Children's Behavioral Health Task Force
July 19, 2007

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JIM JENSEN: Try to get started. Well, welcome, everyone, to the first meeting of the Children's Behavioral Health Task Force. I'm Jim Jensen and, by the passage of this bill, I guess I am Chairman of this task force and I'm honored to be selected as that. And it's very, very important work and I think there's a lot that can be accomplished and I'm very, very pleased with the selection of the committee. And we'll proceed. And we do have just a brief agenda that is before you. I hope you've had the opportunity. It was also circulated to your offices. And if there's no additions or corrections, we will move along with that agenda. Also, in front of you is a expense document. You don't receive any pay, other than we will reimburse for mileage, and so please fill that out and leave it here and the staff will take care of that then and make sure you're reimbursed, at least for that period. Today we will really look at organizational issues, and I would really like to have your participation as we start today. Also, shortly I will ask that we go around and do self-introductions, and along with that self-introduction I would very much like to hear, first of all, where your role is in children's behavioral health, what do you anticipate this task force looking at. And then after that I would...we'll look at the charge that we have before us and I would even like to then have your participation again to look at what goals that we can come up with, and we will start to put those down as to where we hope to end up. Of course, now almost four years ago, well, and it even started before then, when the passage of LB692 was with the tobacco settlement dollars, we as a state, one of only four states in the United States, have taken those dollars and put them all into healthcare. By the way, a lot of states used theirs to help and aid and assist in their budget. Some used it to put roofs on buildings and whatever. Nebraska chose to go a different role and, matter of fact, we set up a trust fund so that the dollars that come in from the tobacco settlement go into a trust fund and then those are...we use the interest. We used some of the principal in the past. And we have set up a trust fund where we are funding, started out at $50 million, then $52 million, and it may even increase beyond that... []

JEFF SANTEMA: It's $55 now. []

JIM JENSEN: ...to $55 million. And unless future Legislatures should choose to change that, this can go on into the next century almost. Well, the reason I mention that is those dollars, with the passage of 1999... []

JEFF SANTEMA: The original bill was LB692 in 2001. []

JIM JENSEN: ...2001, but again...and actually, it even extended out before then, we had dollars coming into the state at one time to look at the difference between what Medicaid was paying for...or what Medicaid would be allowed to pay for its nursing home care, and then a difference between that and what the state of Nebraska was paying. And we had the opportunity of taking $80 million and spreading that across, and we developed assisted-living units throughout the state in a grant form. And after putting that grant money forward, there were some dollars left over and the Health Committee, which Don Wesely was Chairman at that time, was trying to decide what do we do with this little remainder, not small remainder but it was about $17 million, and there was a suggestion that we set up a trust fund with that to fund healthcare issues that would come along with a change in the evolution of things. And then when the tobacco settlement came along, we just took all that money and put it in that same healthcare at that time. []

JEFF SANTEMA: LB1070, Senator. []

JIM JENSEN: Yeah, LB1070. But along with that, at that time we funded about $19 million a year into the community-based services to help and aid those providers, and that really had a great emphasis in establishing community-based services throughout the state. Then LB724 was passed later on, then LB1083; LB1083, LB724, which both looked at the regional centers, and then also of reducing, perhaps, that population, but to develop community-based services. That was all adult driven and we didn't...we did

mention juvenile behavioral health issues in there a little bit, but we knew at the time there was not money to fund that and we had hoped that someday down the road that we could take a look at that. I think that time has come that we can do that. And, well, it is just so important. When I came into the Legislature in 1995 and went on Health Committee, it became so apparent to me as we talked to individuals with behavioral health issues, when we talked to families and we listened to the stories and the maze and the struggles that people would have trying to find services, and those were adults, and yet so many times there were issues that really manifested themselves very early on in youth that, had they been addressed and had they been addressed with therapy, prescriptions, whatever it might be, they would not have been as severe when they became adults. So this is an issue I think that is very timely. We've looked at other...we've had other studies in the past, the Legislature has, individual groups have, but I think we have an opportunity that's set before us here that we can really make some impact on the state of Nebraska. The Governor, it's certainly part of his emphasis that he wants to move on. The youth of this state are one of our greatest assets and so that any way that we can provide services for them and the best services and, of course, produce productive citizens, that's certainly our goal. Joining me at this end of the table is Senator Joel Johnson from Kearney, who is Chairman of the Health and Human Services Committee. Then to my left is Senator Lavon Heidemann, who is Chairman of the Appropriations Committee. And so two sitting senators and one has-been at (laughter) at this end of the table anyway. One thing I've noticed, that, you know, I'm not receiving the pay of a state senator, but somehow my income has increased. (Laughter) But that's...when you agree to run, that's all part of that. So with that, I would really like to start this introduction process, and as we go around the room, and I think I'm going to ask Beth to start first, first of all to tell us a little about yourself, the position that you hold, and then what you see in this very important area. The members you have before you are also on this list. And we're to have a report done by December. And then after the introductions we'll start looking at, and you people will decide, how we want to organize, how we want to proceed. And I think there are several options that are before us. So with that, Beth, why don't you just start, give us a little of

your background, what you do, and what would be your thought process as we work through this committee. []

BETH BAXTER: I'm Beth Baxter and I serve as a regional administrator for Region III Behavioral Health Services. So I'm here representing the regional behavioral health system. Region III, we're in the central part of Nebraska, so we're fairly rural. We have the tri-cities--Kearney, Hastings, Grand Island--in our region, and then a fairly rural area around us. I came to the region about 18.5 years ago to work in children's services, to look at system of care work, and really had an orientation towards that type of work for the last 18.5 years. I think my training is educational psychology. I've been in a private practice. I'm been a teacher at the...it was the Youth Development Center at that time and now the Youth Rehabilitation and Treatment Center, and just had a variety of experiences working with children and families. I think my vision for this group is, for maybe the work that we do, is looking at how we can implement a statewide system of care for children and their families based on system of care principles, such as being strength based, outcome based, community based, team focused, obviously family driven, and a system that we integrate child welfare, juvenile justice, education, behavioral health, all of those individual systems that impact children and families. Children are unique because there are lots of systems that interface with them. I'm also hopeful that we can look at how we can be preventative, prevent children from...parents having to relinquish custody of children for placement and treatment purposes, and I think also reduce the number of children that we send out of state for treatment and placement, and that we can just really be...develop a proactive, preventative, early intervention. And so I thought about this a lot and really, really excited about the opportunities that we have, because I think we're...we've looked at these issues previously, but it just seems that the, you know, the climate that we're in, I think we have a very...we have some very action oriented, let's get some things done type of work ahead of us. And it's been exciting to see what's happened with adult behavioral health reform, and so I think there's still some (inaudible). The stars are aligned, I think, to be able to make some real impact. So I'm just really delighted to be part of this. []

JIM JENSEN: Thank you, Beth. Kathy. []

KATHY MOORE: And I'm Kathy Moore. I'm the director for Voices for Children in Nebraska, and Voices...I've worked so closely with so many of you, I feel this is a little redundant for some, but Voices is a statewide independent organization that deals with all children's issues. So we are independent in that we don't derive any income from government or from state-funded initiatives, therefore, we can truly analyze what children need and make recommendations accordingly. As a multi-issue organization, that has it's pluses and minuses, because it means that we're looking at everything from poverty and healthcare, behavioral health, foster care, juvenile justice, child abuse, the whole spectrum. So we certainly see more clearly than some, the interconnectedness between all of those issues. You can't deal with one without realizing the impact that other areas, particularly poverty and some of those high-risk-factor areas, have on the connectedness between the issues. The disadvantage, of course, is that on any given day I might have to have, as I did this morning, a conversation about some completely different topics before I want into a room dealing with behavioral health, and then in the middle of the day I have to have a topic conversation about another topic. So I bring actually a lot of breadth but not as much depth as someone with Beth's background. I did start on this advocacy journey as a foster parent, so had many children in my home who were there presumably because of abuse/neglect, but as we all know had numerous behavioral health issues. I think when I look at the work that Voices is doing and how it relates to this work, Senator Jensen probably had to face me in his office at least a half a dozen times during those initiatives that he was describing when I walked in, where I would be saying, but what about the children? And so I am glad that we're here today to truly direct our attention to the children because, as you very directly pointed to, we really haven't had significant discussion or planning about children. Also, Voices for Children has been working for the last several months on a report dealing with juvenile justice and mental health, and that report will be ready for release in October. So I'm hoping, as I begin to see drafts of that, etcetera, I certainly will not

protect them and keep them from you. If it seems as though some of that information really interfaces with what we're doing here, we will share drafts, as soon as those are ready, to see how it might inform the work that we're doing here. When I look at my hopes for this group, I probably could spend an hour or two, and I'll spare you all from that. I think my first goal, I've looked for years at the fact that Nebraska has just not quite gotten its arms around what a behavioral health system should look like, particularly for children, so my first goal, as Beth said, is really to have us figure out what a behavioral health system should look like, with all of those components that she mentioned. However, I would also like us to focus a significant amount of time on the policy framework that will guide that system, as well as funding. And I know that it's scary when people start talking about money, but Nebraska has not invested a significant amount of General Fund money, if any, on children's behavioral health. So I think it's really incumbent upon us to look at what money we do have, from where, because some is from Medicaid and some is from child welfare, and then I hope that we'll truly say, all right, what will that do for us; how can we better manage and more effectively spend those dollars, but what other dollars might we need and where would we get those from; and then what box would all of that fit in the best. And I think, lastly, I would really hope that we keep looking at behavioral health or mental health, and these keep changing, in the framework of health. I think that there is so much negative stigma still on the issue of mental health and behavioral health that if we can continue to frame it in that entire healthcare discussion, for children particularly, I think it's going to serve them much better. []

JIM JENSEN: Thank you, Kathy. Todd. []

TODD LANDRY: Well, good morning. I'm Todd Landry. As of Monday, I will be the director of Children and Family Services in the reorganized Department of Health and Human Services. I come to that position, as some of you know, as...until Monday, as the president and CEO of Child Savings Institute in Omaha. And certainly I share many of the comments that Beth and Kathy indicated. I look forward to working with this group

in developing and using this opportunity that I think we have before us as we do really throughout Health and Human Services right now, to look at new ways of doing things, to look at new opportunities that we have on the table so that we can achieve all the outcomes that we really want to achieve. My background is a combination of corporate business and human service management. Spent 13 years at Conoco in Houston in a variety of corporate roles before leading a nonprofit child welfare agency in Houston, and then for the past 3 years in Omaha with Child Saving Institute. My hope with this and my vision, I guess, with what I hope comes out of this task force is really relatively broad and simple, but I think it's also very meaningful in that my hope is that when we, as we progress forward, we will have a children's behavioral health plan and an implementation plan that's going to enable us as a state to be able to help families succeed, to help those children in need reach their full potential. And if we can do that, we're going to reap tremendous benefits and reward for the entire state for many years to come. []

JIM JENSEN: Thank you, Todd. Candy. []

CANDY KENNEDY: Morning. I'm Candy Kennedy and I'm the director of the Nebraska Federation of Families, as well as a family member today and every day, I guess. (Laugh) I, too, want to...I agree with what everyone was talking about. I think that I would like to focus on a statewide system of care for children's behavioral health. I would like...simply, I would like our maze, that we've so many times spoke of that a lot of the families and children have to do, to turn it into just a streamlined super highway so it's easy for everyone to research services and to experience recovery and have a chance at a wonderful, adult, successful life and allow their families to assist them with that along the way. []

JIM JENSEN: Thank you, Candy. Terri. []

TERRI NUTZMAN: I'm Terri Nutzman. I'm the new administrator of the Office of

Juvenile Services. Been in position about three months and it's quite an eye-opening experience. I also work within the Department of Health and Human Services and Todd Landry is the director that I will be working with within the department. Give you a little bit of background: it's quite diverse and I've held many different types of positions within...and Kathy shakes her head--I've known Kathy for a long time--within the juvenile justice system and even outside of the juvenile justice system for a number of years, beginning in 1978. I was a juvenile and adult probation officer for approximately six years. After that, I became an attorney with Legal Services at Southeast Nebraska and worked with Roberta Stick in Lincoln, did a tremendous amount of juvenile court work defending parents in child abuse and neglect cases. So I was able to get the perspective of the parent in these situations and the problems that they had with regard to getting the type of services that, you know, they needed to keep their family intact or bring their children back into their home. I also worked for the Douglas County Attorney's Office as a juvenile prosecutor and, actually, Judge Crnkovich was also in the Douglas County Attorney's Office at that time and she trained me to become a prosecutor. []

ELIZABETH CRNKOVICH: Explains a lot. (Laughter) []

TERRI NUTZMAN: Absolutely. (Laughter) So I was able to learn about the system and some of the good things that were happening, and also some of the things that needed to be changed during that period of time. So I was able to get that perspective. Also, while I was in Douglas County, I also worked as a guardian ad litem. I was appointed guardian ad litem by the Separate Juvenile Court of Douglas County and also the district court in domestic custody cases where I worked with health professionals and developed programs for youth and families. Then I was an attorney...assistant Attorney General for approximately seven years; started out in the Child Protection Division prosecuting misdemeanor...well, actually, felonies throughout the state of Nebraska in child abuse and neglect cases, so worked with victims. Got very close to some of those child victims and that was a very rewarding experience, but also, again, understanding

the need when working with those child victims, the need for good treatment and good consistency in treatment. And now, as I indicated, I am with the Department of Health and Human Services, administrator of Office of Juvenile Services, and my job responsibilities at this point in time are overseeing the Youth Rehabilitation and Treatment Centers in Kearney and Geneva, and working with the different service areas and the juvenile service officers, as well as the protective service workers, and sometimes they hold dual roles, in developing programs and providing treatment for our youth that are in the juvenile court system. As far as what I would like to see some of the goals for this particular committee, I want to see that...we need to work on the fact that children and families need to have individualized treatment programs in the least restrictive environment while affording safety to the youth and to the community. I think that's very, very important. We need to develop a system that is going to ensure that. I, too, Kathy, agree that we need to come up with a definition of what children's behavioral health encompasses; you know, what the system looks like; who the players are; how do we work to...what their roles are, each player's role; how do we work together to accomplish the goals we have set; how do we measure; and once we've accomplished those...how do we work together to accomplish those goals and then how do we measure outcomes so that we know we are actually achieving our goals. And I think that's a big issue right now. You know, sometimes it feels like we're spinning our wheels. We all have good intentions, but are we actually giving...delivering what we feel we are delivering? And the only way I know that we can do that is to develop a system to measure the outcome of our goals. I have a whole number of things that I would like to see this committee work on, anywhere from exchange of data, okay, good information systems, continuity of care, building on the history of treatment so that we aren't repeating treatment. We build on that history. Everybody is privy to that so that we can continue to treat families and youth. Providing comprehensive treatment programs for youth; we have a lot of youth that have dual diagnosis of conduct disorders, chemical dependency, anger management, mental health issues, sex offender issues. We have kids that are DD, developmentally disabled. And a lot of our kids that are in the juvenile justice system have many of these, more than one, certainly, of these

diagnoses, and we need to be treating these diagnoses all together. You know, what can we do as a system to work together to help families before they come into the system? I think that's very important. You know, we have diversion programs. We have Health and Human Services where we do some voluntary work, you know, with them before they come into the system, but we need to expand that. You know, we need to be able to provide services to work with families and youth before they come into the system. We need to bridge the gap between out-of-home placement and when we're moving them back into the community and back into the homes, called a reentry program, because there is a big gap between out-of-home placement and getting them back into the home. There has to be something there that's going to ensure transitionally to take them back into the home successfully, and that's going to include wrapping around services with the family, even in advance, I think, of taking that child back into the home. An area I think we really need to work on, and I want to see something come out of this committee, is decisions about the YRTCs, okay? []

ELIZABETH CRNKOVICH: Oh, I just wrote that down. []

TERRI NUTZMAN: Oh, okay! (Laughter) []

