE: (Exhibit 5) Good afternoon. My name is Alan Greene. I'm with the Mental Health Association. I did submit a letter for your review that kind of covered a lot of stuff that was talked about today, which I'm very happy with. There are just a couple things I want to talk about. One is the housing that Jim Harvey spoke about, and my

only comment is, is that slide was only highlighted in yellow. It should have been highlighted in gold with fireworks going off, because that is a program that has been exceptionally effective and has provided meaningful, firsthand "touch" help to people, and it's exceptional. And it needs to be recognized over and over again. Two, I want to talk a little bit about inclusion. Carole spoke about the letter of the law, and inclusion is a primary ingredient of the letter of the law. What I want to get to in regard to that deals with a couple things that were spoken and addressed to during the meeting. One that came to mind was the EPC road show, which I think is really interesting, but we weren't told who were the participants, how were the meetings handled, how was notice issued. Were there consumers involved in the process? I think it was asked, you know, maybe you ought to ask the person who is actually being EPC'd how they think about being EPC'd. You know, was there an agenda issued, or if they're ongoing, are there agendas being issued? And then also the topics that are going to be...that are being discussed. Are they talking about preventative...prevention activities that maybe can forestall an EPC; say, a program like a living room where some of these other programs that have been showed...well, the...can't think of what the term is now, with the police department.

_____: CIT?

ALAN GREEN: Yeah, the crisis intervention teams. Those type of things are extremely effective and help lessen...not only save money, but lessen the demand on the other end of all the services that primarily are the focus of behavioral health service delivery in the state. The other, with inclusion and recovery, the report that Joel and...well, primarily what Joel provided for recovery, it was very interesting, but it didn't tell us anything. It didn't tell us what is being done, what activities are there, who all is involved, how many people are getting involved. There could be...I think there are a lot very important things going on that need to be talked about. There are seven consumer specialists in the six behavioral health regions. They can have reports that I think would be very effective in determining how behavioral health is going on. I think that that could be expanded and benefit everybody. And then again, the third thing that I wanted to bring up again is my

letter. And first, in recognizing the hard work and the commitment of this commission, but also emphasizing the importance of a formal oversight mechanism for behavioral health in this state. As long as the Department of Health and Human Services remains a code agency and basically run out of the executive branch, we don't have this level of oversight and accountability for something that is so primarily important and deals with people's lives. The work you guys are doing is phenomenal and extremely important, and as I said in the letter, we will be...the Mental Health Association will be working very hard to help educate our senators on the need for the continuation of a vehicle like this. Thank you.

SENATOR JENSEN: Thanks, Alan. Any questions? Excuse me. Carole Boye, did you have question of Alan?

CAROLE BOYE: Alan, I just want to exclamation point on a couple things you said, and something that we are extremely...I'm going to brag here a little bit, too. Something that we are extremely excited about, that has been going on up in the Omaha Metro area is the CIT program, and I was actually sharing it with a few of the commission members at lunch, just some anecdotal information. But this is a two-year-old effort, collaboration of many, many agencies, but at the head are consumers or people who have experienced mental illness and substance use issues--multi-agency, law enforcement sanctioned by both Chief Warren in Omaha and Sheriff Dunning of Douglas County. And already 92 law enforcement officers have been trained. Here's the two exciting things: A two-year-old program, just two members of that council just received national recognition--national awards among the country. As we know, this is a national model--it's growing. One of those two people is a person who has experienced mental illness, and the basis of the national award--you know, why would this program get it more than any other?--is because of the level of the consumer involvement, from not just sitting on the council and developing the curriculum, but the basis of that award was absolutely the number of consumers that are there, doing the role playing, doing the feedback, leading the tours, doing the curriculums, all of those kinds of things. I have

not experienced in my many, many years such a real active partnership. To me what is most exciting is the level of respect and communication that has developed between people who are experiencing mental illness and law enforcement. There are now...they happen to meet at our offices. You know, there are now five police officers walking in with badges and guns once a month, and before, that caused great trepidation when that happened. (Laughter)

_____: I was going to say, is that good? (Laugh)

CAROLE BOYE: Now people are meeting and greeting, and they're buddies and that type of thing; more importantly, outcomes. Already, story after story. Someone is in a mental health crisis, the law enforcement is called, the individual is potentially very assaultive, certainly in crisis. The handcuffs don't come out. A police officer walks in, and I'm in shock when I see this and when I hear of it. The police officer comes up, and instead of "We need to control the situation," it's "Do you happen to have a rap program?" Let's talk about that. That's how we're avoiding EPCs. That's why what I'm hoping I'm starting to see the drops in EPCs. It is truly one of the most participative, humane, heartwarming, and outcome driven, results driven thing I have seen in many, many years. So I think we are seeing consumer involvement. I think we are making a difference. We have to capture that more, and I am extremely, extremely proud of, without sounding paternalistic, of the individuals who've experienced a major mental illness who have gotten so involved and are truly making a difference in a lot of people's lives in Omaha because of it.

