Developmental Disabilities Special Investigative Committee
September 19, 2008

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The Developmental Disabilities Special Investigative Committee met at 9:00 on Friday, September 19, 2008, in Room 1524 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing regarding Beatrice State Developmental Center. Senators present: Steve Lathrop, Chairperson; John Harms, Vice Chairperson; Greg Adams; Abbie Cornett; Tim Gay; Arnie Stuthman; and Norm Wallman. Senators absent: None. []

SENATOR LATHROP: (Recorder malfunction)...everyone. My name is Steve Lathrop. I am Chairman of the commission established by the Legislature pursuant to LR283 to investigate and to study issues related to the delivery of developmental disability services to folks in the state of Nebraska. Today we are going to visit and hear testimony regarding oversight, surveys, reviews, what the process is to...for government to check on how people are doing, whether it's at Beatrice or in the community-based programs, how...what government does to make sure that the people who are receiving services are in a safe environment and that they're cared for the way we expect them to be cared for. And for that we're going to hear from some folks from the licensing arm of Health and Human Services that have some responsibility for that. I might add before we begin that we wanted to have by today, we hoped to have, CMS in here to talk about the surveys that they've done. They've been very involved in doing surveys at the Beatrice Development Center, particularly since 2006, and they've been unwilling to do that. I've asked Governor or, rather, Senator Nelson to help me persuade CMS to come in and so far the best we've been able to get is an offer to come in some time in late November to meet with me and me alone. So we're still working on that. Hopefully, we'll hear from CMS, but I just want you to know that, some of you I've told that we were going to have them in, we're having trouble getting them here, trouble getting them to cooperate and notwithstanding the best efforts of Senator Nelson. We will hear today from Helen Meeks initially, and I think you'll find that we have some people here in the state of Nebraska that are nationally recognized for their ability to do surveys and their

ability to oversee the care provided to folks with developmental disabilities. So we hope to learn a lot from listening to Helen and Dr. Schaefer as well, both from Health and Human Services, in their licensing arm. And we'll have a little testimony so that you know that these two have a Chinese wall between the folks in licensing and John Wyvill, whose responsibility it is to run developmental disability services. So with that, let me also introduce my colleagues: Greg Adams is to my left, who is the senator from York; Tim Gay to my immediate left from District 14 in Sarpy County; Doug Koebernick is my legislative assistant; Senator John Harms is from Scottsbluff; and Beth Otto is our committee clerk. She's going to make sure we do everything the right way and she's given me a list of things to read and I haven't read it, as you can see, and I don't know if it irritates Beth or not but... []

(UNKNOWN): (Inaudible). []

SENATOR LATHROP: ...one thing she'd want me...(laugh) yeah, because it starts to sound like a stump speech up here. One thing we'll ask you to do is, if you're going to testify, you have to speak up so everyone can hear, adjust the microphone and that sort of thing, but we also need to have you fill out a sheet so that Beth has the information she needs to make sure we have a good and clean and clear record, and we can track you down if we have questions. So please make sure you fill those out and...what's that? []

BETH OTTO: Cell phones. []

SENATOR LATHROP: Oh, yeah, cell phones, if you have a cell phone, if you wouldn't mind turning that off so that we're not interrupted, same with the pagers. And with that, I think we'll start and our first invited speaker would be Helen or Dr. Schaefer? []

JOANN SCHAEFER: I'm starting. []

SENATOR LATHROP: Okay. That's good. We'll start out with Dr. Schaefer. []

JOANN SCHAEFER: Good morning. []

SENATOR LATHROP: Good morning. []

JOANN SCHAEFER: (Exhibit 1) I am Dr. Joann Schaefer, S-c-h-a-e-f-e-r, and I'm the chief medical officer and the director of the Division of Public Health. The Division of Public Health has numerous responsibilities for the health of the public and one of those is the regulation of healthcare facilities and healthcare professionals. Under the Uniform Credentialing Act and under the Health Care Facility Licensure Act, the role of the director of the Division of Public Health is to oversee the regulation and licensure functions of the department. The role of chief medical officer is to be the final decision maker in contested cases where the Division of Public Health has taken action against an individual or entity for violations of the public health regulation and licensure requirements. Because I hold a medical license in Nebraska and I am the director of the Division of Public Health, the Health and Human Services Act provides that I also perform the duties of the CMO. The Division of Public Health is distinct and separate from other divisions in the Department of Health and Human Services that are responsible for overseeing entities that Public Health regulates. The divisions do not share employees, nor do they have access to electronic communications or documents, paper files, or any other data that would interfere with the separation of the divisions that is necessary and required by CMS to allow the Division of Public Health to maintain regulatory oversight of these state owned and operated facilities. The directors of other divisions have no more say in the regulatory process of the Division of Public Health than the public participants in our rule and regulation hearings. It is also important to note that the CMO's decisions in contested cases are not subject to review by the executive branch officials, whether that be the CEO of DHHS or the Governor. These decisions, which are basically the final decisions in regulation and licensure enforcement actions, are reviewable only by the courts. My unit administrator, Helen

Meeks, will testify next to explain the survey process and provide some definitions and share the relationship with CMS and how it relates to our role. As you are aware, we've been out on many surveys to BSDC, as well as our other ICF/MRs within the state of Nebraska. We have been out on complaints, annual surveys, and revisits, all of which have been unannounced. We have shared copies of the findings of our surveys for the last ten years with you and can answer questions regarding those and the survey process in general. But first, I'd like Helen to explain the various types of surveys we perform and the oversight of us by CMS. I appreciate very much the ability to be here today and explain that to you guys. []

SENATOR LATHROP: All right, Dr. Schaefer. Before we see if anybody has any questions, I want to... []

JOANN SCHAEFER: Sure. []

SENATOR LATHROP: ...let folks know we've been joined by Senator Wallman. Glad to have you here today. Dr. Schaefer...anybody have any questions? Just so that...you and I have had some conversation, I want to make sure it's clear... []

JOANN SCHAEFER: Sure. []

SENATOR LATHROP: ...what your role is in the big scheme of things. When we look at a place like Beatrice, which is an ICF/MR, or the community-based programs, to the extent there is oversight by the state, it's done by your office. []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: And what you've explained to us is that you are...even though you are technically part of Health and Human Services, you are...there is a wall between you and the folks that run Beatrice so that your ability to judge how they're

doing is not compromised. []

JOANN SCHAEFER: That's correct. []

SENATOR LATHROP: And the person who's actually doing those surveys would be the next speaker, and that's Helen Meeks. []

JOANN SCHAEFER: That's correct. []

SENATOR LATHROP: Okay. Senator Gay. []

SENATOR GAY: Dr. Schaefer, you know, I understand how we do that, but do other states? Are we like other states? Is that what everybody does, where we have a separate and distinct branch or...? []

JOANN SCHAEFER: Yes. []

SENATOR GAY: Is there other methods that we could use? Most states have it set up that way, where their chief medical officer or somebody within a department regulates. []

JOANN SCHAEFER: Right, and within a department or an agency, regulates the other side of government, which has the ownership and operation functions of those facilities. []

SENATOR GAY: And that meets the CMS guidelines. []

JOANN SCHAEFER: Right. []

SENATOR GAY: But...so no other states do it any other way? []

JOANN SCHAEFER: Not that I'm aware of. []

SENATOR GAY: Okay. []

JOANN SCHAEFER: I can certainly check, but if the CMS designates us to be the survey agency of the state, whoever has that responsibility must be separate and distinct. []

SENATOR GAY: Yeah. []

JOANN SCHAEFER: In fact, when we went through the Health and Human Services Act, that was one of the things we had to do, was submit the language and the charge to CMS to make sure that they were okay with the way we were setting up the department, that they didn't see a conflict. Because if you look at it straightforward on the organizational chart, it looks like there very much could be a conflict. []

SENATOR GAY: Sure. Yeah. Well, you don't need to check. We'll check it. []

JOANN SCHAEFER: Okay. []

SENATOR GAY: As long as everyone else is generally doing it that way,... []

JOANN SCHAEFER: It's generally the same. []

SENATOR GAY: ...that's all I wondered. []

JOANN SCHAEFER: Everything...every one of my colleagues that I've talked to,... []

SENATOR GAY: Yeah. []

JOANN SCHAEFER: ...if they have a regulatory responsibility. Not all chief medical officers do, but some of them have a completely separate person that does that. []

SENATOR GAY: Okay. So as we go throughout the day, this is just standard what everyone is doing then. []

JOANN SCHAEFER: Yes, pretty much. []

SENATOR GAY: All right. Thanks. []

SENATOR LATHROP: I do have a couple more questions that I thought maybe I could... []

JOANN SCHAEFER: Sure. []

SENATOR LATHROP: ...ask to clarify your responsibilities. As a licensing agent, a place like Beatrice, in order for it to even open its doors, it has to be licensed by...and that's your responsibility to license it. []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: Is that true? []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: And if we look at a facility operated by Mosaic or ENCOR or another one of our community-based providers, before they can begin operations they have to be licensed, which means they go through an inspection. []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: So if we look at the opportunities your office has to be involved in evaluating the care provided, whether it's at Beatrice or in a community-based program,... []

JOANN SCHAEFER: Uh-huh. []

SENATOR LATHROP: ...those opportunities are first when they are licensed. Is that right? []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: And second, when you conduct a survey? []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: And a survey is kind of a term of art, but basically that's an inspection, is it not? []

JOANN SCHAEFER: Absolutely. []

SENATOR LATHROP: Okay. And then the third opportunity is if there's a complaint... []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: ...you might go out and do an inspection or a survey in response to a complaint. Is that right? []

JOANN SCHAEFER: Yes, that's correct. []

SENATOR LATHROP: So there are licensing surveys, some of which are random... []

JOANN SCHAEFER: Uh-huh. Right. []

SENATOR LATHROP: ...where you just show up at a place, and then responding to a complaint. []

JOANN SCHAEFER: Right, or going out on a revisit on a complaint that we've already established that there's a problem. They've done some things to correct it. We may go out on a revisit survey as well. []

SENATOR LATHROP: And that's a good point. If you find a problem, if your inspectors or your surveyors, and Helen will explain this I'm sure momentarily, but when you find a problem you develop a plan of correction with the institution or the facility, and then a revisit is to see if they actually did what they promised to do. []

JOANN SCHAEFER: That's correct, yes. []

SENATOR LATHROP: Right? []

JOANN SCHAEFER: Yep. That's exactly... []

SENATOR LATHROP: And that's basically the process. []

JOANN SCHAEFER: Yes. You've got it down. []

SENATOR LATHROP: Maybe take a second and share with us what your relationship is with CMS. You do a survey or an inspection and you share that with CMS and they share theirs with you. Can you kind of tell us how that works? []

JOANN SCHAEFER: Sure. All of the information that we put...and all our survey pieces are put into a central database or, you know, a computer that talks with CMS, so they have the ability to go on and look at our surveys at any given time. In addition to that, you know, when we ever have a question about any of the findings that we may have in a survey, they're always available for consultation. They've designated us as the state agency for being the ones to do the regulation on all of these, so that they're handing us that duty. At any moment, they could take that duty away if they weren't happy with what they were seeing or if they wanted to go back and do some checking themselves, but we've maintained that duty. Sometimes there's a slight discrepancy between the definition of what you'll find as far as a deficiency and the way they define it, the way we define it, and we have to go back and forth and kind of argue out the cases and see who really has the correct way of defining that deficiency. We just had a survey or a CMS review yesterday, actually, on our intake process. They were looking at two of the functions that we do where they compare how we triage and they compare the quality of our investigations and they review those. They score them. They're done on a percentage basis. They pull charts randomly. They just come in. We have it, usually, yearly and then we get the results from that. So if they see areas where we're not performing well or they think that there are issues, they point them out for us and then they give us opportunities to correct them or do some additional training and make sure the surveyors are up to speed. And they actually call it correctly on-site when they're writing the deficiency. []

SENATOR LATHROP: Okay. I have a few more questions and that is maybe to give people an historical perspective. You were kind enough to provide ten years worth of information in response to requests made by this commission and we've gone through an awful lot of the documents, one or which basically revealed to me that your office has been primarily responsible for doing the surveys of Beatrice up to a point in about 2006. Is that right? []

JOANN SCHAEFER: That's correct. []

SENATOR LATHROP: I mean, if we looked at how many were done by CMS and how many were done by your office, mostly you were doing that work up to 2006. And then we see CMS coming in and doing a large number of surveys themselves, probably in cooperation with your office. But they became the primary person to do surveys... []

JOANN SCHAEFER: That's correct. []

SENATOR LATHROP: ...since 2006. []

JOANN SCHAEFER: Yeah. We've been doing more with them more recently,... []

SENATOR LATHROP: Okay. []

JOANN SCHAEFER: ...but, yes, you're correct. []

SENATOR LATHROP: And just to maybe give you a pat on the back, I saw that there was some concern in your own mind, in an e-mail perhaps that I read, as to whether or not CMS stepped in because your office wasn't doing a good job. []

JOANN SCHAEFER: Sure. []

SENATOR LATHROP: In fact, that wasn't the case. []

JOANN SCHAEFER: Right. []

SENATOR LATHROP: You guys have been doing it the way you should. You'd been doing it in an acceptable way. And they actually used some of your people to help train people on how to do the surveys. []

JOANN SCHAEFER: Yes, that's correct. []

SENATOR LATHROP: So when we see the surveys done at BSDC go from primarily your office to primarily CMS, that didn't have anything to do with the quality of your surveys. []

JOANN SCHAEFER: Not according to any feedback that we've received. No. []

SENATOR LATHROP: Okay. Okay. That is all that I have, if anybody has... []

SENATOR HARMS: I just have one question. []

SENATOR LATHROP: Senator Harms. []

SENATOR HARMS: The surveys that you do, you identify where there may be issues and problems? []

JOANN SCHAEFER: Uh-huh. []

SENATOR HARMS: The question I have is how could we get ourselves into this environment that we have today with you looking at and surveying and identifying what the problems are? How could an organization go so far astray? It's just staggering to me every time I read these reports and look at the documentation. It just pulls at my...tugs at my heart to try to understand how we got here. Could you explain or give me any... []

JOANN SCHAEFER: Well, from my perspective or vantage point, you know, I look at this has been a ship that kind of slowly veered off course. And although the survey process is there to, you know, to check on all the things that we're supposed to check each time that we go in or based on a complaint, you know, many times those things can be addressed, answered, corrected at that time, but those are only during the times

that we're there seeing a specific window. That doesn't mean that during other times other things aren't happening that we're not there to see. And, you know, the complaint process actually works fairly well to take care of anything that is egregious, but I think a slow turn off course is probably the best way, if you look back over the last ten years, because there have been consistent deficiencies cited within the ten years of surveys that we've provided. But I think that to get to where it is now it does boggle the mind. But I think everyone has a role in that. []

SENATOR HARMS: Okay. Very quickly, the other question I would have then, once you identify the issues... []

JOANN SCHAEFER: Uh-huh. []

SENATOR HARMS: ...and identify this as a concern, and I'm sure there are other things that are going on at the same time, it's hard to get your hands around, it's the same question I've asked everyone and it's still in the back of my mind, comes back to the...it comes back always to the issue of management. It comes back to the issue, who's in charge? []

JOANN SCHAEFER: That's true. []

SENATOR HARMS: It comes back to the issue, do we have the appropriate staffing? It comes back to the issue, do we have the right credentialed people there? And that's how I'm beginning to sum this up. I just...I'm just kind of interested, since you've been there and you've watched this, what are your views about that? []

JOANN SCHAEFER: Well, I think there's definitely some truth to that. A slow change in leadership, a change possibly in culture, maybe slipping away from some of the best...standards of best care that are being done nationally and having leadership, may not be up to date on some of those things over time. And maybe it's so slow that people

don't realize or haven't realized that it's veered off course so much until they turn around and they look in the past and they can see where it's gone and where their peers are in other states. []

SENATOR HARMS: Let me ask you another question. In regard to the culture,... []

JOANN SCHAEFER: Uh-huh. []

SENATOR HARMS: ...could you give us any idea or suggestions of how that culture can change? Because I know that's really a difficult task... []