KATHY MOORE: (Laugh) You trained her well. []

TERRI NUTZMAN: Okay. Decisions about the YRTCs: Are we going to build capacity at the YRTCs to treat in a secured setting? Are we going...and how are we going to do that? If we decide we're going to do that, are we going to bring community-based providers into the facility to provide that treatment, or are we going to maybe hire staff that can provide that treatment? I think we need to look at the need for treatment programs within the YRTCs. We need to look at the need of maybe specialized RTC programs, residential treatment centers. I want to tell you kind of what we've been doing at the Department of Health and Human Services. Since I've been here for approximately three months, but my predecessor was always also working on this, what

we have done so far with regard to the YRTCs, and again, we're going to be willing, I think Mr. Landry will, although I haven't talked to you about it (laughter), but so far what we have done is we have brought Dr. Edward Latessa. He's from the University of Cincinnati. He is an expert in evidence-based treatment modality, particularly the cognitive behavioral approach. He has gone in with his team, and he's already done and he's gathered information and they're compiling that right now and they're going to have the results of their study and their recommendations to the department probably around the middle of September with regard to the program that is currently out there in both YRTC-Kearney and YRTC-Geneva--they went into both facilities--with regard to what's going on right now out there and what recommendations they would have as far as the treatment modality. The other thing that we have done is we are contracting with Ed Loughran right now. He's the executive director of the Council of Juvenile Correctional Facilities, which is an organization representing CEOs of state juvenile facilities in the United States, and he is centered out of Boston, Massachusetts. He is going in August 20 with his team and he is going to look at structure, organization, and security. So that's his part of it, and he also will have his story and his recommendations done around the middle of September, as well. So once we get all of that, I believe, and I will talk to Todd about this, but potentially we should be able to share that...and Scott...we should be able to share those results with you, which will give you a really good idea, I think, of what's going on the YRTCs. So I have big hopes for this committee. I'm excited about it. This is my passion--juvenile work; it always has been. And so I'm really looking forward to working with what I think is a really good group of people to guide and direct the future of our system. []

JIM JENSEN: And all that and only three months on the job. []

TERRI NUTZMAN: Yeah. (Laugh) []

KATHY MOORE: Well, and if I could editorialize and add to Terri's list, when she talks about YRTCs I want to make sure that we remember Hastings Regional Center in that

context. []

TERRI NUTZMAN: Yes, also Hastings Regional Center. Uh-huh. []

KATHY MOORE: Because I didn't really mention that and should have, and that's really what drove the original introduction of LB542. So it's kind of that elephant in the middle of the table. And Hastings Regional Center, some of it, is RTC related but some of it is not. []

TERRI NUTZMAN: That's correct. []

KATHY MOORE: So you could...if you would accept that (inaudible). []

TERRI NUTZMAN: I'm sorry. I was going...well, you know what, I was going to mention that and I didn't, so thank you, Kathy. (Laugh) []

KATHY MOORE: (Laugh) So was I, and I didn't either, so... []

JIM JENSEN: Okay. Ruth.

RUTH HENRICHS: Good morning. I'm Ruth Henrichs and I'm the president and CEO of Lutheran Family Services of Nebraska. We are a statewide agency that really has three distinct areas of work that we're involved in, one being behavioral health services, including both substance abuse and mental health; child welfare services or children's services--adoption, foster care, child sex offender treatment--but child welfare related kinds of services; and then community services which address very specifically immigrants and refugees among us. And we find that that work more and more gets connected to behavioral health simply because as we have more and more children of new Americans here in the state there is more and more interconnectedness between that. So I face the challenge of integrating a system within one agency that has three

distinct ages and areas of work, and I think my hope for this committee would be that we would be able to develop and...I guess my hope would be that we could look at new ways of doing old business. The business is really caring for kids and making sure that we raise healthy kids and give them the best possible chance of success, and Nebraska has a lot of work to do in that area, but I would hope that as a group we would be willing to have the courage to think high enough and not get into the detail immediately so that we can really look at systemic change. And I agree with you, Kathy, that has to do with policy and that has to do with being willing to say, even though Lutheran Family Services has always done this book of business, maybe we don't do that in the future. Or maybe XYZ organization has always done this, but maybe going forward someone else should. Maybe it is the private sector. I hope we can really look openly at new ways, because the business is the same. We have new language. I've been around 30 years. I've seen these task forces many times over and I think it's time to have the courage and I think the climate is there for that. So I'm optimistic and hopeful that we will all be willing for a period of time to take our own hat off and say, how can we get better outcomes and what is it that we need to do? I agree with the portability of assessments. It's absolutely a waste of time, energy and money to do a new assessment of a child every time we put them in a different silo. It's absolutely a waste to have parents being funded and treated by this set of providers that aren't even talking to the providers in my children's services unit that are working with Liz's kids who came for sex offenses. That is absolutely ludicrous in this day and age. I would hope we would have a data system and the policies that would allow one assessment to be seen by everyone. So I think we need to look at changing the policies and the things that will make that kind of access and portability and partnership a possibility. Personally, I have...the experience coming out of where I've worked these 30 years is on the lower end of the continuum, the outpatient end. I don't have experience in running residential treatment facilities. It's on that other end. Think the last thing I would say is I want to support what was just said about the YRTCs and Hastings. I think that's critical to the discussion and we cannot avoid that elephant in the room, as we cannot at some point avoid the role of unions in all that of the conversation that goes on around the delivery

of service in this state. So I'm optimistic and I'm hopeful, and I thank you for allowing me and inviting me to be part of this. []

JIM JENSEN: Tom. []

TOM McBRIDE: I'm Tom McBride. I'm the director of Epworth Village. We have a mental health, behavioral healthcare system that we've developed over the past, about 15-16 years. We've been around for 119, and done everything from orphanage style of care to what we're doing today. First of all, thank you for the opportunity to serve on this and the appointment. There's people around this table and in the chairs back here and outside of this room that I have respected and really just been in awe of for a long time. I think you've got a terrific, terrific bunch around here. I've been involved in human services for over 30 years and started in adult corrections, both male and female adult corrections, and indicated at that time to me that after a number of years in that, that maybe we needed to try or I needed to try something working with children and see if we could prevent some of that revolving door aspect that we were seeing. I think that was a tremendous, tremendous experience for me and the last 20 years now I've been involved in working with children and families. And if you talk to my family, they'll say it's the best 20 years of my life because we really, you know, believe in what we're doing. And we've got a...you know, you talk to people from different states and we talk about, you know, the problems that Nebraska has and, yeah, we do; we can get around some of those. But, you know, when you talk to some of these other states, I am so glad that I'm in Nebraska working with people in the system, you know, that we have here. Started out as a therapist and also hold a master's in healthcare administration. We have the RTC experience. A lot of people think that Epworth is just a residential program. We have two residential treatment units. We opened the first treatment group home in the state of Nebraska. We have three of those. We have group home A in Grand Island, and also have a very large day treatment population, outpatient population. Work with local school districts in some education components, and we have two separate education venues that we work with--an alternative school that has

been hugely successful, and then a level three, or now they call them Rule 18 interim program schools. And just, you know, we have an opportunity to work with people from across the state. We're, sometimes in York, we're considered in the rural part of the state and that's okay. We like that. But we really have exposure to, you know, working with kids and families from Benkelman, from Chadron, from Omaha, from Sioux City, you know, every place around there. Some of the experiences I've had is within the system in Nebraska comes out of the work we do daily, affiliations within the Nebraska Association of Homes and Services for Children, Children and Family Coalition of Nebraska, NABHO. Have also, I don't know how many years, been on the state advisory group for juvenile justice and was Chair for four years, and also the federal representative on the juvenile justice federal advisory committee. You know, for the future, I see this as really an opportunity to finally congeal program systems and develop a vision, a road map. I was thinking, you know, coming into this, in my tenure at Epworth Village we've had eight different department directors and I think probably eight different directions that that's coming out of. And I think that with some of the work that can be done in here that, regardless of who moves in or out of that, that we have a road map and a place to go with that. Well, there will be idiosyncrasies, you know, specialized things that will be developed by that person, yes. But, you know, as providers, as juvenile...Office of Juvenile Services case managers, case managers, administrators, whatever, we need to have a vision and everybody needs to, you know, kind of know where that is and how we're going. One of the things I think that is going to be important also within the work we do in here is monitoring other aspects of legislative reviews, other legislative attempts that, as we're marching this way or trying to identify something that is going to go down this road, that we don't have, you know, other studies, committees, legislative efforts that derail that because we're looking at this. And, you know, and I talk, like, right now there's a...I think it's out of LB316 on special education services, and there's a committee looking at special education, State Board of Education, which will have a direct impact on the services these kids believe...receive. I just...I echo everything that's been said, recognizing that we also can't speak in absolutes all the time. As we talk about early intervention, there will be those children

that are impacted very positively by early intervention; there are those children that are going to need ongoing assistance; and we have to recognize that we also have chronic behavioral health/mental health, you know, kids. And so the plan has got to be developed to manage all of those. And I'm excited. I think this holds tremendous potential for the state of Nebraska and I think that it was an important piece of legislation. I'm just, you know, honored to be a part of it.

JIM JENSEN: Great. Judge.

ELIZABETH CRNKOVICH: I'm Liz Crnkovich and, true be known, my real qualification for juvenile justice is I'm number seven out an Irish-Catholic family of eight. (Laughter) []

(MAN): (Inaudible). []

ELIZABETH CRNKOVICH: You must (inaudible) that. Right, yeah. But actually, I'm a juvenile court judge in Douglas County, Nebraska, 12.5 years now. Before that I served as a deputy county attorney in Douglas County prosecuting in juvenile court, and I did that for nine years. And so I've worked with many of you, have worked with children and family (inaudible) services. I guess I'm...I, too, truly am honored. I just think this is a great opportunity and I would ditto, ditto, ditto, ditto, ditto what everyone has said. I guess I'm here to...I like that notion of a common vision. I think we do have to...we all have a whole laundry list of things, but to begin with finding that common vision, because I just feel like if we can start there everything else will fall in place. But also more than being a judge I very strongly believe in the responsibility to get off the bench, and I think I've demonstrated that over the years by being a part of committees and new adventures and (inaudible) but so that to bring together the best of the services and the court piece, which I view as the accountability piece. And so that includes meetings. It includes the opportunities I've had through drug courts. I've presided over a delinquency drug court for seven years and have been doing a family drug court for three years now, which is just that particularize idea of bringing services and court together in a whole

unique way, has just changed everything about what you do in the whole system, not just in terms of what you do with chemical dependency. There was a time early on in my involvement in juvenile justice where those kids who were law violators did not have the benefit of the services that other kids who might come before the juvenile court had, and I know Kathy Moore was a mover and a shaker in terms of, you know, the office, even thinking up the Office of Juvenile Services and everything else, and more power to you. What I'm seeing, though, is... []

KATHY MOORE: But we're still not there yet. (Laugh) []

ELIZABETH CRNKOVICH: Well, and my concern is a trend then, now that we've opened the correct door to providing those services, we're forgetting about accountability, and there is still that piece that...not only with the piece but with the families. And as we speak, we're sitting here assuming that every family is just dying to jump into the array of services that we have to offer them and that simply isn't the case. []

RUTH HENRICHS: (Laugh) Yeah, absolutely. []

ELIZABETH CRNKOVICH: If anyone said, you better quit doing that, to you, you know exactly what I'm talking about. So what we...and I think each...everyone has touched on every little bit, that array of services individualized, but I think what we want to make sure we have is the entire array, from the least restrictive--that sounds like an accountability, but it's also community based, which is the services side--to the most restrictive, which again is accountability but also RTCs and services. So I think the best meeting...the needs of the kids is going to require that whole spectrum and not services without accountability, any more than you want accountability without services, and that includes the YRTC-Kearney, which...the other...the other concern, and sometimes you...it's very hard but you have to step out of what you do occasionally and say what am I seeing in terms of trends and things. And this isn't so much a court issue as more

and more there are mental health and behavioral health services through Medicaid that are available to families outside of court. We don't want to have to have them make their kids state wards. But I'm starting to hear testimony and to see things that raise concerns about who's accountable; who's making decisions outside of Health and Human Services and outside of the court system about kids going into foster care because they can go into foster care now without those; about who's providing treatment. I had a--I don't want to just tell stories but just to tell you where I'm coming from--testimony about a ten-year-old who wasn't with any government agency but was getting Medicaid money, was being seen by psychiatrists. The therapist, it's not about the therapist, I'm just thinking, well, you don't know this person. You know, if it were my kid...Mom is at work. A therapist comes and picks up the ten-year-old, takes him to psychiatric appointments--Mom is nowhere around--prescribes medicine, takes...goes to have therapy treatment at school and then sometimes at home. And then Mom is...this mom isn't thinking anything of it, and I'm thinking, oh, there's something brewing out there that we need to be aware of and want to make sure that there's accountability. So I think that should be thought about and looked at too. Anyway, I just want to work with you all and I'll save my laundry list for later. []

SCOT ADAMS: Don't you think it's all been said already? (Laughter) Good morning. My name is Scot Adams and I have the honor of serving as the director of the Division of Behavioral Health Services for the Department of Health and Human Services. It's a new spot for me, twice new actually. The Health and Human Services organization was reorganized effective July 1. And prior to July 1, I was the director of the Department of Services for that organization and I got to see a lot in a short period of time. My phrase was that it was like drinking out of a fire hose, and I think that this committee will have a bit of that sense of things as well as we go through the issues. I'm very excited to be here. I think it's a wonderful opportunity for the state of Nebraska for a couple of reasons. I think that from the Department of Health and Human Services' perspective, there's an unusual moment of unfreezing, if you will, and openness to change that probably doesn't happen all that often in government institutions. New structures, new

faces, new people, new business processes are at play and so it is a time ripe with potential and I hope we're able to realize that. Before coming here my job was with Catholic Charities of the Archdiocese of Omaha for 31 years, and I was a substance abuse counselor for awhile and a fund-raiser for awhile and different things, and executive director for the last 13 years. Served a lot of different needs and issues, much like Ruth in terms of a multi-service agency focused in different areas. And, Kathy, I agree with you about the impact of poverty on all of this as a theme that sort of undergirds and makes everything more difficult across the board, and I hope that that's a dynamic that we keep in place. Some of you talked about goals and hopes and elements, if you will, for this committee to work with. I jotted down some things and I think a number of people have touched on many of these, but certainly following the money is an important element to that. The development of sound policy is going to be an important element of that. I think that the relationship of the public sector and the private sector, the roles and responsibilities there, the opportunities for partnership. A particular one, the relationship of Medicaid and private insurance, I'd like to encourage examination of that. Think we should look at facilities, other kinds of resources. I think staffing resources in this state and the spread and the deployment of staffing...qualified staffing resources across the state is a critical issue that is becoming more and more difficult. Judge, I loved hearing you talk about accountability. I hope that we can talk about making sure that people just do their jobs. []

ELIZABETH CRNKOVICH: Right. Yes. []

SCOT ADAMS: Just do their jobs. []

ELIZABETH CRNKOVICH: (Inaudible). (Laughter) []

SCOT ADAMS: I tell you, it's...boy. The need for data and good information is a sorely...is a sore spot. It's one of those things that people like to chalk off to administrative expense and, therefore, let's not put money into administration. Boy, you

come to a place like this and all of a sudden we want data and information and it's difficult to come by that's accurate. I hope that we retain a wide view, not just services. That's sort of not even the point of it. If we're about a wider view, we wouldn't need services in an ideal world. But I also hope that as we look at it that it's not just about services and actually not just about kids. That's too narrow. It's not just about families. It's is about communities, I think, and the strength of Nebraska over all. Kids lead to that. But it's not...they're not the only component and not the only piece that factor in that. There are oftentimes unintended consequences to decisions and to actions, and I hope we consider those as well. Finally, throughout this process I'm going to keep one kid in my mind that I've come to know recently. He has been...he has been through at least two acute care hospitals. He has been through six private providers. He has been out of state of Nebraska. He has been brought back to the Hastings Regional Center and in five weeks at the Hastings Regional Center has not had one family member call or visit. This is a sad situation. He is 15 years old and that's the kid I'm going to keep in mind. []