ALAN GREENE: Um-hum. And I think that the key is to recognize that this is a partnership, that it isn't anything that's owned by any one particular person or one particular employment or profession or anything else; that if we all work together, we can really make something good happen. Thank you.

SENATOR JENSEN: Susan, you had a comment?

SUSAN BOUST: Yes, and I want to thank you for your letter. That was very nice, and nice to know that the commitment and passion here is recognized by the people who are more important than we are.

ALAN GREENE: Yeah.

SUSAN BOUST: I wanted to follow up a little bit on Carole...about the CIT. I happen to do the first two hours, right after the chief of police leaves. They get me for the first two hours of their 40 hours, talking about brain function and psychopharmacology. And that's a tough thing to teach, right off the bat. When we get our evaluations back, the highest ratings by these officers at the end of 40 weeks is always the consumer panel. It is always...they really, really appreciate the information firsthand from the people who have been in these situations. So the consumers there have done a great job of teaching.

SENATOR JENSEN: Yes, J.Rock?

J.ROCK JOHNSON: Yeah, I just want to put it on the record that it was Ken Timberman (phonetic) who received the national consumer of the year award from the crisis intervention training. Also, that two members--one Cindy Scott of our group here, and Sheryl Krouse (phonetic), who many are aware of, were...presented a workshop at the crisis intervention training that was just held in September, and there were some officers from Nebraska that had gone, and I think one or two who might not have otherwise gone if they hadn't heard about it in the way that they did, so I think that...coming back to...I guess the bottom line here, I would say, is let it be a lesson to you.

SENATOR JENSEN: Right. Anything else? Thanks, Alan.

ALAN GREENE: Thank you.

SENATOR JENSEN: Anyone else wishing to make public comment?

C.J. JOHNSON: I had to. (Laughter) Most of the members by now probably have figured out why, when I left for college, my parents had a huge celebration. Based on their reports, I understand it was well attended. That's a joke. (Laughter) I don't want to quibble over dollars, because I...you know, Carole brought this up today, but I had kind of been playing with numbers myself, partly because looking that the commission's term was to end, I believe June, 2008, I began to think we need to really look at this. And I have to be honest. Up on the screen I seen...had I seen the figure of $5.5 million, I wouldn't have stood up here, okay? Because I would have said, you know what? When you look at the original amount of General Funds that were in the regional centers, both for in-patient, the out-patient, and the ACT teams, $5.5 million would have been the General Funds that probably should have transferred, okay? But I do want to point out that...again, not to quibble over dollars, but I do want to point out how critical it is your decision today to really review this. On page 55 of the Nebraska Health and Human Services System report to Governor Johanns and the Nebraska Legislature on July 1, 2004, under a section on page 55 that was entitled "Summary of Regional Center Appropriations Available for Redirection to Community-Based Services," it showed an amount of $29 million. Now I want to point out that that $29 million did not include the General Fund money that was allocated for the out-patient services at HRC and Norfolk, and it also did not include $1 million that was for the ACT team at HRC. So when you start putting that together, you know, you really come up with a sum of about $31 million, which I think Carole was kind of close to, in relation to hers. And not considering those increases, as Carole said, I came up with a figure of $8,700,000. So I just wanted to point out that I really think, as you look into this these next years, it really has to be a serious look, because...when I say that we need to look at where it was, what money really was there, because as I've looked at the funding that's been allocated to the regions, I've looked at some other things, I actually came up with, if nothing else got transferred at this point, based on the original amount, that we will have actually