JOANN SCHAEFER: Uh-huh, yes. []

SENATOR HARMS: ...in any organization, particularly a troubled organization. []

JOANN SCHAEFER: Sure. []

SENATOR HARMS: What would you recommend to this commission about how to change that culture? Because it is...you know, we can make all the changes we want and recommendations, but if that culture doesn't change we'll be back here five years from now having the same discussion. []

JOANN SCHAEFER: That's true. You know, culture change, as you said, is very difficult to do, but it has to be very driven by the fact that it's...patient safety has to be, you know, up there, and you have to be able to ensure that the people that you are taking care of are your primary responsibility and that everyone is appropriately trained to the level that they should be and can provide the services that they're supposed to be according to their job title. Change in culture can, you know, take anywhere from outside companies coming in and telling you how to do it, to being very persistent but getting a positive culture. This is a staff that's been beaten down on quite a bit and has

had a rough go of it as well. And so, you know, John has done a really good job of uplifting them and having them really go and take this head-on and be really hard working in trying to change the course of where they've been. So I think it's that kind of leadership that's going to help change that culture, but it has to be constant and driven around patient safety. []

SENATOR HARMS: Thank you. Thank you, Mr. Chairman. []

SENATOR LATHROP: We have been joined by Senator Abbie Cornett, who has questions so we'll... []

JOANN SCHAEFER: Morning. []

SENATOR CORNETT: Thank you very much for coming today, Dr. Schaefer. When you have done the surveys and you've gotten the reports back from the federal government and they've cited deficiencies over and over again, the same deficiencies,... []

JOANN SCHAEFER: Uh-huh. []

SENATOR CORNETT: ...what have you done or what has been done to correct these when it's the same type of offense over and over again? []

JOANN SCHAEFER: Sure. Well, and sometimes it's not uncommon to see the same sort of deficiency found each time. You know, we go through with a plan of correction. We try to make sure, when we go out back on the revisit, that they're up to speed and they're following everything in the plan of correction. And then really, you know, after that it's based on complaints and revisiting and their annual surveys, and they have to keep up that behavior to keep them from doing the deficiency again. []

SENATOR CORNETT: But what happens if the deficiency is found again and again? []

JOANN SCHAEFER: Well, I think at that point, you know, this is not the only facility in the state that we've had problems with multiple deficiencies in the same area. You know, you really have to hold them to their plan of correction and changing that. I mean, it gets down to the point where you take a censure on their license and you do disciplinary action and those kind of things. But, you know, the goal is to get them to come into compliance with the regulations and understand what it is that they're not doing that gets them into trouble. []

SENATOR CORNETT: When you mention censuring on their license with some of the repeated deficiencies, have any of the professional licenses been revoked at the facilities? []

JOANN SCHAEFER: You know, I believe there have been some licensure actions taken place, but I don't have them and I could find that out for you. []

SENATOR CORNETT: Okay. What would the process be for that? []

JOANN SCHAEFER: For a professional license, they go into our Investigations Department, and our Investigations personnel go out and do a complete investigation on what was reported and then that license, that individual's license, action is taken against it. That then goes to the board of what...if they're a nurse then it goes to the Board of Nursing. Board of Nursing and the assistant attorney generals that work with the board come up with charges that may or may not be something that is filed. If they file the charges then it goes forward and the licensee has the opportunity to either work with an agreed settlement, where they come into compliance and agree to some censure on their license or a financial penalty. If they don't like the charges that are there and they don't want to go to agreed settlement, they have a contested case hearing. Those hearings are then heard and then the...it comes to me and I make the final decision on what the discipline should be for the person, which can include

revocation, suspension, suspension with taking courses and training, civil penalties. There's a large array of penalties that can be levied on a license. []

SENATOR CORNETT: Okay. Thank you. []

SENATOR LATHROP: Senator Gay. []

SENATOR GAY: Just following up Senator Cornett's question, is...so when it goes to the board, you find deficiencies--she asked the same questions going through my head--how are they corrected then? Then it goes to a board, right? Who's on that board? []

JOANN SCHAEFER: Well, it depends on if you're talking about the individual, a nurse, did something, then it's the Board of Nursing that would go right on that nurse about that case. []

SENATOR GAY: On her nursing license. Okay, let's... []

JOANN SCHAEFER: Yeah, not on the survey in general. []

SENATOR GAY: ...let's put it this way. Let's say it's a general deficiency... []

JOANN SCHAEFER: Sure. []

SENATOR GAY: ...on how the operation is being run. You've been down there and we're talking about a ship going off course over ten years. []

JOANN SCHAEFER: Uh-huh. []

SENATOR GAY: And let's say three years in a row you got the same deficiency and you

want to say, hey, no longer, we're going to do this, we're going to write you up or do whatever, but does it go to a board... []

JOANN SCHAEFER: No. []

SENATOR GAY: ...before you see it? It goes directly to you? []

JOANN SCHAEFER: Yeah. No, it comes to...it comes to us and we review it and then... []

SENATOR GAY: But when you say it comes to us, who is... []

JOANN SCHAEFER: To our division. So... []

SENATOR GAY: Okay. []

JOANN SCHAEFER: ...so the surveyors and Helen and myself and, you know. []

SENATOR GAY: At that point, though, here's where I kind of...I know we have a wall there... []

JOANN SCHAEFER: Sure. []

SENATOR GAY: ...and all the states are doing it this way, but at that point is...you guys are looking at this, there's no other input from outside sources, parents, there's no other review board. And I'm not big into creating new boards, but at some point, I mean, you know, we all have a boss kind of. That would be a hard decision to make. If you've got facilities around the state and you say, hey, we're going to shut you down, that's tough for anyone to make,... []

JOANN SCHAEFER: Sure. []

SENATOR GAY: ...especially when you...you know. So what I'm saying is should there be something in-between there that says, hey, as a group. Maybe it includes a department or Health and Human Services Committee members. I don't know what it would include, but some providers, an independent review board that may look at this before it gets to you. I mean that's a tough decision for someone to make financially and pressure and everything else. []

JOANN SCHAEFER: Sure. []

SENATOR GAY: I just wondered if there should be something in between. []

JOANN SCHAEFER: You know, I've never thought of that. I would have to think about that for a little while, to be honest, but... []

SENATOR GAY: Because somehow things weren't being corrected over the course of time and I think there's plenty of blame to go around. []

JOANN SCHAEFER: Sure. []

SENATOR GAY: I don't think we could say it's this person's fault. []

JOANN SCHAEFER: Sure. []

SENATOR GAY: I think over the course of time, as people change, and that's just what's happened. But what we're looking at in the future, maybe how can we correct that so we do have the best facility? Because I, you know, we've all heard, oh, we used to be the leader, the best in the country,... []

JOANN SCHAEFER: Uh-huh. []

SENATOR GAY: ...and obviously we're not now. I think we could be again, but maybe in the future we look at ways to say, you know, what can we do to be the best. But I just think that would be a tough decision for you to make. []

JOANN SCHAEFER: Well, it depends on the deficiencies that are cited, again, in what it is that we have found and how egregious it is. If it gets to the point where we have to take action on a facility and close them or restrict them in any sort of way, we have done that before... []

SENATOR GAY: Where at? []

JOANN SCHAEFER: ...not...I couldn't tell you offhand but I could...I can find it. []

SENATOR GAY: Very few times though. []

JOANN SCHAEFER: I can find those for you. But, you know, we want to give them the change to comply with regulations. And then if you go back and you see that they're complying, that doesn't prevent the next thing that can happen. And sometimes something bad will happen but the facility did everything correctly that they were supposed to do. And so, yes, something bad happened, but they followed their process perfectly. And so we don't find issue with that, but it is noted that something bad happened. []

SENATOR GAY: So you can't...and I understand you can't see into the future and say, oh gee. You can only correct it after it's happened, I understand that. []

JOANN SCHAEFER: Right. []

SENATOR GAY: But I'm just saying, I don't care if it's Beatrice or any of these facilities,... []

JOANN SCHAEFER: Sure. []

SENATOR GAY: ...that's a tough decision because you've got clients there, I know, you know, wherever it is. []

JOANN SCHAEFER: Oh absolutely. []

SENATOR GAY: So maybe there's some kind of other barrier or review panel or something we could set up between...and I don't know what it is today but I just...I think that's a tough decision for even if you weren't in that position. Whoever is sitting in your position five years from now, it's going to be tough, but maybe they could use a little help like we do on a 407 review or something like that, a bigger group. I don't know. It's something we could talk about maybe later. []

JOANN SCHAEFER: Sure. Be happy to. []

SENATOR LATHROP: Maybe to follow up on Senator Gay's question, ultimately, you can't vary from the standards because CMS is the ultimate arbiter of what's right... []

JOANN SCHAEFER: Right. []

SENATOR LATHROP: ...and what's wrong... []

JOANN SCHAEFER: Right. []

SENATOR LATHROP: ...and so all you're doing is taking their standards and interpreting them and applying... []

JOANN SCHAEFER: Right. []

SENATOR LATHROP: ...them to the care that you're seeing on your surveys, right? []

JOANN SCHAEFER: That's correct. And then they will levy... []

SENATOR LATHROP: So if they're violating them, you write them up just like CMS tells you how to do it. []

JOANN SCHAEFER: That's right. And CMS has, you know, the ultimate, you know, you know, stopping their funding as a tool, you know, that is used frequently. []

SENATOR LATHROP: Okay. Senator Wallman. []

SENATOR WALLMAN: Yeah, thank you, Chairman. Thank you for being here. Sorry I'm a little late. As far as the gravity of these offenses, you know, these complaints, is that...I hate to see that, you know, and I think everybody does. Do they... []

JOANN SCHAEFER: Uh-huh. []

SENATOR WALLMAN: ...are they against specific individuals, as a rule? Do you check into that? Is it, you know, is it verbal abuse? Is it sexual abuse or physical abuse? []

JOANN SCHAEFER: It could be anything that we get a complaint on and then... []

SENATOR WALLMAN: And is it against...do they take into account if it's against one person, you know, one resident, if they happen to embellish the truth, or do they keep track of that also? []

JOANN SCHAEFER: I guess I'm not quite sure I understand your question. If there's a complaint... []

SENATOR WALLMAN: Well, just say that I'm the person. []

JOANN SCHAEFER: Okay. []

SENATOR WALLMAN: You know, I don't like you as my caretaker. []

JOANN SCHAEFER: Okay. []

SENATOR WALLMAN: And I say you abused me this morning or something, and I scratch myself. And if this person does that over and over again to somebody, is that taken into account? []

JOANN SCHAEFER: Yes, we do take that into account. []

SENATOR WALLMAN: Okay. Thank you. []

JOANN SCHAEFER: And we try to be as savvy as possible on those difficult cases. []

SENATOR LATHROP: Senator Cornett. []

SENATOR CORNETT: When...you said that you followed CMS's guidelines, correct? []

JOANN SCHAEFER: Yes. []

SENATOR CORNETT: And that the ultimate threat was the revocation of funding from CMS. []

JOANN SCHAEFER: Sure. []

SENATOR CORNETT: You also stated that there had been facilities closed before in the state? []

JOANN SCHAEFER: Or put...not... []

SENATOR CORNETT: Maybe not under your direction but... []

JOANN SCHAEFER: Yeah, I know we've done some suspensions and we've done some...the payment issue is usually the thing that brings them around and is pretty swift, if they cannot come into compliance with their plan of correction. []

SENATOR CORNETT: Were those measures looked at, at Beatrice? Since we are in a situation where we're facing losing federal funding and obviously the situation was that grievous, how come the state hadn't stepped in and done something before that? []

JOANN SCHAEFER: Well, I think that that's exactly what was done, is that we have found deficiencies. They had come in to do a deficiency look and it got to that point. Plans...opportunities for plans of correction were given. They couldn't meet the conditions of participation and that's when, you know, the case went that way. So that... []

SENATOR CORNETT: You didn't need to look at shutting it down as a state because you felt the federal government would? []

JOANN SCHAEFER: And...well, we didn't find this...no, we didn't find the same amount of deficiencies or the type that they found when they sent in their large team. []

SENATOR CORNETT: That's what I was getting...now do your survey teams work

together at the same time? Do you send in survey teams at different times? And why is there such a discrepancy between what you found and what they found? []

JOANN SCHAEFER: Sure. Well, we send in two for maybe a week or however long it takes to fill out the entire survey, do the entire survey process, everything that we're supposed to do on it. They sent in, I believe, 11 people for two weeks. So there's already, there, you're going to set up a huge discrepancy in what they can find. If you put that many people in a facility, will find multiple things because you've a longer time to observe them. When our folks are there for a lesser time, they may not see all that there is to see that is bad, per se, even though they're completing the full survey process. []

SENATOR CORNETT: That brings up another question. When you have limited resources, when you're talking about two people for a week or... []

JOANN SCHAEFER: That was just an example. []

SENATOR CORNETT: ...that you send in, and there is the thought that maybe moving to community-based services would be the direction we should move for some of the patients, if we can't provide the staffing to oversight our own facility, how are we going to provide the proper level of oversight in community-based? []

JOANN SCHAEFER: Well, we're doing some community-based now, which Helen is going to explain how we do that now and, you know, that's going to be a challenge for us. But, you know, CMS funds us to do the work that we're told to do and that's what we...we do with what we have. []

SENATOR CORNETT: Do you see that you will be able to supervise or provide the proper level of oversight in community-based since we're already having a difficult time doing it at our own facilities? []

JOANN SCHAEFER: Sure, I see your point in that. You know, we have a lot of community-based providers right now that we're already doing that process. If there's a huge number the come on board, that all of a sudden start providing new services, get licensed and, you know, that could change the dynamic very much and we may have to look at things. But at this point we're doing some community-based, in fact many community-based, surveys and follow though. So one would hope that we'd keep up. []

SENATOR CORNETT: Thank you. []

SENATOR LATHROP: Senator Harms. []

SENATOR HARMS: Thank you, Senator Lathrop. Dr. Schaefer, in our earlier conversation that we were having, you indicated that Beatrice just slowly over time moved off course. How do we prevent that from ever happening again? I mean that really, to me, is the heart of the issue. []

JOANN SCHAEFER: Yeah. []

SENATOR HARMS: How could we actually start that from occurring, and what do we have to put in place to never allow that to happen again in this great state? I mean, that's really what this issue is all about. []

JOANN SCHAEFER: Absolutely. []

SENATOR HARMS: No matter what we find and no matter what the recommendations will be, we still have to think about the future, making sure that we don't have to do this kind of conversation again, you know, in the next five or ten years. And so what would your recommendation be? []

JOANN SCHAEFER: You know, they've made a lot of changes right now in their leadership down there and I would hope that that would start to, you know, really change things, in fact it already has, so, you know, strong leadership, strong management and very well-trained staff that have a clear eye on what the mission is of BSDC. []

SENATOR HARMS: So in that process, would your role change any to make sure that we're not drifting aside? And if it is then what would you do to start to correct that? []

JOANN SCHAEFER: Well, it could. That would be something separate, an addition that the state would ask us to do. It would be kind of above and beyond what CMS expects us to do, so it really would be up to your discretion as to what you saw our future role is doing anything on or above that. []

SENATOR HARMS: In regard to our community-based programs, as you look at our community-based programs as we have today, are we prepared to move more patients out of that center into community-based programs? []

JOANN SCHAEFER: I think it depends on the patient and the setting that they're going to. It's got to be a good fit for both of them and I think there are a lot of great places out there that do fantastic community-based services. []

SENATOR HARMS: Do we have the system established to be able to do that, to be able to monitor that, to be able to supervise that? Because my greatest fear would be,... []

JOANN SCHAEFER: Sure. []

SENATOR HARMS: ...as we make this transfer, we could get ourselves into a much more difficult situation than we have today because we have no...we may not have the

right staffing to monitor. What are your view about that? []

JOANN SCHAEFER: Well, of course I have concerns. We are doing a lot of monitoring already in the community-based services area so, you know, we would continue to do that. []

SENATOR HARMS: So your concerns center around what points? []