JIM JENSEN: Thank you. Senator Johnson. []

SENATOR JOHNSON: Well, Todd, let me tell you I'm kind of disappointed. When we heard you were from Texas, why, we thought you might have something to do with the Dallas Cowboys instead of Conoco, but (laughter)...and, at any rate, why, let me tell you kind of a little bit how I see things. And first of all, one of the things that is the common denominator of everybody around the table, and I think it's extremely important, is that you are forward-thinking people and see the state as a whole, and that was one of the criteria that we emphasized in looking through. Because we had a good group to select from and I think we got the cream of the crop after, as we look around here. Let me tell you just a couple other things. One is when Governor Johanns came before several of us in the Legislature to talk about the mental health reform and so on, soon as he was done Jim Jensen and Senator Byars both said, Governor, we think this is a huge step in the right direction, but let's not make the mistake of tearing apart the old system and not

constructing a new system. And so I think we're in kind of a critical place right now that we go forward with that second step. And so one of the things, let me just kind of tell you what else I've got on my agenda here regarding this, and that's this; is that last fall we made a tour around all six regions in the state and the one common entity in every place was that we need mental health workers, not just psychiatrists but the gamut from top to bottom, and they are in very short supply. So one of the things that I'll be working on this fall is trying to figure out different things that we might do to increase that supply of mental health workers, again, from top to bottom, so that these people are out there. Because you cannot have a community-based system without having these available; that I think it's an impossibility to have a system. So that's one of the things that we'll be working on, and I think it's an extremely important part of this. Then the...kind of along with that I've got another thing going and just make you aware of this one as well. I don't anticipate that this next one will come to any fruition this coming year or this coming session, but around the United States there are states that are becoming more and more concerned, as well as the national government becoming more and more concerned, how we are going to be able to fund healthcare. As you look at the demographics of the United States, we have a lot of people who, at the rate that they're going in how they're conducting their own personal health, they're going to be...end up being diabetics, which, by the way, accounts for about 50 percent of the money spent on healthcare. And so if we double the number of diabetics just from a dollar-and-cents standpoint, you can see that you're in huge trouble right there. But the other ones that are out there are things like hypertension, which lead to strokes, kidney failure and so on--again, hugely expensive things. And I could go on with several others. Someone from the Surgeon General was...Office nationally was here about a week ago to kind of put a little emphasis that we need to change the course of public health and that this...we have to look at it from that standpoint rather than figuring out how to fund these diseases after they become such huge problems. The United States nor no country in the world can afford to do this. And just one little thing about it. Had the good fortune of sitting by the Minister of Health for Scotland here a few months back and over the course of the meeting had conversations with him about this, and basically he said that

we have to develop the best public health systems in the United States. That's the only way that we're really going to be able to afford this. And we've got a lot of work to do in Nebraska. There are only a handful of towns, for instance, that fluoridate their water and it is the single cheapest and most effective thing you can do for dental care. And yet, like I say, you'd be surprised how many towns do not have fluoride in their water. It's a lot easier when you can use about one hand to tell the cities that do. So those are the kind of things that we must go on this. There are people who are very much interested in this kind of issue. Our thought is to raise the awareness amongst the people of Nebraska, not just with healthcare providers, but we have a very viable insurance industry, etcetera. How best can we attack this in the future? There are a half a dozen states around the country that are implementing legislation to do something. We might be well off to just stand back and see how these different plans work for a year or two, and then go from there. So that's kind of what I have on my agenda here in this coming period of time as well, and they do kind of blend in with what we're talking about. So I am delighted that we...all of you have agreed to participate. This is, if you stop to think of it, kind of like what we're talking about on the national basis of preventive health. This applies here. If we do a better job with our children, hopefully we won't end of taking care of so many expensive things down the line. So that's where we're coming from and let's do a good job. []

JIM JENSEN: Thank you. Senator Heidemann. []

SENATOR HEIDEMANN: Hello. After listening to you all talk and realizing the depth of expertise (inaudible) you have in this, I decided that the best thing that I can do here is listen and to learn, because I'm not an expert at what we're dealing with here. So I think the best thing that I can do is listen and learn. I think we put together a great task force. The one thing that Terri said that hit home with me is passion. If I have anything that I can contribute, there is passion here with me to do the right thing. Ruth said take your hats off, and I think that's very important because sometimes when we get something new started or a task force together we have always somebody coming up and saying,

what's in this for me, and I think we need to get past that. And I think we need to do what's right for the people that need these services, and I believe that would be a goal of mine. And once again, I am Chairman of Appropriations Committee, and I think you had mentioned follow the money, and eventually we will only have so much money to spend so we need to figure out the best way to do that, and that's very important for me, too, so (inaudible). []

JIM JENSEN: Okay. Thank you. Yes, Candy. []

CANDY KENNEDY: Senator Jensen, I'm sorry. You guys, I'm new at this and I was very nervous and actually, after hearing everyone speak, I thought maybe it would be appropriate that I explained exactly what the Federation of Families...who they are and what we do a little more, and maybe my background. My personal background is I actually have a background for 20-some years in clinical nursing and administration. And, of course, as I say that I'm a parent of a son with bipolar and so that's actually my experience with that. The Nebraska Federation of Families for Children's Mental Health is a statewide organization and we actually have seven family organizations to complement each one of our regional behavioral health--two in one region is why--and we work directly with family advocacy for the children and are the voice of the families to try to let everyone know, first, to receive the services, what we need to do to help them navigate the system and to explain to everyone what the difficulties are and challenges and what the needs are of the families. And basically if I could...a lot of the things I've been to, speaking nationally, at national conferences to hear what's going on around the nation, and I do know that we have a lot of work to do. But if I were to go to one of these conferences and explain this room of people and what we're talking about today, it's just incredible. It's more than anyone could hope for. So I am very, very thankful. And if I were to speak as a family member, the two words that seem to fit in every conversation that I have with everyone is "hope" and "fear." Those seem to be what family members deal with the very, very most. So thank you, and sorry I...(laugh) []

JIM JENSEN: Thank you. The task before us, and there are really eight different items that were addressed...by the way, this bill...or this results from a bill that was introduced by Senator Synowiecki, and I had hoped that he would be here this morning. He said he was going to try to. But he introduced it as a bill that would have changed and taken some of the funding certainly from the Hastings Regional Center and put that into community-based services. And as so many times, as you work through bills, and he decided after consultation with many people and with the senator representing Hastings that we do this in the form of a task force. So that's how this actually came about. But there are eight different items that are discussed within there. Now how we proceed from here, and this is your committee and so I really want to throw this open and talk about a couple things, and then I want to get into some goals and we'll actually put those on paper to examine where we might think we want to go, but we've also got to look at a time table. First of all, today we will break at noon and after lunch then we come back and we'll have a presentation from Health and Human Services that kind of tells you where we are. But along with that, we are to have a report back by December 1. How many times we meet, how many...what does it require or what is required of us to come to a conclusion I think we'll have to decide. Certainly we must meet, I would think, more than once a month. And so we're all busy people and how we arrange that we'll have to see. There are some things that perhaps we need to explore a little bit as we look at that time table, too. Should we, at some point in time, look at some of the facilities in the state? Certainly Hastings has been thrown out on the table here many times. How many of you have been to Hastings? If most of us have, maybe that's not necessary. But are there other facilities? Do we need to go to Epworth Village and see how...or something that Beth or Ruth is involved in, and those are things perhaps we could do in-between meetings, too, by touring of what is available. I'd like to throw out, too, should we bring in a facilitator? It's been done before. We do have...there is funds that we could do that, to bring in a facilitator to look at where we have been in the past, where we are at the present, maybe what we wand to look to in the future. Then how do we, when we get ready for a report, there's an authorship that somebody needs to put down on paper that we can present. And then whether the Legislature decides to come

up with some bills, that's their purview. So those are things that are kind of out there. I would like to kind of move towards goals of what you see might be goals and hopefully we can...not "hopefully," but we'll see how far we can go. If we can get those done before noon, I think that might be worthwhile. And then maybe that will lay before us how should we proceed in the next several months to come up with a report back to the Legislature. And then these very...these eight items, do we do those, divide them up and say take two at the next meeting, two the meeting after that, and so on and so forth? Again, that's all items that we could do. There were a tremendous amount of things that were mentioned as we went around the room, and a road map, accountability. There's one that wasn't mentioned that I think we sometimes need to think about, too, and that's how can we involve the private sector into this. We do have finite amount of dollars within the state budget and how can we involve communities, how can we involve the private sector, perhaps, into this might be something also that we might look at. Certainly that parental involvement--you know, we have looked and the state has addressed education issues--so many times the difference between the education of a child really results in that parental involvement, no matter where they are along that system of care. So those are some things that we'll throw out. But what I'd like to do at this present time is...and, by the way, we do have staff here: Jeff Santema, who is the legal counsel to Health and Human Services Committee; Erin Mack is the committee clerk to Health and Human Services; and Kendra... []

KENDRA PAPENHAUSEN: Papenhausen. []

JIM JENSEN: ...yeah, is the (laughter)...that's a easy one...is on Senator Heidemann's staff. And so we do have good clerical and assistance to help us throughout this process. Certainly all correspondence comes through the Health and Human Services Committee, to Jeff and to Erin, and then we'll distribute all that from there. We've kind of decided that perhaps the three at this table, right after this meeting, will sit down and also talk a little about how we can serve you the best also. We're going to have time for public comment later on this afternoon, and we always enlist that from anyone who is in

the chairs behind us, and we do solicit that; also solicit at any time any e-mail letters that any of you have along the way that we can feed in, and then distribute them from there. So let's just talk a little bit and throw some things out--and, Erin, if you would man the board there--of goals that you think that we should be directing this task force to. And so let...excuse me. []

SENATOR JOHNSON: No, Jim, I was, if I might, I was going to say one of the things is that this did come out of a bill that originally Senator Synowiecki had in regard to Hastings, the funding or changing things there and so on, but I'd be greatly disappointed if that's what this committee turns out to be is just looking at Hastings. I think that we need to look at the full system and that what eventually becomes of Hastings is part of it. And so I would, I guess, plead with you that we show this broad vision that we talked about at the table here this morning. []

JIM JENSEN: Thanks, Joel. I might mention that the Behavioral Health Oversight Commission introduced or passed a resolution to look at the long-range view of the three regional centers. I don't know if that's going to actually come to fruition or not. There's some discussion still going on, on that. But I did receive several comments from individuals after that resolution was passed--well, why just the regional centers; why not the 24/7 facilities that the state operates--the YRTCs, Beatrice. The veterans' home are also part of that 10...24/7 facilities. Well, the veterans' homes, the new one in Bellevue that will replace the Fitzgerald Home, and so the veterans' homes seem to be on a pretty secure path. But the other 24/7 facilities, maybe they all should have been examined, but we'll see where all this comes from that too. []

BETH BAXTER: And I think I could make a comment here, and there are others around the room who worked really hard with LB542 and maybe just some assurances. Because I think really the initiative started out of looking at a comprehensive system of care for children. Just based on some of the work of people around the table and our colleagues, that's really where the impetus came from. What was...you know, and

through the process of bills and so forth we came up with maybe something different than we started with. So I just want to share, folks, that that really was the impetus, I think, behind where we are in this process today, was really to look at the whole system and how we could do that. []

JIM JENSEN: Okay. Well, let's just throw out, like I said, some goals, and many of you mentioned them around the room, but things that we might look at and, as a committee, try to come up with. []

KATHY MOORE: And when you're asking for goals, are you asking for the end result, the end product, or are you asking for the process that will take us toward the development of a plan? []

JIM JENSEN: I think, yes, that would direct us towards completion. []

KATHY MOORE: Okay. So kind of a strategy type (inaudible). Okay. []

JIM JENSEN: Yes. []

SENATOR JOHNSON: Well, then I guess I think maybe there's two kind of goals, too, Jim, in that maybe we're talking goals that would be implemented through the reorganization of Health and Human Services now without legislation and then also look for the potential for additional legislation that might come out of these goals as well. So... []

JIM JENSEN: Okay. []

KATHY MOORE: Well, maybe if I throw one out we'll see exactly where...which direction we want to go, because I do think there are process ones. For instance, money, and you have the money sitting on the table here, so to speak, I think all of us,

as we looked at what we were saying, we were mentioning the most effective use of dollars to provide the full array of services in the least restrictive way. So a goal, you know, an end result is that, is the most effective use of our dollars. However, for about 20 years I've been trying to understand exactly how many dollars we have and exactly where we're spending them. So the process that...I would like to believe that this committee in the next four months is going to have the most comprehensive understanding possible of current expenditures of state...probably state and federal dollars. So I'm not sure... []

JEFF SANTEMA: So it's an education process you're talking about, Kathy? []

KATHY MOORE: Yeah, it's a...I feel as though we have to have more information put in front of us, but the goal ultimately is most effective use of dollars and identification of how adequate or inadequate those dollars are. []

TODD LANDRY: So kind of a two-step thing: one, an accounting of the dollars currently being utilized for children's behavioral health, and the second piece is a long-term plan or long-term vision of how those dollars should be most effectively spent. []

KATHY MOORE: And how sufficient those dollars are... []

TODD LANDRY: And (inaudible). []

KATHY MOORE: ...so it's really...so it's the gathering of information, the analyzing of the information. So gathering information about current funds available. []

BETH BAXTER: I think I'd like to add, too, and it's probably a process...we're in the process of orientation, but I think that we utilize efforts that have begun. And when you talk about the gathering of the financial information, I think through the state infrastructure, the Children's SIG grant process, there's been some work to gather that

kind of information. So if we could just utilize things we already have in place and maybe enhance or those types of things, but I think that the SIG process is a great resource for us. I think we have some maybe new opportunities with the SIG process now. []

KATHY MOORE: And then if I could carry this to completion then, the next one up there would be analyzing adequacy of funding. []

RUTH HENRICHS: Adequacy of funding, Kathy, assumes that we know what that continuum and that integrated... []

KATHY MOORE: Right. Right. Would look like. []

RUTH HENRICHS: ...requires. So really, to do that one, we have to have a goal up there somewhere... []

KATHY MOORE: Right. []

RUTH HENRICHS: ...of understanding what that...identifying or naming what that continuum is. []

KATHY MOORE: Right. Well, right. And then the next goal I was going to put up there was then making recommendations about funding needs, but then your point absolutely tied to the system of care that we believe...that we recommend. []

RUTH HENRICHS: Right. []

TODD LANDRY: What are the services and settings required to meet the needs of children's behavioral health. []

ELIZABETH CRNKOVICH: Well, that was one of the things I'd written originally and didn't say. That's our challenge, that...the challenge of fiscal responsibility in the context of raising kids and giving them what they need. And basically, you're saying we have to start. It's our responsibility to look at the family budget and say where's the money going... []

KATHY MOORE: Right. Right. []

ELIZABETH CRNKOVICH: ...and why. And we can't get anywhere till...is basically that's what you're saying (inaudible), you know. []

KATHY MOORE: Yes. Yeah, that I don't think we know. []

ELIZABETH CRNKOVICH: What's coming in and what's going out and where's it going, and then you kind of go (inaudible). []

SCOT ADAMS: And I would just add the comment in the analysis, compared to what. Dollars are just dollars, but it's then compared to what? Optimum? Compared to cancer research, compared to liver transplants for kids, compared to expenses on kids for education, compared to what? Otherwise, it's just a number. For instance, is $79 a kid for every kid in the state too much, is it too little, is it adequate? Compared to what? So context and purpose is important analysis of (inaudible). []