defunded, okay, defunded money that was available for behavioral health services, right around $9 million, which is close to Carole's figures. So this...you know, we need to really pay attention to this, because when all is said and done, even if that $3.7 million came in, we'd still be walking away with the potential that we actually defunded the behavioral health system, based on the money that was there in 2004 by about $6 million--you know, $5.2 million. So we...that's all I'm saying, because I really would hope that it's really looked at and then really challenged, because it would be a shame to have started something in 2004 with the intention of...and we were told at the time there wasn't any new money, okay? Everybody understood. But what I would hate to have happen, when it's all said and done, is that we actually walked away with millions of dollars less for behavioral health services than we started with. That would be a shame of that kind of legislation and that kind of reform, because to me, that's not reform, okay? The other thing I would like to just mention is, last time the commission met I had talked about that there had been some conversation about 23 additional behavioral health beds or psychiatric beds being talked about at LRC, and today we heard another 30 beds are being considered at NRC. And the question I have, and this is just a question I hope the commission asks this, is when you...if those 23 beds are being talked about there, and 30 beds up there, when you start using figures like Carole shared today about that increase in per-bed per year, you're really talking about almost $8.3 million in psychiatric bed increases as of the current situation right now. And of course my question is, is where is the $8.3 million coming from in order to fund those additional, what I hear, is 53 beds. So I just want to throw that out, as well. The last comment I want to make, and I have to apologize. I've a contact that's been around, that...there was questions about working together, HHS, the regions and everything. I do want to point out that first of all, HHS and the regions have for years had a charter, and we do get together on a regular basis, every other month basis. It's a time when we talk about a lot of these issues, we challenge a lot of these issues, we come to a lot of conclusions together, in relation to...and I do want to say that over the last six months or so, you know, from my perspective, those meetings have become much more productive than they might have been in the, you know, prior two years that we had. So

I just to share the information that has been going on. There seems to be a higher level of transparency in those discussions, so I really see that as critical. The other thing is, on the alternate months the regional administrators also get together, and we discuss what's going on in our regions. We take a look at it, we try and figure out how we can help each other, support each other in relation to some of the challenges we have. And then subsequently from those meetings, agenda items may come up that, again, we forward on for those what we call NMT or the meetings where HHS, DHHS now, and the regions do get together and discuss a lot of issues, and I just want to share that, because I kind of got the sense, as people were talking today, that maybe there's not a lot of communication that goes on. But the reality is, it feels like not only has the communication improved, but it's on a regular basis. And I know all of us have had regular meetings with various members of the department, as well, on a regular basis, around things that are just specific to our regions. And like I said, the level of transparency has definitely increased the ability to have those conversations. I think it has increased. It doesn't mean I won't keep challenging things I hear, whether it be figure for anything else, as anybody should when they see something. With that, any questions?

JIM JENSEN: Thanks, C.J. Carole?

CAROLE BOYE: In follow up to that, Scot,...thanks for this, by the way--even a color version, I'm aghast.

SCOT ADAMS: It's the legislative budget. (Laughter) DHHS, it would have been black and white.

CAROLE BOYE: Goal three, the last bullet point under goal three--maintain a 30-bed mental health unit at NRC for special populations. Can you amplify on that?

SCOT ADAMS: Well, as I said there, Carole, what I would want to reiterate, I suppose,

was it's recognition of the present reality. We've been trying for a long time; we're down to 46 and stuck. And at least for the short term, it looks like we could get 30 and be under 30. Thirty is sort of the magic level because it's a unit, in terms of the facility that we get to work with, and so that's sort of a target. So 15 is as good as 30, is whatever in terms of that, from the facility perspective. We are not giving up on the idea of moving folks to community wherever it is possible, as fast as possible. I just want to recognize out loud to this group--we're having a hard time. That is to say, the state is having a hard time.

CAROLE BOYE: Okay, thank you.

JIM JENSEN: Mary, and then...oh, go ahead, Bill.

BILL MIZNER: I was just going to clarify. When we talk about 30 beds or whatever, this isn't additional beds. But these are (inaudible) trying to get down,...

SCOT ADAMS: They're currently at (inaudible). We're going from 46 to 30.

BILL MIZNER: ...and we're reaching this point, but maybe not being able to get below that point, just because of need or whatever.

SCOT ADAMS: Yes, so today there's 46. We want to decrease to 30. And I think we can get under 30, but that's a real critical goal for us.

BILL MIZNER: So as we talk about savings and additional funds or anything like that, this isn't taking savings and using it to put in 30 beds. Basically it's funds that were hoped to have been saved or recouped, but we haven't gotten there yet, and so those funds still have to be utilized for that purpose. As I...if I understand that correctly.