JOANN SCHAEFER: Having enough people to get in to review complaints if complaints went up dramatically. In fact, that's something that is of concern but we have no reason to suspect that will change. We have a long number of years of watching and being able to keep up, but I'm sure there are concerns there because that's where you get at the heart of what's happening in a place when a complaint is filed by anybody about the care of either their loved one, their friend is receiving at a place. []

SENATOR HARMS: Thank you. []

SENATOR LATHROP: Doctor, now I have some questions. []

JOANN SCHAEFER: (Laugh) Okay. []

SENATOR LATHROP: It sounds like you're telling us that in the community-based programs they're complaint driven, primarily,... []

JOANN SCHAEFER: They get surveys too. []

SENATOR LATHROP: ...and that's where you get to the bottom of it. So we have in many instances people that can't communicate at all and we're waiting for a complaint to come in before we can do an inspection to kind of get to the bottom of whether or not some provider in some part of the state is doing a good job, a poor job or whether we

have a systemic problem within an institution that we don't randomly survey. That... []

JOANN SCHAEFER: Sure. We also have random surveys of the community-based as well. []

SENATOR LATHROP: And that's kind of the other question. I put...I had the page put in front of you a document that we...that I think it came from your office, didn't it? Do you recognize that? []

JOANN SCHAEFER: (Exhibit 2) Yeah, I believe so. I think Helen put this together. Yeah. []

SENATOR LATHROP: Do you see it? It says DHHS,... []

JOANN SCHAEFER: Uh-huh. []

SENATOR LATHROP: ...Division of Public Health. That's your office? []

JOANN SCHAEFER: Yep. []

SENATOR LATHROP: And the line below that is, "Information on On-site Visits to Entities Serving Persons with Developmental Disabilities." That would be sort of a tally of the inspections made in 2006, 2007, and so far in 2008 to the various institutions that provide services to people with developmental disabilities. Would that be the case? []

JOANN SCHAEFER: Uh-huh. Yes. []

SENATOR LATHROP: And if we look at it, it breaks it down into three categories. One is ICF-MRs, which would include Beatrice. And Mosaic also runs three ICF/MRs. Is that right? []

JOANN SCHAEFER: That's right. []

SENATOR LATHROP: That's intermediate care facilities. That's what the... []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: ...that's what that stands for? []

JOANN SCHAEFER: Uh-huh. []

SENATOR LATHROP: Okay. The next category is CDDs. What's CDDs? []

JOANN SCHAEFER: Centers for developmentally disabled. []

SENATOR LATHROP: Pardon me? []

JOANN SCHAEFER: Centers for developmentally disabled. []

SENATOR LATHROP: Can you give me an example of that? []

JOANN SCHAEFER: Well, actually, that's what Helen was going to do the whole explanation of that. She has quite a bit to say. It's a step down and it's a limited number of individuals that are taken care of at those sites. []

SENATOR LATHROP: Are those high-need people, or is this the Bridges Program or... []

JOANN SCHAEFER: They're not as high need and, yes, Bridges is in there. []

SENATOR LATHROP: Okay. And then the last one is DD HCBW Providers. []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: What's that...? []

JOANN SCHAEFER: That's home- and community-based waiver providers. So they are slightly different and, again, Helen has the finite details of what makes them different, but these are Medicaid eligible providers for paying. []

SENATOR LATHROP: Okay. In the rundown or in the summary we have, under the ICF/MRs, we have an annual survey for each institution, and there are four of them. We have a category for annual survey, a category for complaint investigation, and a category for revisit. Is that right? []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: And then that's true with all four of the ICF/MRs. []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: And then we go down to the community-based providers, which is the third category, and we don't have a category for annual survey. Do you see that? []

JOANN SCHAEFER: Uh-huh. []

SENATOR LATHROP: We have a category for complaint investigation and for revisit, where you identify the number of those that your office undertook in each of the three years that are represented in this document,... []

JOANN SCHAEFER: Uh-huh. []

SENATOR LATHROP: ...but nothing in there for annual survey. So my question is, are we doing annual surveys on folks that are community-based providers? []

SENATOR LATHROP: Sure. And I need to ask Helen one technical question about that. Is that on random selected group (inaudible)? []

HELEN MEEKS: For CDDs. []

JOANN SCHAEFER: For CDDs, the percentage. []

HELEN MEEKS: They're randomly selected up to 25 percent. []

JOANN SCHAEFER: It's up to 25 percent for the annual survey on the CDDs, so they are done but they're not done on all of them. So every four years one would be. []

SENATOR LATHROP: Okay. So if I am a community-based provider in any part of the state of Nebraska, you're going to do a survey or an inspection of my operation once every four years. []

JOANN SCHAEFER: Sure. Yes. []

SENATOR LATHROP: And absent a complaint from one of my patients or residents or clients or a family member, I'm just going to...I'm not going to see or hear from the state at all. []

JOANN SCHAEFER: Possibly, yeah, absent a complaint. []

SENATOR LATHROP: Does the...does...we know that CMS has certain requirements for Beatrice State Development Center. That's why we're here. Do they also have similar oversight of Mosaic at Axtell and Beatrice and Tri-City? []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: The other ICF/MRs? []

JOANN SCHAEFER: Yep, exactly the same. []

SENATOR LATHROP: Are they getting written up in the other ICF/MRs? []

JOANN SCHAEFER: Yes. Yes, they are. []

SENATOR LATHROP: Does the...do the...what do they call it when they find something wrong? []

JOANN SCHAEFER: Deficiencies? []

SENATOR LATHROP: Deficiency, that's the term they use. []

JOANN SCHAEFER: Uh-huh. []

SENATOR LATHROP: What's the...are the deficiencies at, for example, any of the Mosaic institutions, do they rival what's going on at Beatrice? []

JOANN SCHAEFER: There are similar similarities, yes, in some of them. []

SENATOR LATHROP: And when we talk about community-based programs, that would include those ICF/MRs that are run by Mosaic? []

JOANN SCHAEFER: No, those would not...those are not community-based. []

SENATOR LATHROP: Okay. They're just institutions that are privately run. []

JOANN SCHAEFER: They are an institution like...yes. Exactly. []

SENATOR LATHROP: How many people do you have...pardon me. Let me back up. Does CMS have any say in how often or what your inspections or your surveys look like... []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: ...of the community-based providers? []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: And they're okay with you going out once every four years? []

JOANN SCHAEFER: That's what their plan is. []

SENATOR LATHROP: Okay. So you're doing... []

JOANN SCHAEFER: What they ask us to. []

SENATOR LATHROP: ...what they've asked and that amounts to once every four years. []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: By contrast at Beatrice, somebody was there, either you or CMS, at least once a year. []

JOANN SCHAEFER: Right, in all of the ICF/MRs. []

SENATOR LATHROP: How many people do you have that work for you, surveyors or inspectors, that are actually available to go and inspect all of the institutions that we see listed on this chart? []

JOANN SCHAEFER: Helen, what is our current number? Four. []

SENATOR LATHROP: Four? How many institutions or community-based providers are there represented on this? This is all of them, right? []

JOANN SCHAEFER: Yes. []

SENATOR LATHROP: How many are we talking about that these four people get around or are responsible for inspecting? []

JOANN SCHAEFER: The number of places? []

SENATOR LATHROP: Yeah. []

JOANN SCHAEFER: Do you have that? []

HELEN MEEKS: I can give you the total numbers. []

JOANN SCHAEFER: She has the total numbers written in her testimony. []

SENATOR LATHROP: Okay. Okay. []

JOANN SCHAEFER: I don't have it offhand. []

SENATOR LATHROP: I think that's all I have. []

JOANN SCHAEFER: Okay. []

SENATOR LATHROP: Senator Cornett. []

SENATOR CORNETT: Dr. Schaefer, can you explain to me why there would be a difference in inspection requirements or the survey requirements between a state facility and a community-based facility? If we're there every year and frequently more than that, why is it acceptable that we only inspect the community-based or survey a community-based provider every four years? []

JOANN SCHAEFER: You know, I don't know why that's deemed acceptable. That is what we're asked to do and that's what we are given the resources to do. []

SENATOR CORNETT: Do you personally find that acceptable? []

JOANN SCHAEFER: You know, having taken care of a lot of children in my practice that lived in CDDs, there are a lot of really good CDDs out there and... []

SENATOR CORNETT: But are there bad ones? []

JOANN SCHAEFER: And, yeah, you have your bad eggs, so to speak, in every bunch. But there are a lot of places that are doing a really good job. And just as a physician, I had the opportunity to report anything I found deficient at any time at those places because I was seeing the patient that would come in to me. So if their medications weren't right, if their nutrition didn't look good, if there was something, they had bruises

or something that couldn't be explained with their caretaker, that that's another opportunity that we...you know, the medical community helps us with some of that oversight, too, because they see these clients. []

SENATOR CORNETT: Okay. The question, though, was do you think every four years is adequate? []

JOANN SCHAEFER: You know, if we wanted to make it all fair then everyone should do it once a year, but I don't, you know, the resources for that and whether it would actually provide you with any increase in safety, I don't have an answer for that. I don't have any data that tells me that that's more effective or a better use. []

SENATOR CORNETT: Moving back to some...the line of question that Senator Harms was going at, it brought up to mind a couple of things. Could you describe to the committee the special needs of people at Beatrice and why they are there currently rather than a community-based, and whether you feel that moving towards community-based for all the residents is possible. []

JOANN SCHAEFER: Well, it's probably not possible for all residents, since, as we see, that's why we have Mosaic having three ICF/MRs themselves. They are higher needs patients, in general, or clients, in general, but not all of them. The point of having an institution that does that is that you can provide ongoing rehab services and bring all the services in there for the client so they're all there on one site. In the community it's very appropriate or some folks to live in a small group home and be able to attend services, get the services they need outside of that area, but that's very patient specific. []

SENATOR CORNETT: Moving on, how does your reporting process work from your office to John Wyvill and to Chris Peterson? Do you meet with them directly? Do you file reports with them? How is your reporting process? []

JOANN SCHAEFER: We work with them just like we would any of the Mosaic ICF/MRs. We would send them the letter regarding the deficiencies or the report or whatever we found, whatever an issue is, and then they have an opportunity, just like anyone else in the public has an opportunity who runs a facility, to come in and speak to us about corrective action plans, what needs to be done, and that's how it works. We don't go down the hallway and have a casual meeting. It's all done in the same formal way. []

SENATOR CORNETT: So all of your surveys, your reports, your recommendations are done in a formal process with Health and Human Services. []

JOANN SCHAEFER: Yes, just as they are with Mosaic. []

SENATOR CORNETT: And these are filed, written reports. []

JOANN SCHAEFER: Uh-huh. []

SENATOR CORNETT: And who else has access to those reports? []

JOANN SCHAEFER: You can request copies of your surveys and then they're ours, and we've given you ten years worth. []

SENATOR CORNETT: Okay. Thank you. []

SENATOR LATHROP: Senator Wallman. []

SENATOR WALLMAN: Thank you, Chairman Lathrop. Doctor, I'm not against community-based care. I want you to know that. Our daughter runs one in Iowa and she does her own inspections. And she asked neighbors, it's kind of like a foster parent. So we do not have the staff to do that, I don't think. And she finds abuses and they're fired immediately and no suspensions. They're gone. So do we as a state have that ability to

do that? And some of the clients, she's went to BSDC and talked to them, and those clients there, you probably won't find private care providers for a lot of them, and she told me this. I asked her. And so what are we going to do then? We'll probably put them in a worse situation than they're in. []

JOANN SCHAEFER: Absolutely. If they're not in the right level of service that they need then you don't do...that's why it has to be very patient-focused and... []

SENATOR WALLMAN: Thank you. []

SENATOR LATHROP: Yeah. []

SENATOR CORNETT: Dr. Meeks... []

SENATOR LATHROP: Oh, go ahead, Senator Cornett. []

SENATOR CORNETT: I'm sorry. You were talking, sorry. At previous hearings the question, and it was a question I brought up, do we have the community-based services available to meet the needs, and the response was that as the need for community-based service grows then the businesses will grow with them. []

JOANN SCHAEFER: Uh-huh. []

SENATOR CORNETT: Do you feel that the state of Nebraska is adequate currently in the amount of community-based services available? []

JOANN SCHAEFER: You know, I don't know the numbers cold. I've heard the same responses to my questions about the same, that as the...as... []

SENATOR CORNETT: Need grows the... []

JOANN SCHAEFER: ...the need grows, the services will grow with them. There's certainly a lot of people out there that want to help and be in this line of business. []

SENATOR CORNETT: Do you find any shortage though currently of community-based services? []

JOANN SCHAEFER: We haven't been faced with a situation where we've found a shortage anywhere in trying to find, no. []

SENATOR LATHROP: That's really not your... []

JOANN SCHAEFER: No. []

SENATOR LATHROP: ...in your wheelhouse, though, it is? []

JOANN SCHAEFER: That's right. []

SENATOR LATHROP: I mean, your job is to make...to do the inspections and not to decide whether we have enough capacity. []

JOANN SCHAEFER: That's right. It becomes a little bit of an issue on the nursing home side, When nursing homes close then we try, you know, to protect each client, make sure that each client is taken care of in coordination with the business or when there's a shift of ownership or what have you. []

SENATOR LATHROP: I think that's it. []

JOANN SCHAEFER: Okay. Thank you. []

SENATOR LATHROP: Thank you for your testimony. We appreciate that. []

HELEN MEEKS: Good morning. May I start? []

SENATOR LATHROP: Welcome. Sure. []

HELEN MEEKS: (Exhibit 3) Okay. I'm Helen Meeks and my last name is spelled M-e-e-k-s, and I'm the administrator for the Licensure Unit within the Division of Public Health, Department of Health and Human Services. And my testimony is going to focus on how we regulate or inspect settings that serve persons with developmental disabilities and...go ahead. []

SENATOR LATHROP: Yeah, I was going to ask if you can tell us a little bit about yourself professionally before you tell us about your testimony, because we really are fortunate to have somebody with your background and your reputation here at the state of Nebraska. []

HELEN MEEKS: Well, thank you. Thank you. []

SENATOR LATHROP: Maybe you can share that with the other members of the commission. []