CANDY KENNEDY: And I think for a foundation that we have to have a common knowledge of exactly what services...what is being offered right now, what's being done. I think that everyone knows their piece of it, but they don't necessarily know the whole picture. []

ELIZABETH CRNKOVICH: And does that go back...I don't...it's just one of several goals we talked about. Before we can go anywhere, we all have to reach a point where, when

we speak of children's behavioral health, we all have a definitive idea of what that means. []

KATHY MOORE: Common vision, the common vision is the word somebody used. []

ELIZABETH CRNKOVICH: And that includes, yeah, that includes the definition, what it entails, and what services. []

TERRI NUTZMAN: Uh-huh. Uh-huh. I think you have to start with that goal first. You have to define what children's behavioral health actually encompasses, okay? Once you define that, then you have to look at what the system looks like, identify who all the players are: community, service providers, Department of Health and Human Services, the courts, the family, and the youth. Okay? []

ELIZABETH CRNKOVICH: And community, we talked about. []

TERRI NUTZMAN: And then once you decide who all the players are then what are their specific roles. What are they providing, you know, within the system? And then how do you work together to accomplish those goals? And then again, then how do we measure outcomes? Are we being successful. And then comes, you know, the issue about money, all right? How do we use it cost-effectively then to meet the goals? []

CANDY KENNEDY: Yeah, and along with that we might look at, yeah, what is...we do have some things in our state that are on the horizon, number one, and that are happening right now that are very effective, that are working well. There's the opposite, too, but...(laugh) []

BETH BAXTER: And I think if we... []

ELIZABETH CRNKOVICH: That's don't throw the baby out with the bathwater. []

CANDY KENNEDY: Yeah. (Laugh) []

TOM McBRIDE: Could we get a common denominator of information that we're going to use? You know, if we're talking about the number of children, families, adults, whatever, that are utilizing services, we don't even know precisely how many, you know, how many citizens this would entail. What kind of system do you have to build based around what your need is? You know, Terri talked about some studies that have been done. I'd like to see a compilation of some of these studies. We've got the ones that she has done, the one that Kathy is doing. We've got the Chinn study out there. And then, you know, bring up a common set of data, you know, and so, everybody, this is what we're looking at, this is what we're utilizing as our resources, and not get into, well, but my figures show this and... []

ELIZABETH CRNKOVICH: Well, and what population are we truly talking about? All kids in the state? Those kids who don't have insurance or financial resources? Those kids who don't and also find themselves in the juvenile justice system? Those kids who do, but find themselves in the juvenile justice system? I think we have to narrow that down too. []

BETH BAXTER: And I think the utilization, if you look at under the tasks there, I mean the...in just thinking back in terms of discussions around where we got to today, I think the use of the term "system of care" was very purposeful,... []

TERRI NUTZMAN: Yes. []

BETH BAXTER: ...because it means something. And so I think it's...and that's broader than children's behavioral health, but it's...so I think if we can explore that as well as understanding and having a common, you know, agreement and understanding around system of care, then that helps lead us to the behavioral health, the array of services,

the flexibility, the funding mechanism, those types of things in the accountability. []

RUTH HENRICHS: And it helps us unpack that confusion of children's behavioral health. Some would argue we're paying for that out of child welfare. You know, people would argue that foster care is children's behavioral health, and others would say, no, children's behavioral health is outpatient mental health and substance abuse treatment. So the system of care language allows us to think bigger and differently systemically and get out of the holes we're in right now. []

BETH BAXTER: And that language was very purposeful... []

RUTH HENRICHS: Absolutely. []

KATHY MOORE: Yeah. []

BETH BAXTER: ...when we looked at that. []

JEFF SANTEMA: And as Senator Jensen said earlier, how do you get from point A to point B? How do you get from right now to the next four months having a report ready by December? And that's more the process question. And Senator Jensen was asking how often do you think you need to meet and how are you going to do that? []

SENATOR JOHNSON: Let me throw out another question, as I'm sitting here, I thought of as well. How good is communication between our different agencies? Is the judge provided with the adequate... []

ELIZABETH CRNKOVICH: You sure you want to open up that mess? (Laugh) []

SENATOR JOHNSON: But it's a very important one. When I see where kids have been to 11 different foster homes and stuff like this, you know, I've got grandkids that are five

years old and I can just see one move being so, you know, just awful, one move, and then we move these kids around a half a dozen or a dozen times, things like that. Is it the communication that's part of the problem, and do we need...you know, our electronic records or these kind of things? []

ELIZABETH CRNKOVICH: I think it is part of the problem. At the same time, it's one of those where people with a common purpose and a genuine desire to communicate just sometimes don't know how to go about it. And I say that because I think that there is a genuine openness, at least presently, to talk more and continue so that we can communicate more effectively. I feel that sincerely, but that has been a factor. []

RUTH HENRICHS: I think there's a genuine desire, I think, on the part of providers, public and private, to be able to share information and communicate, but there are barriers that I can't speak to the specifics, but you have an assessment and it's done in this silo and that assessment, because of rules and regs or whatever, and I can't speak to the detail of it, but you can't hand that assessment to somebody over here in adult behavioral health where the parent might be, and so you get another psychiatric assessment. And then they go to Tom's facility and somebody gets in...somebody else... []

ELIZABETH CRNKOVICH: Well, so those are different levels. []

RUTH HENRICHS: ...so nothing... []

KATHY MOORE: If they go to Kearney, if one of the kids goes to Kearney,... []

RUTH HENRICHS: Right. []

KATHY MOORE: ...they would get another one. Yeah. []

RUTH HENRICHS: They get another one. And then we send them somewhere else and they get another one. []

KATHY MOORE: Right. []

RUTH HENRICHS: And if there were common...if there were a way to be able to move that with the child and not spend the money, time, and all that's involved, communication would be better, Liz. []

ELIZABETH CRNKOVICH: Oh, yeah, and I think you're talking about two different levels of communications, because Terri and I are working real...we both immediately are thinking between agency and court, or legal. []

TERRI NUTZMAN: Court. Right. Right. []

: []

ELIZABETH CRNKOVICH: So that's one area, and that's communication in terms of are we using the same language and are we understanding that that, you know, the different blah, blah, blah, blah, blah? []

RUTH HENRICHS: Right. Right. []

ELIZABETH CRNKOVICH: You are also correct, but I would say that's a whole different level of communication. How to share information and how to...and this...I'm not saying this to say ain't gonna happen, but that same balancing act, how to improve that on behalf of kids while still...the word is not coming (inaudible), but be mindful of and balancing confidentiality and privacy and things of that nature. []

CANDY KENNEDY: Yeah, it seems as if there's very specific silos when you're talking

about different agencies, when you're talking monies, when you're...the communication, and everyone has their goals to meet, but that it's their goals. It's not necessarily do they understand that it's their goals and you need to do this much more to reach what I need to do, instead of we do separate processes all the way along the way. []

KATHY MOORE: If we're looking at a goal, Senator Johnson's point, it seems like, I think you've just touched on, that at some times it is...sometimes that information just doesn't get where it needs to go, or it doesn't get there fast enough. Sometimes there's a legal barrier or a perceived legal barrier, and sometimes it is just a regulatory issue of the YRTC always doing an assessment, regardless of whether another assessment... []

ELIZABETH CRNKOVICH: Or someone just not...and not to...you know, someone just not doing their job, as you pointed out. []

CANDY KENNEDY: Their job. (Laugh) []

KATHY MOORE: Their job, which somebody...yeah, exactly. []

ELIZABETH CRNKOVICH: I know sometimes that's (inaudible). []

TOM McBRIDE: Well, and it goes on to treatment philosophy. []

CANDY KENNEDY: Scot, are you not doing your job? (Laugh) []

TOM McBRIDE: It goes on to, you know, some people argue that because we don't have a single entry into care, you know, a gatekeeper, so to speak. We have gatekeepers, but there's however many of them you want to, you know, figure out. []

ELIZABETH CRNKOVICH: So the short answer is, yes, there is (inaudible) communication. (Laugh) []

JIM JENSEN: Well, one of the goals, should there be a common assessment across the state? Should that be one that we're looking at? []

CANDY KENNEDY: Well, there's a group in Nebraska that's actually been looking at that for awhile. It's the CSI group, Diana (phonetic). We actually...I'm involved in that. We spent several months looking at all the different assessments and evaluations, depending on your terminologies, that's needed for which silo, and what entails and how you could share...how...what other successful... []

BETH BAXTER: Oh, good. Great. []

CANDY KENNEDY: ...yeah, from other areas of the state, so...I mean other areas of the country, so we may get that information, if we could, from CSI. We could see what that looks like because they... []

TOM McBRIDE: Yeah, unfortunately, the people we're generally working with, whether they be state wards or, you know, whatever their status is, they cross every department,... []

ELIZABETH CRNKOVICH: Uh-huh. []

CANDY KENNEDY: Uh-huh. []

TOM McBRIDE: ...and every...you know, they touch all of those silos we've talked about, all those different departments. And if the youngster doesn't fall into this one then a family member does, you know, which impact... []

CANDY KENNEDY: Exactly. []

(WOMAN): Absolutely. []

TOM McBRIDE: ...you know, movement, decision making, funding. []

SCOT ADAMS: Great point. Love the conversation. Going to go back to something I said earlier, my comments about unintended consequences and think bigger. One of the best means to get to what you're after is managed care, and so I'd like to throw the idea, topic, on here, the review and the potential exploration of managed care into this system as a possible idea to explore. That will get you a single system of evaluation, folks, and it will communicate it real quick. []

ELIZABETH CRNKOVICH: It will give me heart failure, though. (Laughter) []

SCOT ADAMS: That's what I said about unintended consequences. You know, welcome to my world. []

BETH BAXTER: Well, but I don't think that's the only way we get (inaudible). I think we can...that's not the only way. []

SCOT ADAMS: Maybe; maybe not. I'm just saying that it's the quickest, fastest, best way. []

KATHY MOORE: Scot, but I think we need something up there also about the communication discussion that we've just had, so I'm not sure what...how we want... []

SCOT ADAMS: (Inaudible) something about managed care (inaudible). []

KATHY MOORE: Sharing. Sharing? []

CANDY KENNEDY: Yeah. Well, and, Scot, I went to...I went to a conference... []

SCOT ADAMS: Well, if you want to change the system, that will change the system. []

ELIZABETH CRNKOVICH: Good, bad or indifferent, it has to be talked about. []

SCOT ADAMS: Yeah. Right. []

CANDY KENNEDY: I went to a conference in San Diego just recently and we talked about children's mental health and managed care, with the different states saying...the ones that were using managed care, the ones that were successful, the ones that were not, and how that looked. So it...some of it was very...some of them, their systems were very, very successful; others were very bad. (Laugh) []

ELIZABETH CRNKOVICH: From a court perspective, and this isn't a power struggle, it's... []

SCOT ADAMS: It will be. []

ELIZABETH CRNKOVICH: Well, and this way, I mean I guess it's up to the citizens. For those kids to come before the court, who do the citizens of Nebraska want making decisions--a managed care agency or a judge who is looking at all of the factors and dynamics? Because that's another trend that I've been seeing over the years that...and I'm not dissing managed care. []

SCOT ADAMS: Yeah, understand. (Inaudible) judges (inaudible). []

ELIZABETH CRNKOVICH: You know, I understand where you're...I will (inaudible). (Laughter) But that is an issue--who's making decisions in that context, at least,... []

SCOT ADAMS: Right. []

ELIZABETH CRNKOVICH: ...in terms of the needs of the child? And information is out and applications are out before a judge has even made a decision whether they have jurisdiction or not, or whether they're going to be looking at in-home care or out-of-home care. So some of it is whether you want the cart before the horse or behind the horse, deciding... []

SCOT ADAMS: Exactly, and that (inaudible). []

ELIZABETH CRNKOVICH: There are trends happening irrespective of those. []

SCOT ADAMS: I think you phrased it very well. That's, when I spoke about roles and responsibilities, that's greater meat on that bone and... []

ELIZABETH CRNKOVICH: Yeah, right. []

SCOT ADAMS: ...and I think it's a great thing for this committee to talk about and to develop some recommendations for which direction ought that to be. We ought to clarify that. []

KATHY MOORE: Maybe what needs to go up there is something like deciding who's the hub on the wheel or...because when you talk about managed care I think many of us just have, you know, fear stuck in our heart because managed care has often been viewed in the context of gatekeeping as opposed to care coordination. So maybe if we could put something up there that just talks about identifying the key decision maker, and it isn't that there can only be one decision maker, but who's...who is the keeper of all the information, the communication that you were talking about, and then the disseminator. Because Ruth raises the issue of...or someone said...talked about confidentiality, we don't want careless sharing of information, but someone needs to decide the relevant receivers of that information. []

BETH BAXTER: I think earlier there was...someone mentioned, you know, who are the children we're talking about, you know, and what I've heard much of our discussion around children who are, you know, probably custody...they're in the custody of the state, and there are other children. And, again, if we go back to the language, the adjudicated and the nonadjudicated, that language was purposeful so that we didn't forget the children who the parent...are still with their parents. Maybe they're served through, you know, through a program. They have serious emotional disorders. The Division of Behavioral Health has some accountability, you know, for serving those kids. So that it's not every child in the whole, you know, universe, but it's children that are not adjudicated as well but live with their parents, with their... []

CANDY KENNEDY: Yeah. We have lots of family members out there that are not involved in the system at all, but... []

BETH BAXTER: Right, but they're part of the system. []

CANDY KENNEDY: ...they still have those needs. Yeah. []

BETH BAXTER: They're part of the system of care. They're just not a part of child welfare or juvenile justice or even Medicaid. []

ELIZABETH CRNKOVICH: Absolutely. Right. But can I inquire, that was the question I raised, do we need to of those outside? I mean we, when you say adjudicated, we all know that we've got a population, but the nonadjudicated, are you still talking...who are you talking about? All children who have our ultimate definition of behavioral needs, or all children with those needs who just don't have financial (inaudible)? You know what I mean? That there are families probably meeting the needs, the behavioral and mental health needs of their children without any, you know... []

TODD LANDRY: Uh-huh, without any assistance or (inaudible). []

ELIZABETH CRNKOVICH: And do we...are we troubled...not "troubled," is our scope to consider all kids in the state or to narrow it, and if it's to narrow it, how are we doing that? By their behaviors or by their financial needs (inaudible)? []

BETH BAXTER: But see, some of the children that you may think are outside of the system are not, because they're a part of the Nebraska behavioral health system. []

CRNKOVICH: Right. I understand. Uh-huh. []

BETH BAXTER: There are children who are served through the regions,... []

ELIZABETH CRNKOVICH: Yes. []

BETH BAXTER: ...through providers, through the Division of Behavioral Health who have, you know, clinical criteria... []

ELIZABETH CRNKOVICH: Right. []

BETH BAXTER: ...more than financial eligibility criteria. []

ELIZABETH CRNKOVICH: Okay. []

BETH BAXTER: They're in our system because of their behavioral health needs, and they're children who are served in outpatient clinics or in a psychiatric hospital or those type of children too. []

ELIZABETH CRNKOVICH: Right. Right. []

BETH BAXTER: So they're not outside our system because they're in my system. (Inaudible) []

ELIZABETH CRNKOVICH: Right. []

CANDY KENNEDY: And even more...right, that's exactly right, and even more than that, there are some services that are not available if you're not in the system that they don't have access to. There's also, when you're saying families that are meeting the needs of their children's behavioral health issues, well, it could be to the extreme. We do have families that have completely mortgaged everything they have... []

ELIZABETH CRNKOVICH: Right. Right. []

BETH BAXTER: At what cost, yeah. []

CANDY KENNEDY: ...everything they have, and they're not to the age of, you know,...and being 19 years old with behavioral health issues does not mean that you're going to go out there and have health insurance. And so there's a lot of...and that's a big issue. And because sometimes they do go through the back door to purposely relinquish custody so that they can get those services. []

ELIZABETH CRNKOVICH: In order to access, sure. []