SCOT ADAMS: Essentially, yes. Had the Legislature...another way of looking at the

same question is, had the Legislature not chosen to fund Norfolk this year the way that it did, we'd really be in crisis. We would just flat-out be in a crisis.

CAROLE BOYE: But specific to CJ's count, it's not 53 beds, it's 23 beds. I think that's...

CJ JOHNSON: Now I would...we have to understand that the funding that the Legislature appropriated for Norfolk was for a 120-bed program for sex offenders, okay? The money was not appropriated for behavioral health, okay? And I agree that right now...well, actually, when you look at the funding, it recognized that there was still behavioral health individuals in there, and those individuals could utilize the funding that had been appropriated for the 120 beds for sex offenders, as the transition occurred, okay? But the reality is, if you look at the number of sex offenders that are coming out of the correctional system, that it's not going to be that far down the road, okay, that all 120 of those beds are going to be occupied by, you know, by those identified in sex offense issues and are (inaudible). So when I hear 30 beds for behavioral health, it's hard for me to imagine that those 30 beds are going to be funded by the money that's set aside for sex offenders. So the only thing I can assume is we're still going to have a 120-bed facility for sex offenders that's fully occupied by sex offenders, and we're talking about keeping 30 additional beds for Norfolk. And that's why I said, you know, if you have 30 more beds there and 23 beds at LRC, that's $24 million more. So I have a hard time, you know,...

CAROLE BOYE: Is that the position of HHS?

C.J. JOHNSON: No, that money that was set aside for the sex offenders was set aside for sex offenders and 120-bed unit. And I don't think what Scot is saying is that the plan is, we're only going to allow the sex offender beds to get up to 90, and we're going to maintain 30 beds for behavioral health.

CAROLE BOYE: Scot, is that what you're saying?

SCOT ADAMS: Well, what I'm saying is we have sort of this mid-term kind of thing. We're out...the Legislature got us out of crisis mode, but we've been stuck here for awhile, and so as we all consider new methods and better ways to deal with the revenues, whatever that number is, that's a critical issue. and for the foreseeable future--that is to say, a couple of years, biennium--we're going to have probably a 30-bed mental health unit, at least, at Norfolk long term. Legislation, LB1083, encourages the downsizing of all the regional centers, and so that's the long-term strategy, and that's the law. I mean, that's the movement. I do not intend, though, to be real clear, should Norfolk need to fill with 120 beds of sex offenders, I'm not looking at building a 30-bed unit somewhere else. I hope there's a better solution by the time we get to that point, but I think that's probably on the other side of two years. Is that helpful?

TOPHER HANSEN: So the question is begged, then, what the issue is. Is it a special population issue of...or is it a capacity of existing services; that is, sometimes there are, you know...for instance, the individuals that have developmental disabilities, substance abuse, and mental health, and nobody is equipped to serve them, and that often defaults to the state.

SCOT ADAMS: Yes.

TOPHER HANSEN: Is that what we're talking about?

SCOT ADAMS: Yes.

TOPHER HANSEN: Or are we talking about capacity of existing services?

SCOT ADAMS: Well, I think it's a little bit of both. I think there can be developed long-term secure units--you all talked about that as a suggestion--in the community. I think that's a possible solution. But hot topics...the populations you talked about, and

let's pick on traumatic brain injury, for example, because we've got a lot of veterans coming home with that.

TOPHER HANSEN: Um-hum.

SCOT ADAMS: And so there's a whole other population unforeseen that's going to have to be dealt with. I prefer to think of it as a special populations question and whether or not we can cost-effectively and clinically develop those services in the community. Gosh, I don't know the answer to that one. So far we haven't, is the answer, but that doesn't mean we can't (inaudible). So my only point in the slide with the 30 beds was to...because I identified the special populations as one of the unresolved issues, and then the point about the 30 beds was just to say, within the next couple years we're probably going to have some mental health services there--just to let everybody know, you know, so we are increasingly transparent from the start. The goal is still LB1083, going to the communities as much as possible.

MARY ANGUS: I would definitely encourage you, and I think you're probably already going this direction, knowing you, to look at whatever other states may be doing, or developing something that's new to Nebraska, to avoid and prevent a situation in which we find ourselves with people who have been so institutionalized and are still so sick that we have institutionalized them by virtue of our treatment.

SCOT ADAMS: Yeah.