HELEN MEEKS: I've work in Nebraska state government for about 33 years and my professional training is in speech and language pathology. I am a graduate of the University of Nebraska, a master's degree in speech pathology. My undergraduate degree is in speech communication from Jackson State University, and I always say that's the school that Walter Payton attended, so people will know that. And I've been in Nebraska for 30-plus years and love it. It's home for me now. We have a history in terms of the regulatory activity for various entities. The Licensure Unit, we have four major programs in our unit. One is the licensing and certification of healthcare facilities,

and many of your questions, we can talk about some of that. We also license all of the people. If you have to have a license or certification, registration to do anything that's health or health related, we administer the licensing activities for those groups. We also license all the childcare programs, and then we do certificate of need. So those are our four major programs within the Licensure Unit. And we have people around 157 employees, and they're spread all across the state. We inspect, as an example, all the pharmacies and so I have a pharmacy inspector that is out in the Cozad area who goes west, and we have one in Omaha area who does the eastern part of the state. So many of our surveyors, the people who survey the hospitals, the nursing homes, the ICF/MRs, they're spread all over the state and they report to managers who are located within our central office. In terms of regulating settings that care for persons with developmental disabilities, we are authorized by primarily two things. One is state statute and that's the Health Care Facility Licensure Act, and it's codified in Chapter 71, starting with section 401. That grants the authority for the state to license BSDC, Mosaic or the hospitals in this state, and that statute sets out certain regulatory authority. Now it's primarily the only reason we license anything as a healthcare facility or service is for protecting the health, safety and welfare of the persons who are going to be served there. That's our statutory authority to do that. The second level of authority that we have for regulating Beatrice State Developmental Center and other settings is through what is known as the 1864 agreement--I often say I don't know if it was done in 1864; I certainly was not around if that's the year that that agreement was started--but that's an agreement with the Centers for Medicare and Medicaid Services, or CMS. They contract with various state agencies to do what is referred to, or what they refer to, as survey and certification activities, and the only reason, the only reason that a facility would be under the egis of CMS is if they wanted money, if they wanted to receive Medicare or Medicaid funding. BSDC, as an example, is funded through Medicaid and that's why we survey them in that regard. They have to be licensed first, as your question talked about. That's their ticket, I often say, to operate. The state of Nebraska says in order to be a hospital you have to have a license, and there are certain requirements that they have to meet, and we look at those prior to the time that we would issue a license and then there are some

inspections that go on after they become licensed. In terms of ICF/MRs in this state, we have...in terms of services or settings, I should say, that care for persons with developmental disabilities, there are three types of settings. One is the ICF/MRs, another one is the CDDs or the centers or group homes, and then the other one is the home- and community-based waiver settings or programs. Now an ICF/MR is defined in state statute as well as in CMS's statutes...regulations as a facility where a number of things occur: shelter, food, training or habilitative services, advice/counseling--the list goes on and on--diagnosis, treatment, care, nursing services, dietary services. All of the things that the people who are residing in that facility needs the ICF/MR is to provide it and the statute defines them as if you are providing those services for 24 consecutive hours to four or more persons. That's what an ICF/MR does. And the persons have to have...who are...who have mental retardation or related conditions. And our state statute goes on to say some of those related conditions: epilepsy, cerebral palsy and/or other things that affect one's development. That's what an ICF/MR is defined in state statute as being. Now our statutes do not restrict the size, the upper limits or the maximum size of an ICF/MR facility. However, under our state Medicaid regulations for the state of Nebraska--these are done within...by the Medicaid and Long-Term Care Division within Department of Health and Human Services--there is a minimum of 15 persons that is set under state regulations. An ICF/MR can be as large as it wants to, but it has to be at least, if you're going to participate in Medicaid, 15. Now there are four ICF/MRs in our state and we've talked about those. BSDC, and BSDC has a license capacity of 404. Doesn't mean that they have that many residents at any given time. When we go in to survey a facility, we look at the size, the infrastructure that they have in place, including the staff, their procedures, all of the things, could they care for up to that maximum capacity. And once we make a determination then that's usually how they set their licensure. But again, their census can be anything more than that. Mosaic in Beatrice has a capacity of 140, Mosaic at Axtell has a capacity of 112, and Mosaic Tri-City, which is located in Grand Island, has a capacity of 9. Now you just heard me say that under state Medicaid regulations the minimum is 15. This facility was in operation prior to the time that our Medicaid Division put that minimum of 15 there and

so they grandfathered that facility in. So it's nine and that's why that number is there. In terms of the centers for developmentally disabled, or CDDs, these are...again, they...when you look at the statutory definition, they pretty much can do or care for people with the same needs as an ICF/MR, but it has to be four or more, and we have many of our settings, and when you were talking about community programs, many of the community...things that are in the community, a group home or an apartment or a condominium, many of them only have three people and so those places do not have to be licensed by our state statute so we would not be in there looking at them from a licensure standpoint if they had fewer than four. However, if they are receiving any funding through Medicaid, as an example, or through their home- and community-based waiver program, then there are requirements that they have to meet and we would survey or inspect them in relationship to those requirements. The CDDs tend to provide services to clients who have fewer needs, particularly physical health needs, because...and that's their choice. They are just designed...they are not, as Dr. Schaefer talked about, some community settings will, if the person can be able to get, you know, medical services or whatever by going to their doctor, their physician, like you and I do, they could probably live very well in a group home. If you have a person whose physical health needs, as an example, require skilled nursing on a 24-hour-a-day basis, those people tend to live and be cared for in an ICF/MR setting, just because it makes, I guess, more sense economically to do so. In terms of CDDs, there are 155 CDDs in our state and they have a licensed bed capacity of about 872. So in those kinds of settings we could care for 872 people statewide. If there were more that came on board, obviously we would inspect them to determine if they meet the licensing requirements. Again, CDDs typically, there's no restriction, a CDD could be as large as BSDC if they chose to do that because there's nothing in state statute that would restrict them or limit them. But they tend to limit themselves to four or six beds and usually I think that's just because of the way they choose to set up their service. And again, in addition to being licensed, CDDs typically are certified to receive funding under the home- and community-based waiver program. And again, we're not...we may not necessarily be able to explain all of these different funding streams and so forth. That's not our

responsibility within the Division of Public Health. We serve as the entity that surveys and inspects them. I think all of our CDDs, as an example, maybe with the exception of one, and I can't remember where that one is located, also have home- and community-based waiver clients who receive funding through the home- and community-based waiver, and that's allowable. The home- and community-based waiver providers provide services to adults and children with mental retardation and related services, and again, they must be certified in order to...for the individuals they serve to receive this funding through Medicaid. And evidently there were some federal dollars that came about in our state through our Medicaid, and Long-Term Care Division applied for this, what is called the waiver funding, and so I guess there's quite a bit of money that comes into the state of Nebraska through this funding stream and we have community-based providers that get the benefit of that funding. Right now there are 31 home- and community-based providers in the state, and some of them may be here today to testify later, and they have 1,460 settings. So, as an example, Region V is a provider and in Region V you might have 300, 200, or 100 settings, and so that's how they work. When we go out and inspect them, if we're looking at Region V, as an example, as the provider, we can go into any of the settings in Region V. We just wouldn't go to one setting if we are there doing our routine inspection. We would choose several settings. One setting may be residential, or the only services that they are providing would be residential, teaching people or caring for people in terms of, you know, how to take care of themselves, personal needs and those kinds of things. We also may look at their...if the people...some regions have day treatment programs where folks go to a workshop or they go to other jobs, and we would look at the systems that they have in place as it relates to job training and so forth for those individuals. So we would be looking at various components or aspects of the services that a provider has and that would occur during the inspection. Since the department, at that time the state Department of Health, was already designated as the survey agency, when the home- and community-based program came about it was designated, the state determined back in 1987, that we, the arm of the agency that serves as the public health entity, would also inspect these home- and community-based waiver settings. The regulations,

though, are set by the state. They're set under the authority of the Medicaid Division, not by CMS, in terms of home- and community-based waiver programs. So that is one of the distinctions, and the state has a lot of leeway in terms of what they include in those regulations. So usually there's a joint effort in terms of the regulations development for the home- and community-based waiver. Medicaid, Mr. Wyvill's division, and then Public Health would typically be at the table working on these regulations and those would be the ones that we use to inspect the home- and community-based providers. They provide, again, home- and community-based waiver settings provide usually three types of services: residential, what we call day treatment or what's referred to in the regulations as day treatment, and then respite services, and that's basically where you have a program set up or designed to give the caregiver a break, as I like to call it. If the person is living at home, parents are taking care of him or an older sibling or younger sibling, for that matter, the state, I believe through the waiver program, pays for respite services for people to come in and give the regular caregiver or provider, or respite services that may be occurring in a freestanding facility. The regulatory process that we use for ICF/MRs--and we've talked about this, you've asked a number of questions--under federal rules for participating in Medicaid as an ICF/MR, they must be surveyed annually, and their certification is tied to that annual survey. If they would not pass certification, as an example, if BSDC does not meet those conditions of participation, they would not be recertified and, therefore, they could not receive federal funding. There's a long, drawn out process that one has to go through before they're going to be decertified. We talked about that earlier. You go on site, you inspect them, and they, if there are deficiencies found, depending on the nature of the deficiencies, the facility sets up a plan of correction. The inspecting agency determines whether that plan of correction is acceptable. It might require a revisit or a follow-up visit to see are they implementing it and so forth. Before you're going to get to the point where funding would be in jeopardy, there are several steps involved. The ICF/MR annual surveys can be done by either the state, as we are doing now being the survey agency; however, CMS may choose to participate in the survey either with the state or they can conduct a survey independent of the state, which they did at BSDC in 2006. Prior to that time we

had been conducting those surveys and since 2006 we have been conducting all of the complaint investigations at BSDC. I think we started that. CMS asked us to start doing complaint investigations, I believe it was in...last year. I know it was in 2007. So any complaints that have occurred at BSDC since then, we were in there doing those investigations. The surveys are extensive and they can range anywhere from one week to several weeks, depending on the size of facility, the number of surveyors that go in, and the nature of the survey findings once the survey starts. And we have four surveyors. CMS, as Dr. Schaefer pointed out, had brought in a larger number of surveyors when they went into BSDC in 2006. The surveys examine several areas. There are eight conditions of participation and those are listed in my testimony: governing body, client protections, facility staffing, active treatment services, client behaviors and facility practices, healthcare services, physical environment, and dietary services. Within each of those conditions there are many, many regulations and standards. I brought a little book and if you guys want this book you can keep it, because it lays out for under each condition here are the standards. Like under governing body, as an example, it may have one that you have to...one standard is you have to appoint someone who's in charge. Senator Harms asked about that. There has to be someone in charge of that facility and that person has to have certain responsibilities and those are specified in the regulations. We, their survey agency, do not run a facility. We don't go in there. That's not our job to go in there and do the administering and the day-to-day operation of the facility, whether it's a state-owned facility like BSDC or if it's BryanLGH Hospital. That's not our role to go in there and run that facility on a day-to-day basis. We survey for compliance with the eight conditions of participation and there are a lot of survey tasks that are involved. CMS dictates the protocol in very detailed fashion, however, there are three general methodologies that we use during survey: records review, observation, and interviews. Those are the general methodologies that are used. There's a random selection of clients that occurs when we walk into a facility and the selection is based upon the size. So the premise is the greater the census in the facility, the larger your sample is going to be. For instance, CMS's requirements is that if the facility census is between 17 and 50, you've got to

look at 8 individuals and you have to look at those individuals in a very detailed fashion. If the facility is larger, like BSDC, where you have 100, if it's between 101 and 500 beds, we have...I think the sample selection, we're required to do a 10 percent sample and so, of course, you see the numbers would go up the larger the census would be. We would review the sample clients, review their care, their treatment, training records, medical records, incident reports. The individual program plans would be reviewed to determine what needs had been identified, whether the staff are meeting those needs. We would do observation of care of the sample clients. We...during the survey process, that observation can occur at any time, including early morning hours, evenings, weekends. Once a survey start, the surveyors, whether they are state people or the federal people, can be in that facility at any time and we can remain in that facility as long as possible, and that is so that you can get a depiction of what is actually happening. If you have a situation where there's a problem that relates to, say, the breakfast serving, then you have to be in there during the time that they're going to serve breakfast in order to do an adequate survey. You just can't show up and say we're going to be there for the noon meal and the evening meal, and do the observations then. In terms of interviewing, that includes interviews with all levels of staff, direct care staff, middle and upper management. We also interview clients, those that are cognitively capable of responding, as well as family members and/or guardians. And so, I mean, that gives you a general overview of the methodologies that are used: interviewing, observation, and records review. And I think the rest of my testimony we've touched on already in terms of sampling, procedures for records review, all of that specified and we would follow those procedures. I should point out, too, that at the time of the annual survey, we also would do...look at licensing things. []

SENATOR LATHROP: Senator Harms. []

SENATOR HARMS: Thank you, Senator Lathrop. Helen, thank you very much for your testimony. []

HELEN MEEKS: Thank you. []

SENATOR HARMS: Listening to you in regard to all the rules and regulations that we have that really govern an institution like Beatrice, the thing that still bothers me, how could we allow ourselves to get into the situation that we're in now? What actually broke down to allow Beatrice to be in the position it is now? That's what really...that's what I keep groping with, I keep trying to penetrate to find out. What happened? []

HELEN MEEKS: I think... []

SENATOR HARMS: I mean with everything you've got right here, there should be no reason in the world that we're in the position that we're in today, so what actually happened? []

HELEN MEEKS: I think, Senator, there are a number of things that happened. First of all, Beatrice, BSDC, had not been deficiency free over the years. They had had deficiencies and so...but there's a process by which you can correct them. Now I think also you can have a change--and we don't just see this in an ICF/MR facility, we see it in a nursing home--you can have a change in administration and we normally will see, too, when you have, if your administrator...something goes awry, or your director of nursing, you can have a facility that can go downhill very, very quickly because of those kinds of changes. You know, I can't tell you and give you a this-is-exactly-what-happened act at BSDC. What I can tell you is that there were deficiencies that had been cited. They were given the opportunity to correct those deficiencies and they got back on course. And then you can steer back off course for a variety of reasons. []

SENATOR HARMS: Well, it seems to me, at least from my observation, that's all it is, is that somehow we don't have the check and balance system truly in place to correct what took place. If it happens that rapid, and I think this has been a slow process of

occurring because of earlier conversation, it went off course and we were unable to bring it back. And I guess what I am trying to come to grips in my mind, how do we stop that from ever happening again? I mean you have policies, you have the rules, we have the regulations. But, in my mind, something broke down and we should have had the brakes put on this much quicker because we're...I think we're putting people at risk and that families place their loved ones there and that we have the responsibility to make sure that they have the best care possible, and it's clear in many cases that wasn't true. That didn't happen, and that's what I'm driving at. I mean how do we...how do we fix that? []

HELEN MEEKS: Well, I think certainly from a survey standpoint, you could say you're going to put in enough resources that we're in a facility every month, but I don't think the answer...I think it's a multiprong answer. The fix, I should say, is multiprong. I think it's regulatory piece, it may be more frequent oversight, more in-depth oversight. But it also has to be accountability within the operation all the way through the facility, and I think that's part of the fix. And we, as the regulatory piece of it, cannot assume and have not assumed the responsibility for it. So, in my mind, it's multiprong, that starts with the operation, the day-to-day operation of the facility, you touched on cultural change, holding people accountable for what's going on in those facilities, and that doesn't necessarily...it cannot solely rest with the regulatory piece of it, you know. []

SENATOR HARMS: It's clear to me that we didn't hold them accountable. We identified the issues, but they continued to...they continued to go astray. So in this process, when is it that it should be brought to another level and addressed at another level? Because it's clear that we didn't...to me, at least, it's clear that we did not have the appropriate leadership in that institution to correct this. So where is it in this process that we go to a next level that says, you know what, you have a very serious problem here and it needs to be corrected now? It seems like to me in this whole thing it just fell aside and I don't know if it was ignored, I hope it wasn't, but that's what my observations are. So when do we go to the next level and what process should be put in there so you can go to the

next level to address the issue? []

HELEN MEEKS: Perhaps... []

SENATOR HARMS: You know, I don't think we should have to put a commission together to deal with this. []

HELEN MEEKS: Right. And perhaps it might be something as simple as, at the point in time when we do a survey in a facility and you send out the deficiency report, that goes to the facility administrator. By our state statute, that's where you send it because that's who is responsible and that's who you're dealing with. And perhaps something as simple as saying, in addition to the information going to that facility chief, then it ought to go to whoever owns that facility, which in this case is the state of Nebraska, whoever their governing authority is, if it's a private organization whoever their board of directors is. Perhaps that may be something that should be done because then there is an assurance that someone higher than the chief in the facility is aware of the issues that are going on or that have been cited. []

SENATOR HARMS: Yes, I think that the buck always stops at the top here, you know, whoever has to answer for this. You know, that's where it should go and the overall responsibility is where that should be discussed. Because, as I said as I view this, it's definitely in my mind that something really broke down that was seriously wrong with the system that we have today. So I don't...now what are your thoughts about that? []

HELEN MEEKS: Well, I'm not sure what I'm...what I'm being asked. []

SENATOR HARMS: I'm just...what I'm really asking is where did we break down. That's really... []

HELEN MEEKS: And I think I've answered that. I think, you know... []

SENATOR HARMS: Okay. I feel comfortable with that, yeah. []

HELEN MEEKS: I think I've answered that... []

SENATOR HARMS: Thank you. []

HELEN MEEKS: ...to the best of my ability. []

SENATOR LATHROP: Senator Cornett. []

SENATOR CORNETT: I've read the paperwork. I just want a little bit more clarification. You go out and you do a survey. You find deficiencies. Who gets that deficiency report currently? I thought it was HHS, but you just said that it was the director of the facility. []

HELEN MEEKS: It goes to the director of the facility, gets the deficiency report. []

SENATOR CORNETT: Okay. So... []

HELEN MEEKS: And again, we leave it to... []

SENATOR CORNETT: And I understand you're not responsible for.. []

HELEN MEEKS: Yeah, right, for them to tell... []

SENATOR CORNETT: ...for Health and Human Services or for the facility, the running of the facility. []