CANDY KENNEDY: Yeah. []

JIM JENSEN: Is a statewide assessment system, is that one of the primary goals that you think we should have? []

TODD LANDRY: I think I would agree with that, because I...and we mentioned it a little bit earlier, but I think there is a need for a statewide assessment of...and I don't know if

this is too narrow or not, but at least a statewide assessment of what the services and settings are currently available within the state for children's behavioral health, and I think the second piece is defining the optimum services and settings to meet the needs of children and families with behavioral health. []

JIM JENSEN: I'll never forget one of the first times I toured a YRTC and there was...I think we've improved that somewhat, but there was...it certainly made a difference as to where that child came from. If he came from Douglas County, generally there were a lot more things on his record than if he came from Rock County, where maybe somebody in Rock County just says, get him out of here. []

TODD LANDRY: Yeah. []

JIM JENSEN: Out of sight, out of mind. []

TODD LANDRY: There you go. []

JIM JENSEN: And so there he was. And yet there, you know, there's a great deal of difference between those two individuals. And so we were...but they were both sent to the YRTC but under extreme different circumstances. []

TODD LANDRY: And I believe that's one of the reasons why I would commend, and I don't know if some of the committee meetings actually are held in those settings and locations or if they happen in-between the meetings, but I think it's essential for us to go out and see those sites. []

JIM JENSEN: To... []

TODD LANDRY: To go out and actually see those sites... []

ELIZABETH CRNKOVICH: As a common experience, too. []

TODD LANDRY: Exactly. []

CANDY KENNEDY: Yeah. []

BETH BAXTER: And from this perspective. []

ELIZABETH CRNKOVICH: Yes. []

TODD LANDRY: Yeah. []

BETH BAXTER: From our experience here. []

TODD LANDRY: Yeah. []

JIM JENSEN: Okay. Well, and we have such a broad scope. I mean we're everything from foster care, to the adjudicated kids in a YRTC, to those who are in a behavioral health setting or Hastings or mental health setting, so... []

KATHY MOORE: Well, and technically this legislation should be encompassing three-year-olds who are still living with their parents and...right? I mean, so it's broader than what you just described. []

ELIZABETH CRNKOVICH: We have much work to do. (Laugh) []

JIM JENSEN: Well, and then do we also then look at the educational system that we have? And, you know, that's one thing about the dollars. Now right after lunch Health and Human Services are going to come with I think a very good, detailed report. But that's Health and Human Services. That's not education. That's not the juvenile...well, it

is part of the juvenile justice system,... []

KATHY MOORE: Right. []

JIM JENSEN: ...but not all of it either. []

BETH BAXTER: But it's system of care. So I think if we go back to the purposeful language around system of care, and educational is in there, so to that extent...and I think it's broader than just starting at foster care because, like I say, there are probably, you know, I don't know, Sue, 500 children who are served who have serious emotional disturbances who are served through a professional partner program that's across the state, you know. So those are children who are not in foster care. We're working hard to keep them within their home and their community, but they're still a part of our system. []

JIM JENSEN: But what I was thinking about was when, Kathy, when you started out, when you talk about funding, you know, we're looking at a specific funding here, but education is certainly a great part of that. And certainly the juvenile justice system is part of that also, yes. []

RUTH HENRICHS: Senator, when the adult oversight committee met, as I recall, there was a continuum of services that was identified by some of us early on. I mean there was a continuum that went from very acute care all the way to the least intensive, least restrictive kinds of services. It seems to me that within four and a half months we have to give ourselves some parameters, and we have the behavioral health task. So in my way of thinking, there's a continuum that we need to identify and what services are on that from most to least restrictive, and then I think there are diagonal lines, on my visual way of thinking. There's education and there's a lot of other things that are part of that system of care and they bring resources to the table and services for these children. But between now and December, I don't think it's realistic that we can have a goal of blending all that and coming up with anything, but I think we need to have a goal of

identifying that continuum. We can always add to it and we can identify the others that relate to it. That gives us a place to start, as we did with adults. []

TERRI NUTZMAN: You know, I see...we talk about a system, but within that system there's a number of different types of system, systems. So maybe what you need to do is break it down by type of child and then look at that particular system. Because certainly kids that are in the juvenile justice system, either on probation or are wards of the state, that is a different type of system that we're going to be looking at, different types of services, because you are looking at a different type of child. Then you have the child...neglect/abuse kids, okay, that are in home and out of home. They're in foster care. Okay? And then over here you have the child that you're looking at that really isn't in the system but is still receiving mental health care or types of services. Does that accurately describe what you're talking about? []

BETH BAXTER: Uh-huh, the children who there are clinical criteria around because of their behavioral health needs. And I'm just saying they are in the system because... []

TERRI NUTZMAN: Okay, they're... []

BETH BAXTER: ...because they're a part of the behavioral...the Nebraska behavioral (inaudible). []

TODD LANDRY: But they're a different population. []

TERRI NUTZMAN: But it's a different population. []

ELIZABETH CRNKOVICH: But it may be important then to have, as she was saying, because on the one hand, okay, we're talking about kids. Yeah, I got... []

TERRI NUTZMAN: Right, in general. []

ELIZABETH CRNKOVICH: Then we're talking about kids with behavioral and mental health needs that need services. Okay, we're all...and that covers everything. Once you get a little beyond that, though, then just by the nature of the beast other entities come into play,... []

TERRI NUTZMAN: Exactly. It's not the same for each... []

ELIZABETH CRNKOVICH: ...whether they're made state wards,... []

TERRI NUTZMAN: Right. []

ELIZABETH CRNKOVICH: ...whether they're court involved, in terms of who makes decisions, in terms of not only...now when I was initially referring to accountability, I was thinking of the type that people who are law violators have, or families who are before the...but there is also then the accountability of...and it's this. It's not just the fact that... []

KATHY MOORE: The workers, the providers, yeah. []

ELIZABETH CRNKOVICH: ...of the workers, of the... []

KATHY MOORE: The system. []

ELIZABETH CRNKOVICH: The system, precisely, whether it's judge or director or whatever. And so when we...so that we might, rather than...if we don't sort of categorize them in different ways, we might find more conflict and dissension rather than agreement because we won't be speaking the same language or looking at the same... []

TERRI NUTZMAN: Yeah, I think you have to categorize them, okay, and I think the end

goal is all the same for us. Okay? You have these kids. You have these families. You have to provide treatment, cost-effective treatment, and then you get them back. Because your goal is the same for all kids. You get them back into the family or into the community and hopefully you have done your job. Okay? But I think you have to look at them categorically because the systems are different. []

KATHY MOORE: Well, I actually...I actually like...you've got the word "categorize kids," but you might also add to that look at them in stages,... []

TERRI NUTZMAN: Yes. []

KATHY MOORE: ...because I think what Terri first laid out, I agree that we're not going to be able to really dig into the educational system, per se. I don't want us to, you know, (inaudible) another year. But if we walked ourselves through, maybe at our next meeting, if we began to walk ourselves through, are we talking about children--how do we define children, how do want to fold family into that--and just began to chunk that off, then it strikes me that what we have to do is say...you even went on and said children with behavioral health needs. Who says they have a behavioral health need,... []

ELIZABETH CRNKOVICH: Right, as defined by whom, right. Uh-huh. []

KATHY MOORE: ...based on what assessment tool, that you were talking about. And so it seems like if we just walk ourselves through and said, okay, if any child is noticed as having a behavioral health need by a parent, by a preschool provider, by a school, what's supposed to happen, and then that begins, I think, to take us through the pathway. And what we really, I believe, want to do is define a pathway through which a child and/or a family can go and that's where then the pathway in some situations will take us through the Child Protective Service system or through the court system or the...so it isn't...it isn't as much categorizing children, because that still implies, I think, that a juvenile justice child isn't the same as an abuse/neglect child or as a child who's

served at a regional level. And in fact, it's that same child who takes a certain pathway. So seems like that might help us, if we just look at that pathway and then, as we proceed, we'll come up with things like a comprehensive assessment tool that one entity could create, then how do you make that tool available to every place where those children will be. []

TERRI NUTZMAN: You know, we have the YLS assessment, too,... []

(MAN): YLSI. []

TERRI NUTZMAN: ...a tool right now that we're using... []

KATHY MOORE: Right. Right, for certain (inaudible). []

TERRI NUTZMAN: Yes, for a certain population, right. []

KATHY MOORE: Right. Exactly. []

TERRI NUTZMAN: And so your thought is, you know, you take something like that and then you build that for... []

KATHY MOORE: Right. []

TERRI NUTZMAN: Uh-huh. Okay. []

TOM McBRIDE: You're still not going to get away from specialized assessments and, you know,... []

KATHY MOORE: No, but at least you've got a beginning place. []

TOM McBRIDE: What if you identified our system of care; what services do we want delivered? Identify what services there are, front to back, top to bottom, however you want to look at that, then look at the people...the groups--state, private, whatever--that are providing those services. Do they have good accountability for the services they provide, and how do we access to kids to get those...to get that service? If he's a juvenile justice kid, or her, doesn't make any difference, we've got identified they need this service and we get them in there. And, you know, and, you know, get away...because I do, I look at the more we, you know, we look at them as a juvenile justice kid, as a behavioral health kid, you know, strictly like that, we're...a managed care kid, we have containerized any ability to smoothly access services. So I think if we look at what do we need, what would the system involve, and regardless of how that child sits in there then, how do we get them plugged in and effective case management. []

TERRI NUTZMAN: And, you know, it even...I think it even...and I agree with what you're saying, and then you have to look, I think, when you talk about outcomes and accountability, then you even have to go as far as to look at the type of treatment modality, I think, our service providers are providing. And one of the ways to measure that is through the evidence-based treatment modality. And...because you know what, service providers, I'm sorry, a lot of them are all over the board with the type of treatment that they're providing, and is it...is it... []

ELIZABETH CRNKOVICH: And those with the responsibility of utilizing those don't all...kind of like what we're trying to do, we have the responsibility to be knowledgeable, are not always knowledgeable. []

TERRI NUTZMAN: That's right. And this is tough, you guys, but you know what, hats off, and we really need to discuss these issues, so... []

BETH BAXTER: And then I think, as someone mentioned, policy and practice, we...just

the...I think we have to somehow be cognizant of how policies either undermine or incentivize, and evidence-based practice is one of those, but how our various systems work together. Because there's probably lots of providers who would like to do and, in spite of us, are doing evidence-based practices... []

TERRI NUTZMAN: Yes. Yes. []

BETH BAXTER: ...but we don't incentivize that. We don't even, you know, say thank you for doing that very well. []

TERRI NUTZMAN: Right. Right. I agree with that. []

JIM JENSEN: Okay. It is 12:00. We'll break for lunch, and be back here at 1:30. We will pick up immediately with the Health and Human Services' presentation, and then we'll decide after that whether we should go further into this goal. Okay? Lunch is on your own. Just be back here at 1:30, all right? Thank you. []

RECESS []

JIM JENSEN: Well, thank you very much and we sure hope everyone had a good lunch and we'll begin now with the HHS presentation, and Scot Adams is going to be doing that, so please give him your attention. []

SCOT ADAMS: (Exhibit 1) Well, good afternoon and welcome back, everybody. I really am very grateful, again, to be here and it's really a very exciting time for me personally, and I think for the state and for the Department of Health and Human Services. I'm excited to provide some of this information and I want to especially thank a number of people who were very helpful in putting together this, the information for this presentation this afternoon, including Todd Reckling, and Roxie Cillessen, Ron Sorensen, Lori Harder, Sue Adams, and Pat Lopez, who had the computer crash

yesterday afternoon as the final touches were being done and got to redo this. And so, Pat, especially, thank you for your extra work on this. I also invite them to correct me as I screw this up (inaudible) along the way in any way, because they are the ones who have the best information and knowledge. One of the reasons I'm excited about this moment in time for children's behavioral health is, as somebody mentioned--Kathy, I think it was you--earlier that there seems to be stars aligning in a way that look to produce good things. Recently the Governor identified the top ten initiatives for Health and...for the Department of Health and Human Services. As a result of the reorganization bill, LB296, that went into effect, and as director positions are becoming populated now with new faces, he issued a number of different particular goals and specific targets. In the area of behavioral health was completion of the adult behavioral health reform, and the integration of children's behavioral health. And so here we have this moment where Governor and the Legislature are in line toward a common direction in trying to do something better for children's behavioral health. I think it's a very exciting time and moment, so glad to be here with that. As I go through this, this afternoon, and I hope it will be under...I'm sure it will be under 30 minutes, hopefully it will be under 20 minutes perhaps, we'll see how that goes, I'd like to remain at a relatively high level, and I would also ask your forbearance. If you do have questions, please jot them down to the side. I like to sort of take those at the end because much of this information hangs together into a larger whole, and I would like to be able to get through as much of this as possible at the front end, but happy, of course, to spend as much time as we need to for clarification and discussion afterwards. Want... []

KATHY MOORE: Are we going to have...do we have a handout? []

SCOT ADAMS: I didn't even take my next breath before she (inaudible). (Laughter) And that's amazing. And, yes, you'll all have a set, a complete set, of the slides and we'll hand those out shortly so that you'll be able to have those to go through, too. Kathy, thank you. A point of clarification: This information comes from a variety of different sources--Medicaid, protection and safety, child welfare, Division of Behavioral Health

Services--each of which tends to use slightly different definitions and things. Most of the time when we're talking about children in here, we're talking age 20 and younger, but not always, and we'll try to be clear about that from time to time. But I just want you to know that for this purpose we tended to go 0 to 20 with regard to all of that. Another point of clarification I'd like to sort of make, I suppose, at the beginning is...and I'm still evolving these thoughts, but in the area of behavioral health, we have, I think, come to use of that term very nicely in the state of Nebraska, and I think that's a wonderful step forward to speak of behavioral health and addiction kinds of activities under a common rubric. It also occurs to me that there were and continue to be some very good reasons that there used to be two camps, if you will, and many of those dynamics remain. That's a point for another day and a conversation for another day, but there are some things that are very specific and unique to the substance abuse field, distinct and apart from the mental health field, and vice versa. For our purposes here, I just want to underscore the fact that when we talk about behavioral health we speak about those persons who experience a mental illness, as well as those persons who are experiencing a substance abuse disorder as well, and to remind us all about that. And then, Senator Jensen, when you talked about, this morning, about the maze in which many consumers have to struggle to find services, and, Kathy, when you spoke about wanting a streamlined super highway, what you're going to find is more the maze than the highway through here, I think, and I suspect that the ultimate outcome of the work of this task force will be...at least be, hopefully, a four-lane highway, but there will be stops along the way. There are a number of things that serve as potholes that will serve to slow us down, a variety of things. The money issue is not a small issue. But even the idea that--and Don and I were talking about this earlier--that some organizations develop a speciality focus, for instance, in eating disorders or other kinds of things. With focus comes silo. With silo comes block in communication. And so some of this is just the human condition, and I guess I sort of wanted to say that simply to say that a super highway is a tough, tough standard to come by, but we can make this a whole lot better. So with that, then I'd ask for distribution of the booklets and slide two, and we'll go from there. What we're going to talk about today really can be identified in probably five major