MARY ANGUS: Many of the people that are up there, had they not been institutionalized or treated as they were so sick you can't possibly live in society, they may not be in the position they're in right now. It's iatrogenic, in a lot of ways.

SCOT ADAMS: Um-hum. I think there's a lot of truth in what you say.

MARY ANGUS: And I would encourage you to look at anything that you can do that will not...I don't see any way we can not institutionalize mentally and emotionally ill people. I don't see any way we can avoid that. But to reduce that,...I mean, if I'm going to be in a locked situation, for even two months, and I have been, I'm going to be a little more institutionalized, and it's going to take me a lot more work than if I had never been institutionalized, if I had never been hospitalized. Anything that we can do, especially when we're talking about 30 beds that are long term; we're talking about it's that much more time in which they become institutionalized and less likely to be successful in the community.

SCOT ADAMS: You know, Mary, I think the truth of what you say is, the further down someone slides, wherever that is, in the homelessness, institutionalization in a state hospital, or in corrections, the harder it is. It takes a lot of oomph to reintegrate those people who have had those experiences, and anything we can do further upstream to be able to prevent that slide is where we want to be. And boy, I sure hope one day we can, as a state, put greater emphasis in the front end of services, so that we don't have that. To what degree do we have 46 people today that the barn door has already been...

MARY ANGUS: Yeah, I'm not saying it is.

SCOT ADAMS: Well, (inaudible). I appreciate your comment.

MARY ANGUS: But that would include ways that we as treaters increase the institutionalization, and by that I mean continuing to expose them to trauma by restraints and seclusions, by...I really cannot say how much it means when you haven't got the ability and the power to walk out that door. When you know it, there's a fire. You're at the beck and call, you're at the mercy of somebody with a key. Carole was talking about how wonderful it was, for one the people that she...I have a key, you know. Anything that we can do in the environment, in the treatment, (inaudible) informed care, is so much more effective for everybody involved. And those are the things that we really

need to look at, and I trust that you'll do it--that that's something you would have done on your own, and I'm going to encourage it.

JIM JENSEN: Scot, also a 30-bed unit at Norfolk means--at the regional center--means that there will be no Medicaid participation. That's 60 percent. That's, I don't know, the figure is $4 million? Would it be possible to have a 16-bed unit at Norfolk Regional Center and a 16-bed unit at Faith Regional Center, both in Norfolk? It wouldn't be a whole lot different than what we have in Telecare right now in Omaha. The only thing I'm talking about--LB1083 was really...there was two main emphases; one, to establish community-based services within the community so that the consumer could be close to family and his support system; and two, to maximize Medicaid funds. And I would hate to ever lose that maximization of Medicaid funds.

SCOT ADAMS: I think that's a very important point, whether it could be 16 and 16 in Norfolk, somewhere else. However, I just to assure you that we will be doing our best to move as rapidly as possible to the best solution for consumers, within the realities of where we workm, so.

JIM JENSEN: Any other comments? Yes.

SHANNON ENGLER: I just want to say, a lot of conversation about things. I would encourage you to do the right thing for the right reason for those individuals instead of, look at money, look at we need to do this or that, whatever it is. Every person has their own need. Some people need to be in a hospital in long term. Some people need to have their own house. Some people need all kinds of different things. Whatever it is, just do the right thing.

SCOT ADAMS: We'll do our best.

SHANNON ENGLER: Okay, thank you.

JIM JENSEN: Any other public comment from anyone? Thank you. Within the next two weeks I'll...we'll get together a committee to look at those numbers. Okay, J.Rock?

J.ROCK JOHNSON: I'm sorry. I have a correction for the record. The section that has to do with Mental Health Board training department duties is 71-916, and the relevant sentence, if I could...please, if people would be willing to listen for just a moment, that the department will provide training to members and alternate members of each Mental Health Board and shall consult with consumer and family advocacy groups in the development and presentation of such training. My understanding is the training is up on the web site; it's a self report, and the department has no intention of doing anything to it in the foreseeable future, which is certainly one way of keeping consumers and families out of a rightful position and of something that is a changing field, in terms of the knowledge that a Mental Health Commitment Board needs to know about; say, services in the community for out-patient. So I just wanted to make that correction to the statutory number and add that additional comment, based on the information I was given. Thank you.

JIM JENSEN: Okay, thank you. Thank you, J.Rock. Put on your calendars, at least temporarily right now, next meeting Friday, March 14, subject to change. Thank you. That will conclude our meeting.