HELEN MEEKS: Uh-huh. []

SENATOR CORNETT: So the director is the only person that gets a copy of that report. []

HELEN MEEKS: Currently. []

SENATOR CORNETT: Currently. []

HELEN MEEKS: Uh-huh. []

SENATOR CORNETT: All right. What do you receive back again, a plan of action for correct... []

HELEN MEEKS: Plan of correction. []

SENATOR CORNETT: Plan of correction. []

HELEN MEEKS: Yes. []

SENATOR CORNETT: How many days is that from the time that they receive the... []

HELEN MEEKS: I think there is...I think it is ten days, they have ten working days to provide a plan of correction. []

SENATOR CORNETT: Who...do you happen to...and I know this is not your area. Do you happen to know who has to approve that plan of correction? []

HELEN MEEKS: We do. []

SENATOR CORNETT: Well, who draws up the plan of correction... []

HELEN MEEKS: Oh, at the facility level. []

SENATOR CORNETT: ...at the facility? Is it the facility? Is it the supervisor above the facility in Health and Human Services? Do you know who does that? []

HELEN MEEKS: I don't know who does it as far as BSDC is concerned because there is no regulatory requirement in terms of the echelons within the organization of the facility. []

SENATOR CORNETT: So... []

HELEN MEEKS: We just expect it to come back to us with the chief, whoever is in charge of the facility. []

SENATOR CORNETT: So you wouldn't know if, for instance, the head of the facility even notified Health and Human Services about the deficiencies. []

HELEN MEEKS: No, we would not necessarily know that. []

SENATOR CORNETT: All right. So you receive the plan of correction within ten working days. []

HELEN MEEKS: Uh-huh. []

SENATOR CORNETT: Then do you have to approve that plan? []

HELEN MEEKS: Yes. []

SENATOR CORNETT: Okay. And who is responsible for approving the plan? []

HELEN MEEKS: It's within the Licensure Unit. I have, for each facility type, facility or service type, there's an administrator under me and so that administrator reviews that plan in concert with the surveyors who were there on site and we look at it to see--and then sometimes I'm involved with that review--we look at it to see have they addressed the areas of the deficiency, that's one piece, and then whether or not we need to, depending on the nature of the deficiencies that were cited, do we need to actually go out back on site and take a look... []

SENATOR CORNETT: That was my next question. []

HELEN MEEKS: ...or is there something that... []

SENATOR CORNETT: If you're required by law to survey once a year... []

HELEN MEEKS: Uh-huh. []

SENATOR CORNETT: ...and you find significant deficiencies, you turn those over to the facility. They have ten days to develop a plan of correction. You look at the plan of correction. At what point do you go back out inside that year and resurvey? []

HELEN MEEKS: Okay. Thank you. We would go back out based on the date that they tell us they expect to have that deficiency corrected. []

SENATOR CORNETT: How many days are they given to correct that deficiency? []

HELEN MEEKS: It varies. Sometimes...we have a provision, we have the authority to do what we call a directed plan of correction and sometimes it can be...we will say you have to have this done within five days, depending on the nature of it. Let's say if they...we went into a facility and it was, you know, in the middle of summer and the air-conditioning wasn't working. We would say probably, when we did the deficiency

statement, that would be one where we would direct them, you have to have your cooling system fixed by X date. []

SENATOR CORNETT: And then do you actually physically send someone back out to make sure the deficiencies have been corrected, or do you just take a written report, we corrected this? []

HELEN MEEKS: It could be either/or... []

SENATOR CORNETT: Depending on the level of deficiency? []

HELEN MEEKS: ...depending on the level of it. So we could specify a particular date. In many instances, we leave it to the facility to say when will they expect to be in compliance with this condition of participation, these standards underneath that condition, and then we base our revisit date on that date that the facility has provided. []

SENATOR CORNETT: Back to the line of questioning that Senator Harms has, where did the system break down, in the last couple of years it looks like it has snowballed until we are now facing losing federal funding for Beatrice. With the level of deficiencies that you were finding and the federal government was finding at Beatrice, how often has your office been going out and surveying and doing follow-ups on the deficiencies found? []

HELEN MEEKS: In the last year or... []

SENATOR CORNETT: Over the...we'll just say the last two or three years. []

HELEN MEEKS: Okay. At least...well, obviously, we were in there annually and then, you know, it depends on the number of complaints that came in. You know, we might have gotten 100. We have the numbers and we certainly can give you the numbers of

complaints that came in from any facility type. []

SENATOR CORNETT: Well, I meant in regards to when you sent out the approval of the plan to correct the deficiencies, how many follow-ups did your office do? []

HELEN MEEKS: Okay. I think, and I would have to pull some notes, I think we've been in maybe on two or three follow-ups, probably more, and I will get my notes out and look at that. []

SENATOR CORNETT: You know what, you can provide that later. You don't have to go through the notes. []

HELEN MEEKS: Okay. Yeah, because we can tell you exactly the number of follow-ups that we have done at BSDC. []

SENATOR CORNETT: Okay. Could you provide that... []

HELEN MEEKS: Sure. []

SENATOR CORNETT: ...for the last four years in regards to the plan of actions and then what steps you took after you received those plans? []

HELEN MEEKS: Right. Because that information is in your... []

SENATOR CORNETT: Is it? []

HELEN MEEKS: It is in there. []

SENATOR CORNETT: Okay. []

HELEN MEEKS: Because in there, in the three volume booklets, three volumes of notebooks that we've provided to Senator Lathrop, we listed here's the survey, then here are the follow-ups and the results of those follow-ups to every survey that has occurred at BSDC over the last ten years. []

SENATOR CORNETT: When you say...does it breakdown follow-ups in regards to actual on-site visits? []

HELEN MEEKS: Yeah, it will tell you that. Uh-huh. []

SENATOR CORNETT: Okay. Good. []

SENATOR LATHROP: Senator Adams. []

SENATOR ADAMS: Good morning. []

HELEN MEEKS: Good morning. []

SENATOR ADAMS: Thank you, Senator Lathrop. I noticed in the...one of the earlier sheets that was handed out, and again in your testimony, where beginning in 2006 CMS chose to do their own independent. Do you have any opinion as to why they said to the state, we're going to do our own independent surveys now? []

HELEN MEEKS: Yes. []

SENATOR ADAMS: Could you tell me what that is? []

HELEN MEEKS: CMS had indicated to our division, Division of Public Health, in the latter part of...let's see, I think it was '05, they presented us with some comparison data from facilities, ICF/MR facilities, across the nation how many surveys were conducted,

how long you were in there, the number of deficiencies that were cited. And they indicated to us they were concerned about the number of deficiencies that we had cited at BSDC and, primarily, I think they were saying too fewer...too few. And CMS tends to take a real close look at state-operated facilities, large state-operated facilities. Many states have eliminated large ICF/MR facilities. Michigan, as an example, has one large one and that's it. Nebraska has BSDC. And CMS, frankly, looks at those that are state operated. And I think they had a concern about whether or not we were serving BSDC to the level of strong scrutiny, I guess, is my terminology, even though the times that they had been in there with us, and they had--they had gone on I think two monitoring visits to ICF/MRs in Nebraska between 2003 and 2006, prior to the time they went to BSDC in the latter part of 2006--they had come in and they watched us. When they do a monitoring visit they basically are watching us do the work that we are contracted with them to do. And they went us at BSDC and one of the facilities in Axtell. And we received no feedback from them indicating that they found deficient practices on our part. But they were concerned, we know that they were concerned, they made it known to us. And so we said, okay, well, you know, just because we don't cite deficiencies doesn't mean that we missed something. You can go in a hospital on any given day, you may find something. You can go in a nursing home on any given day, you may find something. You go back; you may not find anything. Look at the complaints that had come in from BSDC. Had we missed investigating any of those complaints? So we didn't get that real specific this is what you didn't do, but there was the general concern. They gave us comparative data. Dr. Schaefer and I met, we were in a meeting down in Kansas City. Then in April of 2007 a CMS official came to the department again expressing concerns, just general, you know, you just don't look like you're citing enough deficiencies at BSDC when we look at large facilities like this nationwide and you compare the number of deficiencies, that sort of thing. We took their concerns very seriously and we put together a plan to address their concerns, even though they did not ask us for one, and we laid out in that plan what we were going to do. We said we were going to monitor ourselves, we're going to send our surveyors--and we only had...at that time I think we had two vacant positions--we will send our surveyors back

to your training, CMS, even though they had gone through that training before. We will, if you come in and do monitoring visits, if you come in and do what they call focused reviews with us, we would welcome the opportunity for you to do that. And so we submitted that plan in June of 2007 and that started toward implementing that plan. We were getting ready to do BSDC's survey in July, I believe. Actually, we actually did go in and do that survey. And before we were able to go back and do the revisit, CMS came in and did their own visit in the latter part of '06. []

SENATOR ADAMS: Thank you. []

SENATOR LATHROP: Do you have any other questions? []

SENATOR ADAMS: Not right now. []

SENATOR LATHROP: Okay. Senator Wallman. []

SENATOR WALLMAN: Thank you, Chairman Lathrop. Yeah, thanks for being here and thanks for you being in the people business. I know that's a tough business; thanks for doing it. And picking up on Senator Harms, the buck stops at the top, I mean President Truman. And it stops with us now. So we have to find a solution. And maybe we are being picked on, which we probably are. But in regard to this, you know, board of directors, elevators, banks, you know, we're seeing a different climate in this country of accountability and it bothers me. You think...how can we turn out future leaders for like the BSDCs and our governors, our presidents and our senators? I think our education system...can we hook into that somehow to breed dedication? You know, we're having trouble with workers. Do you have any ideas on that? []

HELEN MEEKS: Yes, certainly education helps. But I think people have to really care about what they do. And that doesn't mean it's all about education, in my view. Working with people with developmental disabilities, and certainly there are providers here I'm

sure who can speak to this better than I can, you have to care about the people that you're working with. It's not about the...yes, you need to know the regulations. But it's about I have to treat these people with dignity and respect, and you use common sense approaches. I worked at BSDC and I went there in the seventies. And I considered it a blessing. But you have to have that dedication, that's my view. And that to me is part of the culture change and so forth. And again I'm not saying necessarily I don't believe that BSDC is the most terrible place in the world. There's been some bad outcomes, it can happen. But you have to be...you have to hold people accountable and you have to look at hiring and selecting people who really have a desire to help the people who are being served and who need to be cared for in that facility. That's my view. []

SENATOR WALLMAN: Thank you. []

SENATOR LATHROP: Senator Gay. []

SENATOR GAY: Thanks. Thank you. Helen, you had mentioned Michigan. This is a follow-up to Senator Adams question. But you are being proactive to go and say we're going to have our own solution, train our inspectors, which I commend you for doing. Then you kind of touched on this. So Michigan, nationwide does every state have these type of facilities, these large, large ICF/MRs? []

HELEN MEEKS: Some states, Senator, have eliminated their large... []

SENATOR GAY: How many? []

HELEN MEEKS: I don't know the number off the top of my head. We could probably get that. But most of the states, many of the states have gone to what is referred to as the ICF/MR smalls, which are the 15-beds type settings. I think because of the funding streams, you know, it's just probably easier to serve a smaller population. So several states have eliminated the large institutions. And the only reason I mention Michigan is

just because I know that as we have been working with CMS here recently, they do what they call kind of a prep training prior to the time that Michigan surveyors goes into their large, that one large facility that is in...that's located in the state of Michigan, because you don't...it's kind of the proficiency issue. If you only inspect this type of facility only once your proficiency probably may not be theoretically as great if you were, you know, inspecting ten and so forth. And so CMS used Michigan as an example as they were working with us. And they said, yeah, we'll be...we'll come to you. And a lot of this we just do by teleconference as prep work, they said, because Michigan has only one large ICF/MR facility. Washington, D.C., as an example, I know that they've gone all small 15-beds or lower. And they had egregious problems in those a few years ago. And that started the national trend that CMS has been on there for several years in terms of looking at the survey agencies work a little bit more closely, because there were some egregious things that occurred in Washington, D.C. And so CMS set up these...this contract. And they had nationwide people going out in every state attending the surveys with the state surveyors. []

SENATOR GAY: Okay. So, I guess, the idea of what I'm getting at is if we're bucking a national trend to go to smaller facilities, then we're always probably never going to get out of the...from under a microscope. I know you're a national leader in these things, inspections and some of those. I don't know where we're at, but maybe that's something that we need to look into of, you know, what's the future, you know, because we're not looking...we're looking backwards. That's why we're all here. But I think Senator Harms and everyone else is saying, what are we doing to do proactively to be better again? Like you said, you worked there and it was (inaudible). And I think we need to go back there. So maybe we all need to focus on what's out in the future. Another thing, when you do, in that book probably it says this, but I don't have time to look at that right now. But training to me, staff training I'm talking about, whether it's Beatrice or a local community, is training a requirement? Can you talk about that a little bit of how do you train your staff, that they're doing best practices? And how do they stay informed of CMS changes that are coming? I mean, is there updates, bulletins? Can you talk about

that a little bit. []

HELEN MEEKS: Yeah, there are staff training requirements. And the regulations may...it's broadly stated that you are to have a sufficient number of competent trained people. And the training is supposed to be commensurate with the services that you're going to be providing. So it's very broadly defined and it, in my view, should be because it gives the facility the flexibility to train their people in accordance with the needs of the residents that they are being cared for. There are some specific training. For instance for nurse aids there's a requirement that they've got to take a 40-hour course, that sort of thing. But that's a nurse aid whether you're going to be working in any type of setting, an ICF/MR or nursing facility, whatever. So the training requirements, it's broadly stated and it gives the facility the flexibility to train in accordance with their needs. So when we are in there surveying we look at if you have someone, for instance, who is on a ventilator, was their training for the direct care staff in taking care of that? And are they trained so that they know when they are supposed to call the nurse, because obviously the nurse isn't...they don't have a nurse on every living unit where there is a vent client. But the direct care staff needs to be trained in caring for that and then have the understanding--here are the signs and symptoms that you need to look for when you need to call the nurse, so that the nurse comes on board, does the nursing assessment, and then can decide this is time we need to call the physician, this person needs to be taken to the hospital. So we would be looking at it in terms of again, as Dr. Schaefer talked about earlier, patient needs, client needs. And the training needs to be commensurate with that. []

SENATOR GAY: Okay. And then would...so you said there are four inspectors that are out doing...is that the larger ICF/MRs, there's four inspectors? []

HELEN MEEKS: Yeah, right. []

SENATOR GAY: And you have staff of 157 to do all licensure. []

HELEN MEEKS: Um-hum, right. []

SENATOR GAY: You got a lot, you got a big job, I know that. But the question is this, you are being proactive. You go to CMS and you say, show us what you want. How do you want us to inspect? So I commend you for doing that. The question is, they probably...do they get back to you or not. But is four enough? And should there be...are you looking into that? Saying, well gee, maybe we need some more, you know, if we're not doing it right. Have they ever got back to you? And are you looking...what steps are you taking to train future inspectors, because to me it sounds like it's not just something that anyone of us can just walk into and, oh by the way, I'm a quality inspector. What are you doing to train people in the future? I mean, we could add more staff or what's your plan? []

HELEN MEEKS: We are looking at, within the agency, whether or not we should be shifting resources. I think it would be pretty obvious to everybody to say four people cannot inspect to the degree that we need to. For ICF/MR facilities we have 155 CDDs, over 1,400 settings for home- and community-based waiver services. And so we are looking...Dr. Schaefer, Mr. Wyvill, at the resources that we have in the department. Should some of those resources perhaps be shifted from something else to, you know, regulatory oversight? I know that's one thing that is occurring within the agency. We've provided Dr. Schaefer some data in terms of, you know, complaints, the numbers and what you need to in order to make an informed decision about additional resources. Do you need to...and it may be a shifting. I'm not here saying, you know, it's going to be 10 new positions, 80 new positions. But I know that that's being looked at. []