areas. Want to give you an overview of the Health and Human Services structure and talk a little bit about the reorganized agency and other agencies. Want to talk a little bit about how people get into services and service pathways, as well as types of services, numbers served, as best as we could come up with that. That will be incomplete data. Want to talk about the money and the financing strategies and mechanisms, and also then about the SIG, or the Strategic Infrastructure Grant, at the end. Again, there will be a variety of detail with regard to this and, again, I hope to be able to move through this at a relatively high level because there are a number, I counted at least seven, questions today in terms of requests for information or perspective that I think might well be covered here and I want to make sure we cover all of those. We can always go back. If we could have slide three, please. Although this looks like the play that beat Oklahoma in '72 (laughter), this really is something of all of the sort of departments and interrelationships of a great big picture. Includes the Department of Education, and includes correctional systems at the state and federal level, the Department of Health and Human Services and our partners, the regions, and a variety of different kinds of things. I will leave it to you to look through these and to have that information. My point in describing this is simply to say that the...that the system is complex and has many, many different moving parts. With regard to those yellow boxes around the Nebraska Department of Health and Human Services blue box, just wanted to mention LB296 and the reorganization. I spoke to that briefly earlier today. Prior to July 1, all services reported to a single cabinet of four people and a single person responsible for services within that cabinet; those have been broken out into more particular specific areas. And the gift of this structure is the ability to allow for focus and concentration into the content areas of these. The danger of this, of course, is the silo aspect of that. And so we have to work consciously at communicating across silos. I wanted to highlight that because I think that, for those of you frustrated with not getting answers in the past from some things, hopefully we'll be more responsive and be able to do that. However, the danger of silos is an ever-present one. The next slide is an attempt to take a look at how the person might flow through a system from the point of view of who's paying for services, so that you have people who come into the system on the right who have very low

incomes; you have people on the left from the Protection and Safety Division, which includes others as well, into the first question of, are they Medicaid eligible or not? Seems like maybe a funny place to start and I'm not suggesting that this is necessarily where services begin, but it helps to give impetus and underscore how important Medicaid is to the overall system of care and services in the state of Nebraska. From there then a person or a child can be supported in their services in a variety of different ways, including private pay and insurance on the far right. But all services have to begin with assessment, and the conversation today about common assessment, sharing assessment information was very encouraging to me because everything has to start with good, accurate assessment. From assessment then, of course, one breaks out to what would be known as treatment services, for a conversation like this, or children's behavioral health treatment services, and we list a few examples of what that might be down below, or nontreatment services. And again, this is an attempt to try to keep us with a wider point of view and perspective. I guess we'll have to talk...stop talking about Senator Synowiecki now. (Laughter) Oh, hello, Senator. And my point in wanting to include these was simply to say that...that point that I believe, Kathy, again you made this morning, that poverty makes everything more difficult, complicates things, and that those kinds of services--protection and safety, food stamps, foster care, guardianship--are all services that one may not immediately think of as relative to a conversation about children's behavioral health, but can become very relevant to a family in need. The next slide, this is probably as bad as it gets, I think. Okay? Hopefully the rest of these will become not only more legible but also better able to be understood in concept. But when a group of us sat down to walk a child through the system, today the child is here and at the end of the system they're there, oh, my goodness! The conversation went on and on and on, literally over the course of, oh, I'd bet three or four weeks as people with different points of view and expertise came together. This slide is as a result then not fully comprehensive. It may not be comprehensible either, but that's beside the point, but it's not intended to be fully comprehensive but probably is a map of how many children progress through the system with relationship to these services, and so you can see that. Again, as you look through that, especially in the third tier there,

you have courts involved, which can be involved in decision making, placement decisions, which can add complexity to the entire scheme of how a child is to be served. Item three or the middle tier there, the 3B status offender, was also referred to this morning with regard to parents to who sort of give up and have to give up rights of their child to the courts in order to get services paid for, and so that's another category that has been previously discussed and you can see how some of that moves on. Again, my point is simply to say that this is today an extraordinarily complex system, and at times I wonder if anybody can get help, and I mean now shortcoming to the Department of Health and Human Services. People do a great job there and so do providers. My only point is to say that the complexity of it is you really need a score card to make sense of this whole thing going through it. Could we have the next slide? We'll begin a conversation about the community-based behavioral health services, and most of you, I'm sure, know that there are six behavioral health regions in the state of Nebraska. There's the geography of those and major area or contact point and city in them. These were done originally in the 1974-76 era, when mental health regions were established, and then substance abuse regions came in later to mimic those. The next slide identifies the nature of the services in the mental health and substance abuse arenas, as well as the number of persons, young persons, served by those service areas in the '06 fiscal year. The next slide then talks about the regional youth services coordination, and again provides...it is intended that through the regions, at a local...at a more local level, that there's coordination of mental health and youth substance abuse services across areas, and we tried to develop linkages between prevention and treatment systems as well. And so here is sort of the access today, especially for prevention services. And again, a number of us spoke about that as an important component to our conversations over the next couple of...next several months. And so this is sort of today the best mechanism we have for the delivery of those kinds of services. Hastings Regional Center has been identified, originally as part of LB542, very specifically and even yet today in terms of conversations about its role for purpose and function within the overall system of care. I wanted to give you some particular information about Hastings Regional Center and the...and what it does there. And so you have the

number of adolescents in the Chemical Dependency Unit, which are restricted to admissions from the Youth Residential Treatment Center at Kearney. No other kids get there. You got to go through Kearney to get to Hastings for the CDU. It also had...used to have an adolescent acute hospital unit. That no longer functions. That no longer functions as a result of the decision of the psychiatrists to resign their positions and, therefore, we are unable to meet that level of care by standard and definition. So there is not today an acute adolescent hospital at Hastings Regional Center. Many people sort of still think that and think the capacity of Hastings is in that vein as well, that Hastings can take a kid in need of acute residential care. It cannot, and so that's an important element here. The adolescent residential psychiatric facility is about 40 people a year, usually 9 or so at any given point in time. The next slide moves on from there and then begins to identify the children's Medicaid and substance abuse...mental health and substance abuse services, so this is a list in alphabetical order of the services...in fact, not the entire list of services but a partial list of the services, major services, paid for by Medicaid. The conclusion I would like to draw your attention to from this listing is, again, sort of the nature of the complexity. We have here a balance between comprehensiveness system of care on one hand, and in order to assure accountability, another major theme voiced today, you have to come down to definitions of what you're talking about. And so as you come to definitions of what you're talking about, you distinguish between this and that, this and those, apples and widgets, kumquats and potatoes. And each one is different, each one is paid differently, and each one has a different expectation for accountability. So the issue of free-flowing system is in some level of tension, I won't say conflict, but some level of tension with the accountability variable. Those go not necessarily in tandem, and nor do they necessarily go in polar opposites, but they are in a level of tension. The next one identifies the services provided by the Division of Protection and Safety Services of the Division of Children and Families, Department of Health and Human Services--a little broader level of care, but the same kind of concept; that there are a variety of different kinds of services designed to help families manage and get through, if you will, a children's behavioral health crisis moment or period of time in life. In addition, the next slide talks

about things that most of us might not even think about that is available to families of low income: family support, transportation, TANF, food stamps. Those kinds of things may well all come into play, especially when the impact of a behavioral health incident can impoverish some families. Now then we're talking about other systems coming in to help come into care. The next slide talks about the total state wards in care as of the end of 2006. You can read those numbers; total wards in state care are 7,212. Last report, I believe, was just short of 7,000. We have been on a nice downward trend over the past several...actually, about a year or so now, to where we are hopefully going to crack, don't let me jinx that, going to crack the 7,000 barrier here in the next couple of months. The next slide then moves us to the Department of Health and Human Services' sources of funding, so we're going to begin to talk about money at this point. The Behavioral Health Division, that is that regional system with the six regions across the state with multiple counties whose intension was to provide sort of state-level funding with local control around the dollars, is about $5 million a year on children's behavioral health. Medicaid is the monster; $110 million a year is spent by Medicaid in this state on children 0 to 20 for children's behavioral health, behavioral health, not all kinds of health, children's behavioral health. And the last source of money is the Protection and Safety Division, which spends about $5.5 million: total of about $120 million. Now I'm just going to spring a quick pop quiz on you in terms of how much money you think that translates, so pick a number in your head of all the kids in the state of Nebraska you think there are. We're spending about $121 million at least, not counting private insurance or resources. The quick answer is there are somewhere around 450,000 children in the state of Nebraska 0 to about 17, 0 to 18, so it comes out to about $267 per every child in the state. I don't know if that strikes you as a lot of money. That's why I raised the question earlier back,... []

KATHY MOORE: Right. []

SCOT ADAMS: ...compared to what? []

KATHY MOORE: Right. []

SCOT ADAMS: Is that a lot of money or not a lot of money--$121 million, $267 for every kid? Three out of four of my kids didn't use any so somebody got another $700 bucks (laugh) somewhere. So it's just that kind of thing. Moving on, back to the Division of Behavioral Health Services, in terms of where those expenses have gone, the largest section is that blue piece of the pie, that's roughly half of the money, and that's the Professional Partner Program. The Professional Partner Program, through regions, is essentially wrap-around services for nonstate wards. So nonresidential services, a variety of different supportive services that can include therapy, include also other kinds of case management, encouragement, in-home kinds of things, whatever it takes to keep...help keep the kid going in a good life. The yellow and the dark blue represent substance abuse and mental health therapy services, in particular, so that's where the bulk of that $5 million basically goes. The next slide will show, over time, expenditures for the last three years by region of expenditure. Region III had some federal monies and so has developed a strong infrastructure in that area. The next slide begins to talk about Medicaid expenditures. Again, this represents how we spend $110 million a year on kids, and the largest is residential services at around $39 million. That's that sort of reddish color to the right side of the pie. The lower left is a practitioner and clinic, which oftentimes can be associated with outpatient hospital-based care. The blue up top, the solid blue, is inpatient psychiatric treatment, and the lined blue, top left, is prescription drugs. And, you know, my personal reaction to that prescription drugs is, is that a good thing? Are we drugging our kids and...you know? It's just one of those things that sort of raises a question in my brain. The next slide will provide a comparison, really splitting the money that you see, and this is sort of fascinating to me. On the left side, you'll see that 6,900 state wards used $59 million worth of resources, and on the right side, 131,000 people used $51 million. They were not state wards. It's also fascinating to see the difference between residential levels of care for state wards as opposed to nonstate wards. Now maybe you can presume that if you become a state ward your level of need and intensity for services is stronger, and maybe not. I mean, I'm not entirely sure. But

that might be a fair presumption, and Terri might be better able to sort of address that. But I think the data at this point is at least interesting. The next slide shows four-year expenditures of where the money had gone by bar chart. And again, at the far right you see a fairly dramatic increase, an increasing upward trend, in spending of Medicaid funds on prescription drugs. The other thing that jumps out to me is those three low ones in the middle there are largely outpatient, home-based kinds of things, and the ones on the left tend to be the more expensive inpatient kinds of services and out-of-home care. Next slide indicates child welfare and the ICCU, intensive care coordination units, in the regions, the professional partner kinds of things, and again the differences of where those monies were spent. This is the $5.5 million spent by protection and safety, the $5.4 that you saw earlier in the slide. This next slide is probably nearly illegible, and I apologize for that. It is a PDF of a document, but it's a report that's being sent to Senator Synowiecki's office now on a monthly basis and indicates the number of children in out-of-state care. And if I could just highlight a couple things, it runs, from the bottom, from July of '06 through April of 2007. Oh, do you have a...yeah, on the next page. Oh, good. The next page after your page has a blown-up version of it. Oh, thank you. How nice of you to do that. That's real (inaudible). Thank you very much, Pat. But at one point in the last year and a half or so there were as many as 79 children in out-of-state care. I'm happy to report that that's down to 30. And the middle column there represents what we call the border states, and so there are a couple of providers of boys and girls in Sioux City and there's one close in Wyoming, so a couple providers that are real close to Nebraska. And we separated those out because they're sort of part of Nebraska, sort of not part of Nebraska. It depends on how you're feeling that day. And so we thought we'd just identify them as such, and you can count them however you would like to. Next slide that I'd like to turn our attention to, the Nebraska Child and Adolescent Behavioral Health State Infrastructure Grant, affectionately known as SIG. SIG is really quite a phenomenal opportunity for the state. Nebraska is one of, I believe, six states and one native tribe that were awarded the SIG grant, which was really a great idea. I'm sort of surprised how it came through in some ways because it is really very broadly defined as an

opportunity to help states define and help themselves to get better--identify those issues and structures that are either impediments or need to come into play as a dynamic to help us become a better system. And so there is great opportunity for interaction between this body, this task force, and the SIG grant process moving forward. It receives about three-quarters of a million dollars a year to help test out different ideas, to fund the planning process. It may not be used for direct services. And in the next page then you have...next couple of slides you'll see some summaries of it. In total, there are 203 active members involved with the SIG process. There are 27 in that first box that's identified as the committee charter members and the steering committee. There are 27 members there, and the others are spread out in different kinds of committees and play different kinds of roles. The next slide identifies the nature of the grant and its four major components, where it was headed and those elements. And then the next slide will speak to particular pilot projects that have been approved by the SIG at this point. One of the, I suppose, advantages of new faces coming in is that this is one of the areas that some of the directors of the department would like to take a look at. We think that SIG has provided the opportunity for some great thinking and convening of good partners and members to the planning process. It's also my understanding that the original application envisions some large system kinds of struggles and grapplings to get ahold of that. The pilot projects, as you can see, will have specific benefit in parts of the system, but I think that there's a thought and some energy afoot that, while these pilot projects have value, hold value, and represent potential, that we'd like to refocus SIG to a larger level--integrated funding strategies, the coordination kinds of things we spoke about this morning, those kinds of dynamics--so that we have the opportunity, in part, to begin to cooperate with a committee like this, to inform SIG, to have some resources to be able to move forward. We still have about two and a half years left. We have a SIG grant, and so it will extend beyond the lifetime, the presumed lifetime of this task force. And we hope that the ideas from this task force can be fed into SIG as well, as well as legislation, to have everything moving in the same synchronized fashion. Finally, in the final slide, I simply wanted to identify a number of things that the Department of Health and Human

Services finds as system challenges, if you will, and we'd offer these for the...to the task force for items to consider. The system inconsistencies: We've talked about some of those today in our conversation right before lunch in terms of even who are we talking about. Are we talking about state wards? We talking about OJS kids? What makes an OJS kid different from...you know, those kinds of things. The no single point of accountability for children's behavioral health: If you ask somebody who do you go to, you have multiple right answers. I suppose if it were a question on a test, it's one of those that you get credit for no matter what you put down. One answer would be Medicaid. Certainly they have a significant role to play. Another answer would be it could go to the regions. That would be an answer. And from there, up to the state department...Division of Behavioral Health Services, that would be partially a right answer. You could go to juvenile courts. That would be partially a right answer. You would also be able to go to protection and safety as another partially right answer. In terms of policy for the state, and the thinking and the coming together of all that into a single place, it really doesn't exist. And I hoped the outcome of this process is that at least; that there be some place that's identified as a single sort of source for those kinds of issues and questions. Reimbursement issues are also a point of controversy and contention. Providers think there's never enough money, Governors think there's always enough money, (laugh) and so somewhere in-between there's probably truth. But even within the system, we pay different rates between Medicaid in the Division of Behavioral Health as a result of different processes for approving budgets. It's just sort of a fascinating kind of thing. Coming to uniformity and simplicity about some of that would be helpful. The relationship of courts to children's behavioral health: The good judge was right to begin talking about that and I think she pinpointed it quite well in saying who gets to make the call; who do the citizens of Nebraska want to say makes the call in terms of where a child should be placed. Sometimes a judge makes that decision, sometimes the Office of Juvenile Services makes that decision, sometimes others make that decision. And so I don't know that there has been a conversation other than on a piecemeal approach about that kind of thing. Many times those conversations can come into conflict with one another and the kid can languish. Data: I mentioned that in my

earlier remarks. We've got almost none. It's just a little bit scary in that sense and especially in an environment where we want to talk about evidence-based practice. We don't have...we don't have any evidence, let alone a base, but we're practicing. (Laugh) We're having to make decisions no matter what, and some of those on the seat of our pants. Capacity for community-based services in the role of the state's services I think is an important conversation to have, and I welcome that conversation as we move forward. And then finally how we interrelate, coordinate and leverage this task force's opportunities and resources with that of the SIG grant in a coordinated fashion I think is a great opportunity and challenge. So thank you for holding your questions and that. I appreciate that very much. I would welcome any comments or questions that you might have, or either clarification, and I would especially at this point invite other members of the team to be able to be responsive to those questions. []