SENATOR GAY: So it's being looked at. But, I guess, when is the answer going to be made or when would be know that we need 12? And I know people cringe at that, but I think Senator Wallman brought up a point and maybe we're seeing it in my industry, the financial services industry. You can have regulated us fine, but if they never show up, it

doesn't do you much good. So there's a certain point here where...and I'm not a big regulatory person. But I think we owe it to the clients that we...and the parents, everyone that these people who are so vulnerable, that we're doing our job. We don't want to overdo it. But there's a happy medium and maybe we've slacked a little there. I don't know. I mean you're the expert on that. But I'm looking forward to saying here's how we're...and maybe you can't answer that. But maybe here's where we're going, I think it's important that we know that in the future. []

HELEN MEEKS: Yeah, yeah. And it isn't something that I have the answer to. []

SENATOR GAY: Yeah. []

SENATOR LATHROP: I want to ask a few questions. I was...we made a request and we've received, I think, 20,000 to 30,000 pages of material, something like that. So thank you for what you've provided. We have all kinds of people in the Capitol reading this stuff and trying to go through it. And I've had an opportunity to read some of it that's been kind of set aside. And as I was reviewing it maybe historically, and this is a question I was asking Dr. Schaefer. And that is originally, kind of historically your office was doing the inspections up to 2006. Is that true? []

HELEN MEEKS: That's correct. []

SENATOR LATHROP: And you did find some deficiencies. They were kind of, if there's such a thing as the every day kind of deficiencies, they were the sort of the every day, run-of-the-mill sort of deficiencies, general problems? []

HELEN MEEKS: Yeah, some of them were general problems. But, you know, some of... []

SENATOR LATHROP: You didn't identify instances of abuse and immediate jeopardy

in, say, the five or six years before 2006? []

HELEN MEEKS: I'd have to look, Senator. But I know that we had cited deficiencies in the client protection area. And then was it to the extent or same degree that CMS's findings? I think that's where there might be some variance. I don't know off the top of my head if we had cited...I know that we had not cited BSDC as being out of compliance. Where I think CMS's survey they were out of compliance with, what, six of the eight conditions. And I don't believe that we had found them out of compliance with that many of the conditions on any of the surveys that we had done. []

SENATOR LATHROP: All right. You would have, as part of your job with the state and given your responsibilities, reviewed what CMS did in 2006 and 2007 and so far in 2008? That be true? []

HELEN MEEKS: Yes. []

SENATOR LATHROP: And as a general statement, they have found abuses and neglect and instances of neglect at Beatrice in the course of their inspections, is that true? []

HELEN MEEKS: They have. []

SENATOR LATHROP: And I was struck by a pleading that they filed in connection with the appeal done by the state of Nebraska where they summarized it, basically, in this fashion--they said, you have a personnel problem, staffing problems at Beatrice which leads you to move people around from cottage to cottage, from building to building, from assignment to assignment so that we have people that are unfamiliar coming in to a particular resident hall and filling in for people that have called in sick or maybe just for a person that we have not filled the position for. Would that be true? That's essentially their finding? []

HELEN MEEKS: Yeah, I'm sure, yeah. []

SENATOR LATHROP: And the difficulty that that understaffing has presented is that you then have folks who don't know the client. So they really don't know when they have a behavioral issue or if that's sort of their baseline. You have folks that aren't trained to deal with a particular individual with whom they're being assigned. And the staffing problems are also causing a situation where they don't have opportunities to take the people who do work there and go get them the training they need. That would be a fair summary of what they found? []

HELEN MEEKS: Um-hum. Yeah, I think so. []

SENATOR LATHROP: And that has been a chronic condition. And really as I kind of went through this it looks like CMS has said, we've told you this is the problem, we've told you this is it, and by the way, all of this leads to unhappy people who are...they have a tough job to do, it's hard on job satisfaction when you're working too many hours, you don't have enough support. And now we're going to move them around to places that they're not familiar with, and all of a sudden we end up with abuses and neglects. And that's sort of the conclusion of CMS. []

HELEN MEEKS: I would agree with that assessment. []

SENATOR LATHROP: And then the state has come in, in response to what CMS has said in '06 and '07, and basically said, this is our plan to fix it. []

HELEN MEEKS: Well,... []

SENATOR LATHROP: They necessarily have to do that. []

HELEN MEEKS: Are you talking...when you say the state, you're... []

SENATOR LATHROP: I'm not saying you, but... []

HELEN MEEKS: Oh, okay, thank you. Okay. []

SENATOR LATHROP: ...as you observe this, as someone who watches these inspections and this process, basically, the state has come in and said, this is our plan of correction. We're going to fix it in one manner or another. []

HELEN MEEKS: Yes. []

SENATOR LATHROP: Right? And they haven't gotten that done. That's really kind of what got them decertified. Would that be fair? []

HELEN MEEKS: Well, to some extent, because again when CMS did the visit at the end of '06 there was a revisit and there were still deficiencies found at the time of that revisit. They asked us to join them mid-2007 on another revisit, still deficiencies found. We have found, since we've started to do all of the complaints, we have found deficiencies that are...some of them involve neglect, abuse, those kinds of things. There's been, I think, one maybe two immediate jeopardy situations that we found as a result of a complaint visit. And so each time again the facility is given the opportunity to put in their plan of correction. And then, of course, CMS is going to be looking at that. And then we either jointly with them will go on sight and do a revisit or we may go by ourselves or they may go in and do a revisit. []

SENATOR LATHROP: Maybe the point I'm trying to make with these questions is this--is that we've been put together by the body, the Legislature put this commission together to investigate this. And it's really hard when we look at individual incidences of abuse and we say, well, that is abuse, and that is neglect. And we get so caught up in

looking at incidences that we're groping around, as Senator Harms said we're groping around for what's the big picture problem. []

HELEN MEEKS: Um-hum. []

SENATOR LATHROP: And as I read the pleadings filed by Health and Human Services, CMS in this appeal they kind of summarized it sort of succinctly. You know, we don't have enough people and that leads to all sorts of problems. It leads to overtime, which leads to unhappy people who are tending to high needs patients. The hours that they're putting in because there aren't enough of them there is leading to a lack of training, we don't have time to train them and get them through the system. And that...if there's a big picture sort of an issue that's come out of the CMS reports that would be it, wouldn't it? []

HELEN MEEKS: I guess I wouldn't disagree with that. []

SENATOR LATHROP: Okay. This problem at Beatrice has led us to or led various people to talk about maybe the solution is to take...well, the Governor's five point plan that's been presented is to bring the population at Beatrice down to 200. I think I saw something this morning that said to reduce it down to 170 maybe by the end of next year. But the idea is to reduce the population. And that's only going to happen in one of two ways--one would be attrition, and the other would be moving them to a community-based program. That be true or can you think of another way? []

HELEN MEEKS: I would assume...yeah, I would assume so. []

SENATOR LATHROP: Okay. Okay. And that leads us to, all right, if we're moving them to the community, how do we know that there are going to be any safer there? Is the community look like a good idea? Helen, does the community-based programs look like a good idea today just because nobody is watching them the way they're watching

Beatrice? []

HELEN MEEKS: I think from the regulatory oversight standpoint we've got to look at our regulations. And those are being looked at within the agency to see, because we had...the regulations had been worked on for a long time. And we've, as you know, gone through various reorganizations within the agency. And I know that Mr. Wyvill recently indicated we were going to reconvene to start working on those regulations. And I think that needs to happen. And I'm speaking again from the regulatory standpoint. You all have addressed that issue. How much...how many times do you get in there? What are the kinds of things that you look at when you go in there? And then again it's just not all about that piece but also what are the requirements that people who are going to be...who have a group home, what are they supposed to be doing and how are they going to be held accountable through the contracts, with the money that comes from the state, whether it's through Medicaid or some other source. So all of those pieces need to be in place, in my view from a regulatory standpoint and a day-to-day operation standpoint in order to ensure that, you know, community services...people in community who are served in programs that are community-based are being cared for properly. []

SENATOR LATHROP: Aside from the people that are already there and maybe whose families would like to see a little more oversight, you're suggesting though that before we make some kind of a wholesale move to community-based programs that we need to put something in place to make sure there are proper inspections and surveys. []

HELEN MEEKS: Yeah, yeah, I think our regulations really do need to be put in place and ready to go. []

SENATOR LATHROP: You mention that Mosaic operates ICF/MRs, three of them, in Axtell and Beatrice and also in Grand Island. Is that right? []

HELEN MEEKS: Um-hum, yeah. I don't know if it's Mosaic or...I have the name, so I...yeah, Mosaic, yes. []

SENATOR LATHROP: That's on this list here. []

HELEN MEEKS: Right, yes, the three. []

SENATOR LATHROP: And are you involved in the surveys of those institutions? []

HELEN MEEKS: Yes. We survey them annually. []

SENATOR LATHROP: The one thing that we haven't done is look at those survey results. And I'm not sure...maybe I need to have you give me a little idea what they look like rather than to request and get another 10,000 pages. (Laugh) How are they comparing to Beatrice? Has CMS come in, Helen, and taken that and said, we're also going to look at Mosaic and how they're doing with the privatized ICF/MRs? []

HELEN MEEKS: CMS has not come in and conducted the annual certification survey for any of the Mosaic operations. They were in last week, I think, or week before now and did a monitoring visit with our surveyors and gave us glowing reports. We found some deficiencies. []

SENATOR LATHROP: They were glowing about your survey,... []

HELEN MEEKS: Yeah, about that we were following...yes. []

SENATOR LATHROP: ...your ability to do a survey or about Mosaic's... []

HELEN MEEKS: No, about our surveys, because they were there checking on us. []

SENATOR LATHROP: Okay. []

HELEN MEEKS: And so that said, we were identifying...properly identifying deficiencies, if there were any. If we didn't find any we, you know,...so they gave us glowing marks. But we did have, we did find some deficiencies. I don't know the nature of the deficiencies that have been cited...that were cited on that survey or all the Mosaic surveys. That's something that we could do in a summary for you where you wouldn't get, you know, the 1,000 page job. We could give you a view if that's something that the committee... []

SENATOR LATHROP: That would be...I think it would be helpful for us. But can you put them side-by-side and tell us how Mosaic is doing. They're running the same kind of a facility the state runs at Beatrice, am I right? []

HELEN MEEKS: Yes. []

SENATOR LATHROP: They're... []

HELEN MEEKS: Under the same regulations. []

SENATOR LATHROP: Mosaic is running the ICF/MRs privately and Beatrice is running one as a state facility. How are they comparing to one another? []

HELEN MEEKS: Right. And we can put together a document that will give you that view. []

SENATOR LATHROP: You can't tell me today? []

HELEN MEEKS: I can't tell you today. []

SENATOR LATHROP: Okay, I won't ask you to speculate. I think that's all I had. Senator Gay had a few questions and others. []

SENATOR GAY: Helen, this is follow-up to Senator Lathrop's about community-based settings. And I think some of us have questions. Right now I'm looking on page 2. You said there's 31 providers with that, and they have 1,460 different settings where clients are. The question is this, is somebody comes in and let's say more people were going to be served in a community-based setting. And right now we have 31. Is there...when you go out and they come in and say, I need a license, I want to enter this business, I want a license. Does the state have to give it to me if I meet all the requirements or do we cap those licenses? []

HELEN MEEKS: We do not have a cap on the number of licenses. []

SENATOR GAY: But you have to give the license to me if I meet all the requirements? []

HELEN MEEKS: If they meet, right, if they meet the requirements that are... []

SENATOR GAY: Okay, you have to do that. []

HELEN MEEKS: Yeah. []

SENATOR GAY: Okay. The second one is then if we do that, when you're looking at 31 different agencies, if we have to give them a license and they meet all the requirements, they get part of the waiver money. There's no priority system, there's no saying that, oh by the way, you top 10 do a much better job, and I don't know the...you top 10 do a much better job than the other 21, we're going to give you more money. We can't prioritize it that way? []

HELEN MEEKS: I don't know that, Senator. That's something...because we don't, public

health doesn't administer the funding. []

SENATOR GAY: So that's... []

HELEN MEEKS: We look at them to see if they meet the requirements... []

SENATOR GAY: Okay. []

HELEN MEEKS: ...to be eligible... []

SENATOR GAY: I'll ask. I'll go find that out later. []

HELEN MEEKS: ...for funding. And the funding decision is made somewhere else. []

SENATOR GAY: Okay, I can find that out on my own. Thanks, Helen. []

SENATOR LATHROP: Senator Wallman. []

SENATOR WALLMAN: Thanks, Senator Lathrop. Yes, Helen, sorry about asking all these questions. But say I'm a private care provider and you write me up. Do I lose my license immediately or am I under jeopardy or do I have to... []

HELEN MEEKS: We have a range of penalties, Senator. And thank you for asking that question. There are a range of penalties that can be imposed on a healthcare facility or healthcare services license--everything from a fine, a monetary fine, which under state statute can be up to $20,000. And we have fined facilities. And we can prohibit admissions. And we use that one a lot, because if we go out and find certain types of deficiencies that are going on, for instance they're not acquiring the medications that the physician has ordered for this person, that probably is going to lead us, when we inspect them if we find that, that would probably lead to a prohibition on admission,

because we're seeing you aren't taking care of the people that you have there, so why would the state authorize you to expose this same kind of deficient practice with other people. So we can prohibit admissions until we see that they have corrected the problem. We can limit the types of admissions. We have found in some facilities where they may have a person who has real high medical needs and they have...there are...they have had some breakdowns in terms of care. We may limit them and say, you can continue to care for all of the other people. But you can no longer care for people who are on nasal gastric tubes, because you've not done that well. But we don't see that the place is bad enough that their license should be revoked or suspended. We can place the license on probation, meaning you can continue to operate but under certain terms and conditions. And we would lay those out in a notice to the facility--here are our findings, based upon this we're going to put your license on probation for...and we can put that license on probation for any period of time. And during that time we're going to be monitoring you to see if you're meeting those terms and conditions. We can suspend a license and for up to two years or we can revoke the license. If a license is revoked then the provider is prohibited from seeking to be relicensed until two years have transpired. So there are a range of penalties that can go on. Now, in every situation when the state says, here is what we are going to do to you, that provider has the opportunity for a hearing. They have to have due process. If you're looking at it under CMS's rules for certification, it's a somewhat similar process, not exactly the same as the state's. But like the Senator was summarizing, at this facility we found these problems, these problems, these problems, you have an opportunity to correct. Now, we've given you ten opportunities, you haven't corrected. CMS would likely say, now we're going to start imposing penalties. They can impose money to a civil penalty is what they call it. They can stop admissions. They can say we're not going to pay for any...they can't say we're...they say, we will not pay you for any new admissions until you fix this problem or you go on up the scale, so to speak, to the point where they say we are giving you notice that we are going to be terminating your provider agreement. So there's a range of penalties that are there. []

SENATOR WALLMAN: And picking up on that, have our state facilities, no matter whether they may be private or public, ever...you get complaints from the League of Human Dignity, whether it be transportation or... []

HELEN MEEKS: Oh, no one, no one is prohibited from submitting complaints. And our complaints come from a variety of sources. []

SENATOR WALLMAN: Yeah, that's fine. Thanks. []

SENATOR LATHROP: Senator Cornett. []

SENATOR CORNETT: I wanted to go back to the community-based providers very quickly. You have four surveyors, correct,... []

HELEN MEEKS: That's correct. []

SENATOR CORNETT: ...for the state? []

HELEN MEEKS: Um-hum. []

SENATOR CORNETT: You are saying that there are 31 agencies. []

HELEN MEEKS: Um-hum. []

SENATOR CORNETT: And I'm going to exclude Mosaic, because they have the same inspection requirements as BSDC, correct? []

HELEN MEEKS: Right. []

SENATOR CORNETT: And under those 31 agencies you have 461 individual settings

or patients. []

HELEN MEEKS: No, 1,400 and... []

SENATOR CORNETT: 1,400. []

HELEN MEEKS: Um-hum. []

SENATOR CORNETT: Okay. []

HELEN MEEKS: It's 1,460. []

SENATOR CORNETT: 1,460. []

HELEN MEEKS: Yeah. []

SENATOR CORNETT: And those are facilities that fall under the 15 person or they can be? []

HELEN MEEKS: No, these are the home- and community-based waiver providers. []

SENATOR CORNETT: Waiver providers, okay. When you have clients in those types of settings are all of those facilities in a four-year period inspected for...when...I got a little confused earlier when you said that you inspected by the regions, like Region 6, Region 5. Or do you just go through and randomly pick different facilities inside those regions for inspection during that four-year period or all facilities in that region inspected in a four-year period? []

HELEN MEEKS: Okay, let me clarify the four-year period. []

SENATOR CORNETT: Okay. []

HELEN MEEKS: First of all, the home- and community-based waiver providers, they may not be, how can I put it? This is where it gets really mucky. If you're not caring for four people who have developmental disabilities,... []

SENATOR CORNETT: Right, if it's three people in an apartment, like you said, are... []

HELEN MEEKS: ...right, we don't have a licensing requirement in this state. So... []

SENATOR CORNETT: But more than four you have to have a license. []

HELEN MEEKS: Right. So some of these... []

SENATOR CORNETT: Okay, let's deal with the more than four. []

HELEN MEEKS: Yes. So some of these 1,460 don't fall under licensure, therefore we would not be randomly selecting up to 25 percent of them to survey. []

SENATOR CORNETT: How many people are...how many are...licenses are there in the state? []

HELEN MEEKS: How many...? []

SENATOR CORNETT: Licensed facilities are there in the state, excluding Mosaic. []

HELEN MEEKS: Of all types of healthcare facilities? []

SENATOR CORNETT: No, in developmental...the facilities we're talking about providing... []

HELEN MEEKS: The one that care...there are 155 CDDs. []

SENATOR CORNETT: Okay. []

HELEN MEEKS: There are 4 ICF/MRs. []

SENATOR CORNETT: Right, which are the Mosaic's. []

HELEN MEEKS: Right... []

SENATOR CORNETT: Right. []

HELEN MEEKS: ...and BSDC. And then there are 31 providers that fall under the...that are funded through the waiver program. []

SENATOR CORNETT: That's the 31 number that came up...that I had mentioned earlier. Now when you say providers are you talking about individual group homes or are you talking about agencies that run those group homes? []

HELEN MEEKS: Agencies that run them, like Region 5 may be a provider. []

SENATOR CORNETT: Are those group homes? Out of those 31 providers, they are licensed. []

HELEN MEEKS: That they...they're...any setting that they are operating, any of these 31 providers, if they are operating a setting that has... []

SENATOR CORNETT: That is under four. []

HELEN MEEKS: ...that has fewer than four there is no license in that setting. []

SENATOR CORNETT: Okay. With the ones that provide care for more than four, they have to have a license through the state. Are those people inspected? []

HELEN MEEKS: Yes. []

SENATOR CORNETT: How often are they inspected? []

HELEN MEEKS: Okay. Those would be centers or group homes for developmental disabled. Under our state statute we can inspect, we don't go in and inspect all of those annually. We can randomly select up to 25 percent of them to be surveyed on...inspected on an annual basis with no more than five years transpiring when they would be inspected. In addition, we can go in on complaints and we can go in for any other cause. And we list out in the regulation for cause, if there's some physical or natural disaster that happens or we get, you know, all of the staff is leaving, the administrator or whatever. There's a whole list of for cause things that we can go in and inspect a CDD for. []

SENATOR CORNETT: So are there group homes that provide care for more than five...four people that might not be inspected, might...I mean as a requirement? []

HELEN MEEKS: Ever? If...if ever...if they...ask me your question again. I'm trying to understand it. []

SENATOR CORNETT: Okay. If you're only inspecting 25 percent,... []

HELEN MEEKS: Um-hum. []

SENATOR CORNETT: ...and that's a random picking,... []

HELEN MEEKS: Right. []

SENATOR CORNETT: ...are there...is it random by region of the state? Is it random by just going through and randomly picking them? How do you select what 25 percent are chosen? And are there people that are not chosen? I mean,... []

HELEN MEEKS: Every...every...in the category of CDDs, the 155, we randomly select 25 percent from the statewide. []

SENATOR CORNETT: Okay. []

HELEN MEEKS: And if, for instance, no one was lucky enough, no, no one was randomly selected, and we keep track of this, then we would go in and if no one had been selected over a five year period, we would inspect that facility. []

SENATOR CORNETT: Okay. []

HELEN MEEKS: So all of them... []

SENATOR CORNETT: And so they will get inspected. []

HELEN MEEKS: ...should be inspected within...once within five years at least once. []

SENATOR CORNETT: And is this done geographically or is it just random throughout the state? []

HELEN MEEKS: Across the state. []

SENATOR CORNETT: Okay, so your inspectors have to travel all over the state

basically all the time,... []

HELEN MEEKS: Yes. []

SENATOR CORNETT: ...because you only have four inspectors for the whole state. []

HELEN MEEKS: Um-hum. []

SENATOR CORNETT: The federal government currently comes in and inspects Beatrice because it's a state run facility, correct? They can. []

HELEN MEEKS: They can, they can go into any ICF/MR facility. []

SENATOR CORNETT: Can...do they go into Mosaic and inspect? []

HELEN MEEKS: As I said earlier,... []

SENATOR CORNETT: I know you've done surveys. Have they done surveys? []

HELEN MEEKS: Independently, I don't think that they've gone into Mosaic and done an independent survey. They've been in there and done monitoring of us, but they haven't gone in, to the best of my knowledge, and done one. []

SENATOR CORNETT: And I assume that they do not go into any of the other agencies or homes that we're talking about. They leave that responsibility up to the state. []

HELEN MEEKS: CMS would not have anything to do with a CDD> []

SENATOR CORNETT: That's what I mean, they don't have any...correct. So... []

HELEN MEEKS: They would not...CMS, the same branch... []

SENATOR CORNETT: They... []

HELEN MEEKS: ...the same branch of CMS would not necessarily. The same branch of CMS that looks...that has looked at BSDC, would not be looking at the home- and community-based waiver programs. []

SENATOR CORNETT: Who looks at the home- and community-based waiver programs? []

HELEN MEEKS: Again, they...the regulations are set up by the state under our Medicaid division. We serve as the survey agency for Medicaid for home- and community-based waiver programs. []

SENATOR CORNETT: So, basically, the last line of defense, if you want to call it, is your office for the home- and community-based. []

HELEN MEEKS: Tell me what you mean by "last line of defense?" []

SENATOR CORNETT: You are the people that go in and do the surveys and make those facilities accountable. []

HELEN MEEKS: We do this... []

SENATOR CORNETT: Is there anyone at that point that makes the state of Nebraska accountable for the people that are in home- and community-based care? []

HELEN MEEKS: We do the surveying and we turn the information over to DDS and Medicaid who makes the decision to stop funding them or whatever. []

SENATOR CORNETT: Okay, that's what I was looking for. []

HELEN MEEKS: That's their decision, not ours. []

SENATOR CORNETT: Okay. Thank you. []

SENATOR LATHROP: I think that's it. []

HELEN MEEKS: Thank you. []

SENATOR LATHROP: I do want to say, just as an aside, I've run into a lot of people in state government in the last two years. And it is a pleasure to work with you. []

HELEN MEEKS: Thank you. []

SENATOR LATHROP: You have a command of the information, you present it well. And I have confidence that whatever you're in charge of is well run. So thank you for being here today. []

HELEN MEEKS: Thank you, Senator. []

SENATOR LATHROP: I think we're going to take a little bit of a break, all right? Before we do that though, can I get a show of hands of folks that are interested in testifying. I'm trying to look behind you to see, where we at, about five? Four or five? Do you want to work through lunch or take a lunch and come back at one? I think, why don't we just take a 15 minute break and then we'll come back. And if it's just four or five people, we'll finish up. []

BREAK []

ROGER STORTENBECKER: (Exhibit 4) Members of the committee, thanks for the opportunity today. My name is Roger Stortenbecker, R-o-g-e-r S-t-o-r-t-e-n-b-e-c-k-e-r. I serve as the chief operating officer for Developmental Services of Nebraska. We're one of the community-based DD providers that we've been talking about earlier today. We provide services in Lincoln, Omaha and Kearney to approximately 162 people. August marked my 31st anniversary of being in the business of supporting people with developmental disabilities in Nebraska, 14 of those years I worked for Health and Human Services in the developmental disability system, about 4 of those years I was the director of the DD system. The current Title 205 that regulates community-based DD services in their current form, I was the last guy to sit there at the word processor into the wee hours of the morning writing those rules and regs and working with the Legislature in trying to make sense of them all. So I'm fairly familiar with what the rules and regulations are. The testimony that I've handed out to you was what I was planning on in the order I was planning on. But for sake of continuity, if it's okay with the committee, what I would like to do is step back into a couple of comments that were made a little bit of the discussion earlier. I think it would be important to clarify that what regulation and licensure licenses are CDDs--Centers for the Developmentally Disabled. They are health facilities and they are licensed as such. But there is no location where people live who have services funded by the state of Nebraska through the developmental disability system where there isn't some state oversight. In addition to regulation and licensure, there is the division of developmental disabilities that has a staff of at least six program specialists. And their job is to serve as the liaison to organizations like mine and all the other organizations in the state. They conduct certification reviews. Granted, they're not licensing, but they are certification, and all locations are subject to their certification review. All services are subject to their certification review. So while regulation and licensure certifies a health facility, the division of developmental disabilities certifies the services that are provided there, if that makes sense. In addition to the DD system central office, there are literally hundreds of service coordinators who...at least one service coordinator sits on the IPP team, the

interdisciplinary team that develops the program plan for every person in services. And that service coordinator has a responsibility, and I'm here to tell you they carry it out, to monitor those services every day for every person on their caseload. They do that in every home, in every vocational setting. And they have the authority to charge us with a plan of correction through their service monitoring form and format. So it isn't exactly true that there are some places that don't...well, it is true there are some places that don't get licensed. But it is also true that every place has a certification review activity in it. So that seemed important for me to bring that out. Another comment that was made in response to a question, well rather than comment on the comment, I'll reply to the question that was asked. Generally the question was, if there is a community-based provider that is sub-performing, are there any financial sanctions, are there any fines or sanctions of any kind? When I was at the department we designed what I think is a pretty good system. The service authorizations are individualized. Every person who receives a service has an authorization that is unique to them based upon their need level. That authorization does not belong to service providers, it belongs to the individual. So if an individual or their team member or their advocate or their service coordinator, if anybody feels like they're not getting proper service that person can take the money and run. They can vote with their feet. They can go to any other qualified certified provider in the state. The money will follow them. So there is a control there, a tension there that if I don't do a good job at DSN I'm going to lose business and pretty soon I'll be closed. And I can tell you for a fact it happens. We have people leave us because they don't like something we've done or something that we won't do. We have people come to us because some other provider didn't do something that they wanted done or a wide number of reasons. It is a very dynamic service population for us, especially in the Lincoln and Omaha areas where there is a plethora of service opportunities, service provider opportunities. So we see a lot of movement. So there are some controls, some tensions in place to help with that service quality idea. With regard to regulations, monitoring and oversight community-based services we've had a lot of discussion here this morning about do we need to, and I'm certainly paraphrasing here, but my perception of what's been going on is do we...how do we prevent bad things

from happening in the future? Do we need to throw more regulations on it, more supervision, more oversight? I guess I would suggest that what we probably need is different rules and regulations and oversight. The people that we're supporting in community-based programs, the mix of their needs is considerably different today than it has been 30 years ago when this system was designed. Even with its updates--the subsequent writing of new rules and regulations--the population continues to change and their needs change. I think probably from my perspective the better question will be, how can we attract and retain high quality frontline workers in the community long enough that they can learn all the rules and regulations and all of our technologies and they can gain experience. We don't really have a recruitment problem. It's actually fairly easy for DSN to recruit people to come and do the work that we do, but it's incredibly difficult to keep them. Sometimes it's a money issue. Our starting salary is right around that $20,000 a year mark. Well, there's not a lot of people can make a go at $20,000. So what we'll find is a lot of our staff have several jobs. And when the job gets tough where we are, those other part-time jobs may pay less, but they look a little easier and maybe it's time to move on, I don't need the headache. So really, I think, Senator Lathrop, you were hitting on it earlier when you were asking about BSDC and do we have kind of an issue of train away as you will. But if a lot of the people are always new, really, how far are you getting? We're spending a lot of time in the classroom. We do that at DSN. We've got a required 40 hours of training for every staff person that comes through the door. We've got another three months of close supervision on-the-job training by our managers. We have a manager in training program where we're trying to grow our next generation of managers. And we can get our staff through that initial training, the 40 hours required, but we found ourselves, for economic reasons, having to take a look at what is essential, what has to be in place for this employee to be successful, because what we know is there's a good chance that in three months as many as 50 percent of those people we hired are going to be gone. So we have to start taking a look at what is essential versus what really develops the skill. Within three months it's hard for the people that we employ to develop necessary relationships that they support. If you can imagine that some of the things that we ask our staff to do can include everything from

helping someone go to their church, helping someone do personal hygiene items, helping someone get to their family, to their doctor's appointments, things like that. They're pretty...they're fairly personal kinds of things. In a high staff turnover situation it's very hard to get that relationship built between the people that we're here to support and the people that are there to support them. And I can tell you no matter where I've worked in these 31 years, without that relationship it just doesn't get done. So I think where we need to go, a lot of our solution, both at Beatrice and in community-based programs is we're going to have to dial in on the quality of our frontline workforce. We employ almost 500 people in Nebraska. And that's a lot of training, that's a lot of oversight. There's a lot of rules and regulations. And if folks are only going to be here three to six months it's going to be incredibly difficult to give them the experience and the skills they need first to even understand what those regulations means and then, second, to live by them and develop a good skill, a good talent for this work. Well, the attachment that I've given you, pages 2 and 3 here, I kind of late in my planning decided that what I should do is give you just some insight into some of the major oversight and monitoring and controls that are in place already in community-based programs. Now, as I went through this exercise the thing that kept coming back to my mind is if this is not enough rules and regulations and oversight already, then what the heck. What can it be? I'm not sure that throwing more on top of this is really going to improve our outcomes. So I think we haven't quite gotten to the root cause of the systemic problems that we do have. And, I guess, to reiterate my perspective is it's right down there in how are we recruiting, how are we hiring, what are we able to pay, what are the benefits, what are the challenges at that frontline staff level. Once we can get somebody up to a middle management and higher job we've got people for life. They'll hang in there. Well, look at me, 31 years later I'm still here. But I got out of direct support a long time ago, back at Lancaster Office of Mental Retardation. And back then the starting salary was $13,000 a year. So we're not a lot further ahead, even inflation adjusted, so...with regard to really one of the...one of my primary interests here is how do we help those people who are ready, willing and able to move from Beatrice to community-based services. I think we're going to have to take a hard look. I get to see every one of those

referrals that comes out, and so do our three area directors. And we talk about every single one of them. In every case we do talk about the service authorization that's coming with that person. Money is important. If we can't pay our way, we're not going to be in business. And we have a responsibility to people who are currently in our services that we maintain financial health so that they still have a place to get their services. But just as important we look at what are the need levels of the people who are waiting for a placement out in the community. It's a mix of need levels. It could be anything from nursing level of care, it could be significant behavioral supports, psychological support, therapy support and those kinds of things. All those things that are included in that daily rate that Beatrice gets to provide their services are there and available for that person. Now as they move into the community we take a look at what do we have available for us. One of the reasons community-based services are quite a bit less expensive than ICF/MR services is not all the services are there in community-based. We don't have nurses on staff. Our reimbursement rate doesn't include nurses. In fact our reimbursement rates prohibit us from using that money to pay for nursing services, it has to be for habilitation. We pay for the places where people live with room and board payments, largely one of the reasons why we congregate people. Our philosophy is congregating is not necessarily a good thing, but take a look at the rent, utilities and the cost of living and the SSI payments of around $700 a month, you have to congregate people in order to find a place for them to live. That's a straight pass through. We don't keep anything off the top of that. In fact most of the months last year we found ourselves subsidizing the room and board for the people that we support. But that's a thing we do. That helps us on our mission, that gets us down the road. So one of the things I think we have to do is take a look at when folks are moving from BSDC person by person, individual by individual, what is their support need? Where are they going to go and how are we going to get that need met? Now, the way things are right now we don't set the rate, we don't set the intervention units and we can't negotiate it. It's here is the person, here's what we're willing to pay, take it or leave it. Well, a lot of times we say, I got to leave it. And as time goes on that seems to be what a lot of other providers are starting to say. DSN used to go out on a limb, say, oh, I think we can do this