JIM JENSEN: Thank you, Scot. Before we do that, Senator Synowiecki is here and we talked about you earlier this morning and certainly you, as introducer of this legislation, and then in this task force forum, we'd certainly be willing to hear any comments that you might have. First of all, I think the committee that was selected is outstanding; very appreciate of that. And we've got a tough task ahead of us, but I think we're willing to accept that challenge too. Any comments that you want to make? []

SENATOR SYNOWIECKI: Well, Jim, thank you for your service. Keep calling you back here to the Capitol because of your leadership on the issues, and particularly in behavioral health, more specifically in the adult arena, now in the children's arena. And your leadership under LB1083 and the shift change of public policy that is occurring there, while it's been bumpy from time to time, it's coming along. I think the bottom line there was we wanted to have enhanced outcomes for consumers, and I see these children as consumers of these kind of same behavioral health services. And while this state has had a lot of task forces from time to time, we're really looking for results here. This is not a task force just to have a task force. Just as in the adult system we have substantive reform, I view this task force as the vehicle for substantive reform on the...in

the children's area. I think we need a response to children in our state that represents a priority for these youngsters, and that every aspect of their treatment, in their behavioral health treatment, is second to none, including the physical atmosphere that they conduct the behavioral health treatment in, and that it's progressive, and that these youngsters can be freethinking as they work their recovery program, and that we look at everything involved with the Children's Behavioral Task Force, everything involved with children's behavioral health. But more specifically, if you look at the bill, it's original intent as it moved through the Legislature, that we do not put children in places in this state, I'm talking about physical venues, that we don't put kids in this state that were not good enough for the adult community, that we place youngsters there. I have a fundamental problem with that. That was the original view of the bill. That was the view of the bill that Appropriations Committee looked at, studied that, looked extensively at. But I also recognize that we need to think this through and that we need to do it correctly and we need planning and, therefore, that job is yours. Then we have a response to children's behavioral health in this state that represents our priority in all aspects of their treatment, including the venue and the physical aspect of that treatment. []

JIM JENSEN: Great. Any questions of Senator Synowiecki? And if not, we'll go on to questions of Scot Adams. Thank you, John. Any questions directed at the presentation from Health and Human Services? []

BETH BAXTER: Well, maybe just a comment in terms of...just kind of start us rolling here. As we reviewed the information that you shared, Scot, around...well, around SIG, but around the system, it seems like...I was just thinking of our conversations earlier around, you know, how much money is being spent. So there's been some work done through SIG and that that I think would be very beneficial to inform this group in terms of...and I know that there's been a study done on the various services that are around the state. So it seems like the SIG process, the work that's been done can, I think, help us move along quicker because we won't have to reinvent. I mean it may not be all of

the information we need, obviously, but a great starting point. []

SCOT ADAMS: Yes. []

BETH BAXTER: I hope we can use that. []

SCOT ADAMS: Yes. []

KATHY MOORE: And I think our next item is the SIG grant, so we're going to have more detailed discussion. I just had one question on page 7 when you breakout the three categories of expenditures. And the third one, the Children and Family Service Division, what all does that include? Does that include the monthly board payments for kids? Does it include staff and supervisors? Does it include purchased services, like in-home families? What does that dollar amount include? []

SCOT ADAMS: It's largely purchased services, but (inaudible). []

KATHY MOORE: And Todd probably can't answer the question today either, but... []

SCOT ADAMS: Yeah, and he's not (inaudible) not back (inaudible). []

KATHY MOORE: Because that's always a struggle, I think, when we try to look at dollars spent in those categories. I'm not clear what that particular dollar is. I don't know if anybody is. []

SCOT ADAMS: Yeah. It's my understanding these are largely the treatment dollars spent. []

KATHY MOORE: And so the Medicaid treat...the Medicaid amount above, does that include treatment dollars for state wards or not? []

SCOT ADAMS: Yes, it does. []

KATHY MOORE: Yes. Okay. []

SCOT ADAMS: And, in fact, as I keep going along here a little bit--and I may be able to get out of here without anybody thinking I'm nuts--the $5 million spent for...would be those where a determination has been made that the service is not medically necessary and, therefore, ineligible for Medicaid. But somebody, like a judge, has ordered that level of care anyway. []

KATHY MOORE: Okay. []

SCOT ADAMS: And so we get to pay for it. []

BETH BAXTER: Or it's a placement service. I mean, you know, there's placement and treatment services, so it could be a placement service, like traditional foster care, intensive family preservation. There are other things that are not medically necessary but, by nature, deemed... []

TODD LANDRY: But that would not be included in the $5.4 million. I mean it's not board payments and things of that nature. If you look on page 10, unless I'm missed reading this right, the $5.4 million is shown there and virtually all treatment dollars. []

SCOT ADAMS: Yes. []

TODD LANDRY: It's not the board payments and things of that nature. []

KATHY MOORE: Okay. Okay, good. I mean... []

TODD LANDRY: But I think, Scot, if I'm understanding you right, and it's my understanding as well, these are required services, either court ordered or determined to be needed services for children who are state wards who are not Medicaid eligible. []

SCOT ADAMS: Yes. []

TODD LANDRY: Or the service is not Medicaid eligible. []

SCOT ADAMS: Yes. []

KATHY MOORE: Okay. []

JIM JENSEN: Now we don't have the same situation here as you do with adult behavioral health systems, that if you are in an institution you have that... []

SCOT ADAMS: IMD thing. []

JIM JENSEN: Yeah, yeah, that IMD thing. []

SCOT ADAMS: Yeah, that's correct. []

JIM JENSEN: So that we're not passing up any federal dollars by servicing or treatment adolescents in an institutional setting. []

SCOT ADAMS: You know, there is at Hastings, would be the place where there is a question at play there, Senator, and it's in process of resolution, but it's not...the adult rule is 16 beds and it's pretty clear, or 50 percent of the total number of beds to psychiatry. In the case of children, the guideline is that it be noninstitutional, in a sense. And so there has been something of an arbitrary setting of 20 beds as a number, but it's by state recognition at that point. And so...and so currently the Hastings dollars, the

Hastings expenditures, are state General Fund revenues. We can change the regulation at the state level and, in fact, are in a process of doing some of that to attract and use Medicaid dollars to help support services at Hastings, and that process of regulation review is in process and going along a pathway, but cognizant of the fact that this group is meeting and that the implications from this task force may well impact that in some fashion. []

JIM JENSEN: Okay. []

SCOT ADAMS: But our plan at the department is to be able to allow for Medicaid funding at Hastings for that, but otherwise it's not an issue. []

KATHY MOORE: So has a regulation been drafted or... []

SCOT ADAMS: Yeah, it's in process. []

KATHY MOORE: Okay. Excuse me. []

JIM JENSEN: No, that's very good. And then the other question, and we discussed this at lunch with a few individuals, and we have a substance abuse facility at Hastings right now. []

SCOT ADAMS: Yes. []

JIM JENSEN: Do we have any idea as to what the outcomes of those individuals that are there? And let me go on just a step further. Certainly in my studies and as I attended national conferences, and I'm a strong believer in this, that on substance abuse, if you don't have some sort of an aftercare program and, nationally, if you don't have some sort of an aftercare program, be that AAA, no matter what it is, really the dollar...and you can dry out anybody in 30-60-90 days, other than meth, takes a little

longer. But if they return to the same environment, perhaps same family, same playgrounds, same playmates, they're going to return to their same activities before. Do we have a tracking system? Do we follow that? What are the outcomes? []

SCOT ADAMS: Yeah. There are multiple answers. Let me first of all say that I fully agree with everything that you said. With regard to the outcomes, all the kids in the chemical dependency unit at Hastings came from Kearney. Some complete treatment at Hastings and go back home, oftentimes with a juvenile services officer involved, and they monitor then that aftercare plan, and there will be an aftercare treatment program developed for that person in conjunction with the juvenile services office. Could include additional outpatient treatment, could include closer monitoring, could include a variety of different kinds of things in the community. Others will return to Kearney to complete their term there, and so if you want to think of Kearney as an aftercare service, I suppose that makes some sense. The core of your question, though, is how is a kid doing after they leave us, whoever "us" is, at some point, 3, 6, 12 months? And, no, we don't do that. We don't have that information. We don't...we don't ask those questions or do that work today. And I don't know that that makes us very different, though, than many other providers as well. []

JIM JENSEN: Yeah. Well, the only thing is hopefully, if we develop this system and some of the goals that we have, I think outcomes is very, very important. []

SCOT ADAMS: It's part of that data thing, absolutely. []

JIM JENSEN: And we, you know, when we have taxpayers out there who are funding the systems, be it a private provider or a government provider, I think it's very, very important that... []

SCOT ADAMS: Yeah, I think it's an essential component of whatever system improvements we make. I think that particular piece, when we talk about data, there's a

subset of data that has to be on point about outcomes and I think that development ought to be a similar standard. Whoever the provider is across the system, how are they doing? []

JIM JENSEN: Well, and as the state seems to be pushing more towards performance audits, I think that's also part of that too. []

SCOT ADAMS: Yeah. Yes. []

KATHY MOORE: Well, I guess that ties back, what you've begun to do, to the data question. I know there are a number of providers around the state, many who met with Senator Synowiecki throughout this whole process, who were absolutely trying to measure those outcomes and who do. I think Uta Halee, I think that several of the facilities do. There is a limitation, however, to the knowledge and data that a private provider has; that a child who's a state ward belongs, if you will, to HHS and HHS can hopefully go to your computer system on any given day and track where that child is. It's more difficult, and I know through CAFCON and perhaps through NABHO there have been attempts at tracking it beyond. But once a child is no longer a ward or in placement at Uta Halee, technically, Uta Halee doesn't have access to those data. So I think it's going to be important. HHS, I would hope, would be the trendsetter, if you will, that you've got those data in your hands and ought to be able more easily to be the first person to set that in motion, and then subsequently I think it would make perfect sense for HHS to continue to monitor children's successes from one facility to the next, to the next. And I would assume that all of the facilities would want that feedback; that you want to know, when a child leaves your facility, how they did, if there's been recidivism that you're not aware of, etcetera. So it seems like that's an important part of what we should be looking at. []

SCOT ADAMS: Yeah. You know, Kathy, I couldn't agree with you more that the state is in a great position to be able to monitor many of the kids, though I'm not sure all of

them,... []

KATHY MOORE: Right. []

SCOT ADAMS: ...just because of the nature of the variety of kids in the system that we're talking about. It...I do want to just sort of make sure that people understand that today we don't...we do not have the technology capacity, nor the staff capacity, to ask/answer those questions. Further, sort of stepping back from the position for a bit--and I don't want to belabor this because this is sort of just Scot getting weird a little bit on us all--the whole question of outcomes verges dangerously close to social science research and most providers, public and private, are not social scientists. And so that the nature of data collection becomes much more difficult than just a simple outcome question. And so what I'm arguing for there is just a greater sophistication across the system, and I agree with you that the state is in a great position, should be at a great position, to lead that way in a collegial conversation... []

KATHY MOORE: Right. []

SCOT ADAMS: ...that will increase all of our capabilities. []

KATHY MOORE: I think you're talking tracking versus outcome analysis; that we can follow the child... []

SCOT ADAMS: Yeah, we'll know where the kid is most of the time, (laugh)... []

KATHY MOORE: Yeah. Yeah. No, I agree. []

SCOT ADAMS: ...but not necessarily how they're doing on any given day. []

KATHY MOORE: Yeah. Exactly. []

TOM McBRIDE: I think there's some things in the works (inaudible) that's going to make that easier. []

SCOT ADAMS: Good. []

TOM McBRIDE: The education individual identifier, where every school-age child will have their own identifier and any time they move through a system it's going to follow. And, you know, so... []

SCOT ADAMS: And you're right, Tom, and I appreciate that. And that gives a little bit of a sense of the complexity involved in this (inaudible); is that's a breakthrough in terms of being able to follow kids. []

TOM McBRIDE: Oh, absolutely. (Laugh) And it's going to make it. It's a tool out there that we need to capture and use because it's...it's not going to be a Social Security number, thank heaven, but if you end up, you know, if you...if you're in school, you get that identifier, you leave school for treatment wherever, that identifier moves with you. Then if you move into criminal justice, that moves with you. Any time you access services, if we use that correctly, we can, you know, we can get some there. []

SCOT ADAMS: Yeah. []

TOM McBRIDE: On page 2, down at the bottom left-hand corner, you've got some numbers down there that I anticipated some, today, that anticipated that 90,000 children are affected with mental health/substance abuse problems in Nebraska, 21,000 with extreme impairment. Is that polled out of, like, the new Freedom Commission kind of thing? []

SCOT ADAMS: Yeah, it's national extrapolations to our (inaudible). []

TOM McBRIDE: So I guess what I'm looking at is that really validates the work that this committee has yet to do when we look at 90,000, you know, kids in Nebraska that have some form of problem that could end up with behavioral health treatment services. We talked about the comparison of $226 for kids, and we compare those...wasn't the Medicaid expenditures? []

KATHY MOORE: Right. []

SCOT ADAMS: Yeah, $267. []

TOM McBRIDE: $267. And we look at comparisons for that. You know, we can only compare it against what we can compare it to. []

SCOT ADAMS: Yeah. []

TOM McBRIDE: Nationally, do we have a figure how that compares to other states if we look at the first 20 years of our life, and anticipating the last 20 years, going from 65 to 85 maybe, what the expenditures are there? []

SCOT ADAMS: Yeah. I think they're great questions. Yeah. []

BETH BAXTER: And I think nationally, too, Tom, I mean we could look...there's prevalence and utilization, financial data around kind of those tiers of children, 90 percent...it's kind that old 20...that 80/20 rule, that 20 percent, and it's true, 20 percent of children, so if that's the 21,000 or whatever, but 20, you know, 20 percent of the children utilize 80 percent of the resources within the system. And I think that's as true in Nebraska as, you know, it is on a national trend base level too. []

TOM McBRIDE: As well as total Medicaid expenditures with the 80/20, 70/30--70

percent are kids, but they only utilize 30 percent of it. []

SCOT ADAMS: Yes. []

BETH BAXTER: Because I know in looking at the integrated care coordination unit, I mean it was that same kind of rule, you know, that the children that utilized the vast...and I think it was about 75 to 80 percent of the financial resources were really 20 percent of the kids who were doing that. []

KATHY MOORE: Well, and I like your...Tom's. I think it's nice if we can look at that 90,000 as the population that we're really talking about. We were struggling a little earlier with that. []

JIM JENSEN: Of what our scope is? []

KATHY MOORE: Yeah. []

JIM JENSEN: Yeah, I would agree. I would agree. []

KATHY MOORE: Exactly. And then if take your $267 per year per child, you might again do the math differently and say, well, no, it's $1,335 per child if you're talking about those 90,000 children. And then you would apply your 80/20 probably to that 90,000 population rather than the 450,000. I don't know, I just think it... []

SCOT ADAMS: Lots of different points of view. []

KATHY MOORE: Yeah, it might help us begin to chunk this down a little bit. []

SCOT ADAMS: That's why I was so excited when the questions were coming out today. I thought, you know, I think we've got some answers in here. []

KATHY MOORE: Yeah. Yeah, good. []

BETH BAXTER: Right. Right. []

JIM JENSEN: Any other questions of Scot? []

TODD LANDRY: Just one. []

JIM JENSEN: Yes. []

TODD LANDRY: Scot, as it relates to these charts of showing the dollars spent in the categories, in each of those do we also have an idea of how many kids those dollars were spent on? For example, if $39 million was spent on residential treatment for the Medicaid dollars, do we know how many kids that actually is, versus practitioner/clinic, where we spend $26 million, how many kids does that impact? []

SCOT ADAMS: Yes. We think we can get to that, Todd, but we couldn't get to it today...by today, and so the team that helped put together this is still working on that and we hope to be able to have cleaner answers for that perhaps by our next meeting, but it was not an easy...that's not an easy number to get to. []

BETH BAXTER: And I'd like just to make a comment on page 8, the behavioral health expenditures, you know, where about 51 percent of the expenditures for the Professional Partner Program, that is you break that out further--I'm trying to think of this off the top of my head, but it's probably around 75 percent, 70 to 80 percent statewide, of those dollars purchase services. []

SCOT ADAMS: Yes. []

BETH BAXTER: The Professional Partner Program is really, you know, it's a therapeutic case management type of program, so those dollars, I'm going to say 75 to 80 percent of those funds, actually purchase services, outpatient, group home, what other other kinds of services that may be necessary, purchase them. []

SCOT ADAMS: Yeah, which highlights a great perspective and an important point to underline. It depends on...the answer to the question depends on the question and who you're asking it of,... []

KATHY MOORE: Right. []

BETH BAXTER: Right. []

SCOT ADAMS: ...from our vantage point or from the regions' vantage point and that kind of thing. And so that's a very good point, Beth, to bring to light. Thank you. []

TODD LANDRY: So, Beth, you're saying that some chunk of that blue is also spent on... []

BETH BAXTER: Service provision. []

TODD LANDRY: ...out...you know, residential treatment, etcetera? []

BETH BAXTER: Right. When there isn't another payer source for that, and then...but it's, you know, it goes forth to support the case management portion and then it also goes for the purchase of services that are within that child's plan of care. []

SCOT ADAMS: And just the... []

KATHY MOORE: So 20 to 30 percent is the case management? []

BETH BAXTER: Actually, I think that's on a regional basis, so I need to kind of back...the regional dollars, about 75 to 80 percent purchase services. So I think in the...I'm sorry, that's not totally indicative of the Professional Partner Program. []

KATHY MOORE: Oh, okay. []

BETH BAXTER: Yeah. But some of those dollars are used to make sure they are supported. []

SCOT ADAMS: And the other thing, just because this isn't complicated enough, some of the...if you have this dollars is sort of the regional monies that go into largely ICCUs in the regions. But if a child is Medicaid eligible, then Medicaid will be charged for the treatment of (inaudible) other page, although it's a service managed by the ICCU. Just...that's just to throw you off-track in case you were starting to think you were understanding it, (laughter) in case it was getting too easy for you. So there's a great deal of interrelatedness among the...even among the funding sources in that way. []

TOM McBRIDE: Looking at that, what Todd was talking about, that $39 million just in residential and that whole pie, is that public-private together, total expenditures? []

SCOT ADAMS: What page are you on? []

TOM McBRIDE: Page 9. []

SCOT ADAMS: Page 9. []

TOM McBRIDE: I guess I could... []

SCOT ADAMS: Well, this is just Medicaid expenditures. []

TOM McBRIDE: Yeah. But is that for, in the case of residential, is it public and private... []

SCOT ADAMS: Yes. []

TOM McBRIDE: ...you know, for... []

SCOT ADAMS: Yes, this is coming out of the Medicaid system. And so whatever they paid, it was shown as behavioral health. []

TOM McBRIDE: And that is the total thing, or is that just the General Fund (inaudible)? []

SCOT ADAMS: Well, it's the total number. []

TOM McBRIDE: Okay. []

SCOT ADAMS: So 40...whatever percentage would be out of state General Fund. []

TOM McBRIDE: Is what's represented. []

SCOT ADAMS: The $110 is a combination of state General and federal money. []

TOM McBRIDE: Okay. []

JIM JENSEN: Those kids that are in foster care and are receiving some sort of behavioral health services, that is on top of the foster care dollars that... []

TODD LANDRY: Yes. []

TERRI NUTZMAN: Yes. []

SCOT ADAMS: Yes. And so the numbers reported here, we have reported the behavioral health cost but not the foster care cost to the system. []

JIM JENSEN: Right. That's what I wanted to know. []

KATHY MOORE: I think that's an important point. That's kind of what I was trying to get at. At some point we need to look at that other amount also, based on the high percentage of our foster care population that has mental health problems. Because you could also, I think, look at...this also doesn't include, does it, the cost of the YRTCs? And so again, when you know that 80 percent of those kids have behavioral health issues or report...I just think at some point we need to look at those dollars because we are--that's what I was trying to get at this morning--we are spending those dollars and often, if we would have spent behavioral health dollars earlier, we might not have to be spending the state ward and juvenile services dollars later. []

RUTH HENRICHS: And where are the YRTC dollars, Scot, on all of... []

SCOT ADAMS: They're not... []

RUTH HENRICHS: They're not in any of this. []

SCOT ADAMS: They're not in here because it's considered a correctional program. []

TOM McBRIDE: Except HRC's. []

SCOT ADAMS: Except the HRC, yeah. I forgot. []

BETH BAXTER: But they're probably not here either, the computer residential service dollars wouldn't be...would they be captured in here? []

SCOT ADAMS: The...which ones? []

BETH BAXTER: For HRC. The acute and the residential psych dollars. []

JEFF SANTEMA: Doesn't seem like (inaudible). []

BETH BAXTER: They wouldn't, or would they be captured? []

KATHY MOORE: Because you're not using Medicaid, right, for those? []

BETH BAXTER: Well, or even in child welfare Medicaid or... []

TOM McBRIDE: Well, they are using Medicaid. []

SCOT ADAMS: No, we're not using Medicaid at HRC. []

KATHY MOORE: Huh? []

SCOT ADAMS: We would not have been using Medicaid at HRC. []

KATHY MOORE: Right. Even for the substance abuse program? []

SCOT ADAMS: Right, because of the 20-bed rule that's inching its way through resolution. []

KATHY MOORE: Okay. []

ROXIE CILLESSEN: Scot. []

SCOT ADAMS: Yes. []

ROXIE CILLESSEN: We are using Medicaid on 40 CD beds. []

KATHY MOORE: Yeah, that's what I thought. That's what I thought. Okay. []

SCOT ADAMS: Oh, on the 30 CDs? Thank you, Roxie. []

ROXIE CILLESSEN: But not the mental health beds. But we will be able to. Once we have the hearing and the regulations pass, we will be able to use Medicaid at HRC on the mental health beds as well. []

SCOT ADAMS: Thank you, Roxie. []

BETH BAXTER: So would those dollars be reflected in the... []

KATHY MOORE: In the Medicaid amount? []

SCOT ADAMS: Should be in the Medicaid side of it then, yes. []

TODD LANDRY: They would be in the Medicaid (inaudible) under substance abuse. []

SCOT ADAMS: Yeah, because it didn't matter for payer there. []

TOM McBRIDE: Does that come out of child welfare funds then, the HRC? []

ROXIE CILLESSEN: Now? The mental health ones right now are...its funding is coming out of child welfare until we get the rates passed. Then they'll come out of Medicaid. []

KATHY MOORE: When will those rates be up for hearing? Do you know? []

ROXIE CILLESSEN: They go to hearing in August. I don't know the date,... []

KATHY MOORE: Has that notice gone out? []

ROXIE CILLESSEN: ...but it's been set for public hearing in August. []

KATHY MOORE: Oh. I don't remember seeing that notice. Okay. []

JIM JENSEN: Any other questions? Did you want to comment anymore on SIG? You did include that in... []

SCOT ADAMS: Well, we...the last few slides were intended to identify some information with regard to SIG. I wanted to highlight the part that we hoped to sort of elevate the level of conversation and planning with regard to that. We're really in the midst of transition about that. If there were particular questions for SIG, be happy to respond to those, but I don't really intend any further discussion at this point in terms of presentation. But Pat Lopez, who has been a key staff person, is also here and would be available to respond to questions. []

JIM JENSEN: Any other questions on the SIG grant? []

KATHY MOORE: Oh, so there isn't going to be a different presentation? Okay. []

SCOT ADAMS: No, not beyond what you had there at the end. []

KATHY MOORE: Okay. []

JIM JENSEN: Okay. Thanks, Scot. []

SCOT ADAMS: You're welcome. Thank you. []

RUTH HENRICHS: Yeah, thanks, Scot. []

JIM JENSEN: It does, information helps, and also it raises other questions too, which we anticipated it probably would. But it does help a lot to help us along the way. Let's just go back for a little bit. After lunch and after thinking a little it, is there anything you want to change or review on the goals that we set forward that we were talking about earlier? Where did Erin go? []

SENATOR JOHNSON: She's just filling the chairs. []

JIM JENSEN: Oh, okay. Yeah. []

TODD LANDRY: Hey, Ruth, do you want to talk...would you mind sharing a little bit of what you shared (inaudible) shared at lunch about, given the time frame that we have here, what's a (inaudible) how to define it? []

RUTH HENRICHS: My comment was just that, given the time frame that we have, which is about four and a half, five months, I think we need to give ourselves some boundaries and some realistic things that we can accomplish. I, personally, think we need to begin...we need to identify a continuum or an array of services, and even though education and many other things...there are many other pots of money as we just discussed, I think in four to five months we have to be realistic about what we can get done. So I think it's important that we do that, give ourselves some boundaries and some realistic things to accomplish. []

KATHY MOORE: I agree. And I'm reminiscent...I wasn't at lunch so I'm just going to

throw this out then others that were at lunch can (inaudible). I'm reminiscent of however many years ago we wrote the Office of Juvenile Services legislation and we spent a year or so before we wrote that, and I've got this lovely little packet back in my office buried somewhere where we did that. We identified the full continuum or all of the needs that we thought juveniles had or exhibited, and then we actually said, well, each juvenile in the system should have access to service A within 25 miles or 50 miles of their community. We were trying to be cognizant of Omaha and Lincoln versus Benkelman, and so we tried to determine within what range. And I would think we might be able to do something similar to this for certain levels of care, for assessment, for early intervention, for whatever. And then determined, of course, that for a residential treatment component that needed to be accessible to family but probably 50 to 75 miles or whatever. I'm not saying miles is the most important thing, but I agree with you that we ought to be able to brainstorm that list of continuum. []

RUTH HENRICHS: In adult behavioral health, the oversight...prior to the oversight committee, we did build that continuum. That's not to say we can't add in things three months from now or nine months from now,... []

KATHY MOORE: Right. []

BETH BAXTER: ...but we need to give ourselves something to begin with. []

BETH BAXTER: And I was just going to say I think...was looking at the SIG, the subcommittee structure, and I was thinking that maybe the youth subcommittee has done some work. (Inaudible) Pat (inaudible). []

KATHY MOORE: Is Pat still here? []

BETH BAXTER: Has done some work on, I mean, kind of the assessment of services across the state, and so it would...there may be some things we could build upon that

are... []

TERRI NUTZMAN: Yes. []

(WOMAN): They have done both that, and Ruth was involved in some of that, that we have some data from (inaudible) and we also have focus group results from both families and youth and from providers across the state, both from the licensed mental health piece and the other providers (inaudible) that continuum. []

BETH BAXTER: So we might have a good start in that (inaudible). []

JIM JENSEN: Kind of in regards to what Ruth was saying also and the time period that we have ahead of us, and I was so pleased that everyone could attend today on this on rather a short notice. And I'd just like to ask at this time I think what I'd like to do is just set some dates. I'm afraid if we start asking, it will never work. []

KATHY MOORE: Absolutely. []

JIM JENSEN: And we'll try to get as many people as we can to attend. And so we'll do that this next week. But is there any day of the week that is particularly bad or that we should stay away from? We're on a Thursday today. And if I don't hear any, we'll just go ahead and set some dates and see how we proceed. []

BETH BAXTER: Are you thinking about once or twice a month? []

JIM JENSEN: Pardon? []

BETH BAXTER: Once or twice a month, every couple of weeks? []

JIM JENSEN: It will be more than once a month and we'll have to say whether it will be

two weeks or three weeks or whatever that spacing is we put in-between there. []

KATHY MOORE: I have several all-day meetings on Fridays. []

JIM JENSEN: On Fridays? Okay. []

KATHY MOORE: And so that is generally a bad... []

BETH BAXTER: So maybe that's a good day to miss. []

JIM JENSEN: Okay. We'll stay away from that then, or take that into consideration. []

RUTH HENRICHS: I think Thursdays are pretty common days that many of us have historically had meetings. I mean, when I look at my Thursdays, they're pretty booked with different kinds of meetings that other people around this table are even included in. []

KATHY MOORE: And the fact that we all are here is probably a pretty good indicator that Thursday is a good day. Is that what you're saying? []

BETH BAXTER: No, I'm saying Thursdays are terrible days. []

JIM JENSEN: (Laugh) She's saying the opposite. []

KATHY MOORE: Oh, bad! Oh, okay. Okay. []

RUTH HENRICHS: But I think you need to just... []

JIM JENSEN: Sure. Okay. []

RUTH HENRICHS: ...we will never, around this table, come up with a date...dates. You need to just pick and we'll be here when we can. []

JIM JENSEN: All right. Thank you. We'll do that. Is there anything anyone has that they really want to see on the next meetings that we have? []

KATHY MOORE: Well, it seems like we need whatever SIG has done. I think that it would be a waste of our time to go through a very exhaustive discussion of that continuum of care or of anything else until we know exactly what they have. So seems like that would be a place to start. []

RUTH HENRICHS: Am I the only person around the table that has not been to Hastings in the last period of time? Has everybody been there and toured it recently? []

CANDY KENNEDY: I haven't, actually. []

TODD LANDRY: It's been...it will be corrected soon, but I haven't been for over a year or so. []

SENATOR JOHNSON: It's been awhile since I've been there. I'll go with you. []

KATHY MOORE: And I think if we scheduled a meeting there, that would be fine. []

JIM JENSEN: To do a meeting there? []

KATHY MOORE: I think that might be a good option. []

JIM JENSEN: I don't have a problem with that. []

BETH BAXTER: Me neither. []

JIM JENSEN: We can carpool or... []

KATHY MOORE: Uh-huh. And along those lines, I don't think I (inaudible), but if we're talking about any touring, etcetera, has there been any thought, and I don't...I haven't talked to Terri, but I don't know if you have visited the facilities in Missouri. And I have touted those to HHS for about five years now and so at some point I view Missouri, the facilities right around the St. Joe/Kansas City area, as exemplary facilities for connecting behavioral health services to juvenile...to the juvenile justice system. So if we get to a point where we're honing in on that, I wouldn't want us to do it first, but I think to Ruth's point, if we decide that a real high priority for us is the juvenile population, I would at least like us to entertain the possibility of some folks...I have visited, I or my staff have visited there three or four times, but I don't think anybody from HHS has visited yet. []

TERRI NUTZMAN: And actually, the first...I think it's the first week in August I'm going to be at the American Correctional Association meeting in Kansas City,... []

KATHY MOORE: Oh. []

TERRI NUTZMAN: And there are groups going from both YRTC staff, from YRTC-Geneva, and staff from YRTC-Kearney, and we're looking at touring those, the two facilities at... []

KATHY MOORE: The two in the Kansas City area. []

TERRI NUTZMAN: Yeah, those two...those two facilities, yeah. []

KATHY MOORE: That would be outstanding. I'd like to talk to you about that. []

TERRI NUTZMAN: You bet, yeah. Sure, yeah. []

JIM JENSEN: In the next few months I'd be willing to go to Alaska to look at...(laughter). Okay. If I don't see anyone else's hand up or anything, we'd be available at this time to take some public comment from anyone who would like to make any comments, if there is anyone. I don't see any. I think we have enough that we can sit down and see if we can work up a schedule for this, for our next meeting, and we'll get that notice out to you as quickly as we can; also follow up with some minutes of what we talked about today. We'll also have to you some of the goals that were put down and, please, if there's anything else on that get it to the...to Jeff or to Erin, and we'll get that on our agenda. Anything else anyone would like to comment on? Yes, thank you for your attendance and I think we got a great start and we will keep going on. With that, that will conclude our meeting. Thank you. []