because in several months we might be able to get those behaviors under control. That's risky business these days because there's a lot of pressure. It might be nine out of ten days we're pretty successful with a person. But when they decompensate, when they have something, maybe a mental health need that brings them into the attention of the local police, the neighborhood or even HHSS now all of a sudden we're doing plans of correction and it's not so economical anymore. So there's a lot of challenges there. I don't want to say that it's impossible to overcome. But I think it's a thing that we're really going to have to dig down into and say, why is it a provider would decide in community-based services that they won't support someone. And it is bigger than money. Money is a chunk of it because you have to pay the bills. But it is bigger than money. We don't want to take somebody, for example, to Kearney if they're going to need a service that's only available in Omaha. If our opening is in Kearney and we have to go to Omaha a couple times a week, we can't afford to do it. That's a big trip and there's not that amount of transportation built into the reimbursement rate. We can't afford to open a place in Omaha if we don't have a current opening that's appropriate for the person. Again we're back to the room and board issue--one place for one person, just can't afford to do that. It's not right to tell people they have to move in three at a time. They might not make good roommates. They might not like living in Omaha, all three of them. So there's a lot of things to juggle there. So it's...yes, it's complicated, but I think it's pretty straightforward. It always goes back to the same thing--what does that person need, can you do it and are we putting forth the resources as a statewide system in order to make that happen. I think one of the other things that's kind of important about the changing system several years ago when I was at the department the eligibility criteria was that you had to have a primary diagnosis of a developmental disability. Along the lines about the same time when there was a consent decree to move people from the regional center into community-based programs if they didn't need the acute regional center care our eligibility changed in DD services. Rather than having a primary diagnosis of developmental disability, developmental disabilities needed to be present. So what could happen then literally is a person whose primary need was a mental health need could find themselves eligible for DD services. In

addition to that then we've had a prioritization system that the only entitlement in Nebraska right now is you have entitlement to service coordination if you're eligible. And if you're a transition student from a Nebraska high school you have entitlement to replace your lost school, essentially a day service. But there's no entitlement to residential. The way that you get into residential services for the last several years was you had to be in a crisis; it's a prioritization process that was laid out in the Developmental Disabilities Service Act. What that means though is that the people who have been coming into residential services for quite some time have been people in crisis. When the reimbursement rates were developed, clear back in the Deloitte Touche days, that rate was built upon several platform ideas. The first one in residential services it was a one to four ratio. So it enjoyed the economies of a one to many supervision span. In vocational services it was one to ten. It was also based upon a mix of high, moderate and low need people. Now, at that time we used a tool that would render this person has high need, this person has moderate need, this person has low need. Now when you do a thing like that in a funding type situation it's easy to see how there would be need level creep. You know, if there's more money for people who are high need, then gradually everybody starts to look like they're higher need because that's where the money is. Well, we took away that high, moderate, low need and just did some averages into the reimbursement rate. But what's happening now is that in fact, because of the prioritization system, our mix is changing to higher need. And a lot of those folks are becoming high need because of significant behavioral causes that they can't stay where they are currently, whether that's with a family or just on the street. So our mix is changing. Now another group that we've become aware of, DSN had a grant with Nebraska Vocational Rehab to look into the prevalence rate of persons with acquired brain injuries in the DD services system. We were one grant recipient, Goodwill, Greater Nebraska and Grand Island also received a grant. And they were doing the same kind of a thing in the outpatient mental health field. What we found out is that there is a significant number of people that we're providing services to that are eligible and that come through the DD system who have acquired brain injuries. And as we worked through that grant, it was three years, we just finished it. As we worked

through that grant one of the things that we wanted to find out was does the community-based DD system work well for persons with acquired brain injury. Certainly, you can be eligible and the funding mechanisms and all of that are there. But really does it work well? Does it meet needs? What we found out is that, yeah, the structure probably does work. So in terms of there's a staff and there's a state agency and funding can come from the Legislature through the department and all those kinds of things. But what we did discover is that there are some differences in the technologies that we should be using. Regulations don't really prohibit us from using those new technologies. In fact, I would hold that the regulations almost support what we discovered, which is the more you use punitive contingencies after a bad behavior of someone we support the chances are good that if you punish them what they'll remember is that you're a punisher. Well, earlier we talked about relationship is important. Well, so what kind of a relationship do we have? It's a bad one. Plus, with many of the people that we supported with acquired brain injuries remembering that contingency the next time the stimulus presented itself wasn't there anyway. So we tried to apply that then to all the services noncontingent...or nonpunishing contingencies. So I think there is some updating in the rules and regulations. Now, I think there is also some updating in how we determine how much funding should be available to a person who has brain injuries, how much funding should be available and how we distribute it, how we monitor it or dole it out to people who have dual diagnosis. I think our system, our service system is getting a little more complex, not quite stratified yet, but it's a little more complex. And so we keep applying this DD model to this ever-changing service population. So if we can dig into that and if we can improve that I'm encouraged to hear that there is going to be another look at rules and regulations. The last time it took about ten years to try and get a graph set of regs out. And they still weren't what was going to work. So I'm glad we're not giving up on it; it still needs work. If we can get these things solved in the community-based program, I think it's kind of gives us some clues as to what we're going to have to do to meet the needs of people who want to be from Beatrice into the community. That's essentially what I've prepared. And I've got a whole lot of wind here (laugh), so I better shut up. []

SENATOR LATHROP: It sounds like you have a unique perspective as a witness. So I'm sure it's going to invite some questions. []

ROGER STORTENBECKER: Good, that's...I hope so. []

SENATOR LATHROP: Senator Stuthman. []

SENATOR STUTHMAN: Thank you, Senator Lathrop. Roger, since you've been with the system for, what, 31 years you said? []

ROGER STORTENBECKER: Yes. []

SENATOR STUTHMAN: Thirty-one years, with the population at Beatrice how many of those people that are receiving services do you feel would be eligible or could go to a community-based provider? Ten percent, half? []

ROGER STORTENBECKER: I wish I could answer that way, I can't. What I would say is as many people as we could find the appropriate services in the community, if they want to move out they could move out. Now, what percent is that? I suppose it's not beyond belief that it could be 100 percent. But to do that we'd have to take a look at what are those needs, because there are some significant needs of people who live there. We'd have to take a look at those needs and we would have to adequately support them in community-based programs. To do anything less would be shameful and it would be a recipe for failure. I hope that answers your question. []

SENATOR STUTHMAN: Yes. And also, when you...your last sentence there, you know, I feel there isn't adequate services in a community-based setting at the present time to truly, you know, take care of those individuals. Would you say that would be...? []

ROGER STORTENBECKER: I would agree with that, absolutely. In some of the rural areas across the state, and I...my hat is off to the folks who are operating services in very rural areas. If I had someone...if I was providing services in Valentine to someone who needed acute psychiatric help and I'd have to drive them down to North Platte or Kearney or someplace like that, I don't know how I'd do it, because you never know when the need is going to present itself. And we're out there working with $9-an-hour frontline staff, working in a one to many ratio, there's a whole lot of decisions have to be made instantly. Okay, do we call somebody in? It's the middle of the night, I'm the only person here working, there's two other people. This person is having an acute psychiatric moment here. I need to do something. How do I do that? There's a whole lot of things has to be built into place before we could make that kind of a placement. []

SENATOR STUTHMAN: What is your interpretation of community as far as an individual? Does that mean that he moves back closer to his original community or does that mean that he just moves to a community that provides service, and it could be 200 miles further from what it is today at Beatrice that's where he could be moved to. []

ROGER STORTENBECKER: I think historically we've talked about community primarily as an alternative to institutional care, so a community being an alternative to Beatrice State Developmental Center, for example. With regard to your question, what is community to an individual, it might be moving back home. When I was at the department we had a lot of discussions about that, what equals community, in fact what equals a Nebraskan if somebody from another state found themselves here in Nebraska receiving services at the Beatrice State Developmental Center and now they say they want to move home. Okay, is home in Nebraska or is it in whatever their state of origin was. As we researched it the legal stuff about it was, well, it's where they intend to be and reside and stay. So community, community could be for that individual, if they say, well, I have these, figuratively speaking, I have these kinds of needs and those needs can be met in Omaha. They move there, that's their community. If they decide later, ah, I want to live in Grand Island. They move there, that's their community. So when we

think about people moving to the community it does involve a lot of choice on the part of the individual, but that choice has to be made within the context of what services are available. Some made the choice they wanted to live in Randolph, they're going to have to talk to Alan Zavodny about, hey, I know you don't have a program there but can you do this for me. And he'll have to make a decision. That may or may not be their community in the end. []

SENATOR STUTHMAN: Is there any consideration to family members as far as, you know, where they relocate these people? I mean, I always think family support for individuals that are in this situation is very, very important. And if you move them further away and they will be seeing them fewer times throughout the year could be more of a stress on the individual than before. []

ROGER STORTENBECKER: Generally, that is true. There are some isolated cases where family contact has been counterproductive. Those are usually things that we try and work through, spend a lot of time. In fact, as DSN, which is kind of atypical, we also provide community-based mental health services both short-term and patient residential and outpatient. In those kinds of situations we'll have our licensed mental health practitioners get into that team meeting, that program planning team meeting and try to work through those differences if they exist between the family and the person. You know, all that is a thing we can offer if the family and the person what to do that. Generally though, if a person doesn't have a guardian and they're age of majority their opinion weighs very heavily. And if they say, I want to live in mom and dad's hometown, okay, we'll go that direction. They say, no, I want to be in Scottsbluff because they're in Omaha, we'll try and move that direction. []

SENATOR STUTHMAN: Okay, thank you. []

ROGER STORTENBECKER: You bet. []

SENATOR LATHROP: Senator Cornett. []

SENATOR CORNETT: Over the coarse of the hearings that we've had I've asked the question a number of times and gotten different answers. And yours again, for Senator Stuthman, was a little bit different, sir. If Beatrice was going to be closed tomorrow, and I'm not talking that that is my intent at all, I'm just saying if, I've heard that the community-based services will expand to meet the need, the money is there if the money follows the patient. Community-based services will expand based on the need. You don't think that we're there now. We don't have enough community-based services to place the people, to deal with the higher needs, maybe behavioral people that are residents at Beatrice. Am I correct? []

ROGER STORTENBECKER: That's correct. If your time line is literally tomorrow, if the doors close tomorrow, we had to find someplace else for all those people to live it would be an enormous struggle. The people that DSN employs are not nursing staff. We are not going to know how to do those G-tubes, we're not going to know how to do nebulizers, we're not going to know how to do any of those more invasive nursing-type services. []

SENATOR CORNETT: Let me move away from the nursing services a little bit. When you said that you could see eventually that 100 percent of the people at Beatrice, theoretically, could be moved to community-based services do you see available services for the high need behaviorally disordered? There are a lot of people at Beatrice that they have two on one care currently, two staff members sit with them. Is that type of service available in community-based at this time? []

ROGER STORTENBECKER: In some cases yes. []

SENATOR CORNETT: And where are those services located, all in the eastern part of the state, is it spread out through the state? How far would be moving people from their

families? []

ROGER STORTENBECKER: You know, I really don't know how many outstate providers are doing that. DSN is serving two people right now who have in excess of one to one funding. It might not be two to one. []

SENATOR CORNETT: Two to one, but it's in excess of one to one. []

ROGER STORTENBECKER: It's in excess of one to one. And in those cases the reason for that funding is because of a certain level of the risk that person presents either to themselves or to others. It could be that they have what would be recognized, not adjudicated, recognized as sexually aggressive behaviors. []

SENATOR CORNETT: That's...oh, go ahead. []

ROGER STORTENBECKER: And so in order to provide, as best as we can as a state, assurances that something bad doesn't come out of that in a community-based setting what we do is we staff-up. My suggestion earlier for maybe we need to take a look at our technologies is staffing-up is a stopgap. It's not necessarily real treatment. And so to be successful, to move folks of significantly high behavioral needs into the community, I think, we're going to have to take a look at what does it really take for them. Does it exist in the community? And if it doesn't, where are we going to put it, because we're going to have the economy of scale kind of an issue where the best of the best experts in their field of dealing with significantly aggressive behaviors, those are expensive folks. And you can't have one in Omaha, one in Lincoln, one in York, one in Kearney, one in Grand Island, you can't do it. []

SENATOR CORNETT: That was exactly where I was headed, because you do have a population that is aggressive, behaviorally aggressive, do you feel that it is appropriate, that the community-based settings currently are safe enough both for that person and

for the community around them? []

ROGER STORTENBECKER: That would depend on the person. You know, I've been surprised over the years. People that I've read their background on it's looked risky, and the staff have convinced me we can do this. I've had to hide my eyes and cross my fingers. And they've done it, they've found the way to do it. So I'm really hesitant to say that there are somebody who absolutely cannot or somebody who absolutely will. It just really depends on a whole lot of factors that have to come together. []

SENATOR CORNETT: Who would be determining the factors? []

ROGER STORTENBECKER: Probably a combination of the interdisciplinary team that would include the clinicians from BSDC, it would include provider staff, it would include Health and Human Services from their oversight perspective and the service coordinator. It would be an interdisciplinary team including those folks who have treated the person. []

SENATOR CORNETT: My biggest fear is both for the safety of the individual, but then the safety, if we move them into community-based, the people surrounding them if the right decisions aren't made in regard to placement. I mean, I understand what you're saying about economy of scale. It may be the best...I mean, maybe the best alternative is keeping the people that are that behaviorally disordered where they can receive treatment for all their behaviors at one time and when you said, you know, you can't necessarily have the funding for one in Lincoln and one in Omaha. []

ROGER STORTENBECKER: Mostly my response there is one of geographical separation, huge geographical separation. If, on the other hand...and where would people go to live, what would be their community. If, on the other hand, there was a, you know at the risk of using a cliche' here, if there was a center for excellence in Lincoln, people could move to Lincoln and we could have the economy of scale it would take to

have a person in Lincoln to oversee the support needs of that person or several people who had moved from Beatrice. []

SENATOR CORNETT: Okay, thank you very much. []

ROGER STORTENBECKER: Sure. []

SENATOR LATHROP: Senator Wallman. []

SENATOR WALLMAN: Thank you, Senator Lathrop. Yeah, thanks for being here, Roger. I want to reemphasize I'm not against community-based care. And I think we ought to be working together. You know, if I...just say I'm a community, you know, I'm a provider and I take a sexual predator and that person rapes my neighbor's girl, 14- or 15-year-old girl. Am I at risk or is that individual at risk? Am I liable? []

ROGER STORTENBECKER: Well, the way it seems to work today? []

SENATOR WALLMAN: Yeah. []

ROGER STORTENBECKER: Yes. []

SENATOR WALLMAN: So... []

ROGER STORTENBECKER: The people find me really quickly in those situations. They... []

SENATOR WALLMAN: So I think we need both, but thank you. []

ROGER STORTENBECKER: Yeah, yeah. []

SENATOR LATHROP: I do have a few questions for you. It sounded like the first point you were making with us is...it was right on the heels of talking to Helen Meeks where we asked about the number of inspectors. You're saying there are other safeguards in place for a person in the community and they are the service coordinator, which each person has, and they can make a complaint to...the can pick up the phone and call the police, they could talk to Adult Protective Services. There's some people that could make a complaint to and then there is the Division of Developmental Disability Services. They have a certain number of people who are involved in or interface with the people who are getting the care, allowing another opportunity for them to complain or express concerns about the care. []

ROGER STORTENBECKER: Yes. []

SENATOR LATHROP: And then, of course, the other safeguard is that, if you don't like the guy who's driving you from where you live to the doctor's office, you can choose a different provider and, as you say, vote with your feet. []

ROGER STORTENBECKER: Yes. []

SENATOR LATHROP: That was the first point that you tried to make or that you did make. You talked about the turnover rate for community-based program or your program. What's your turnover rate? In a year's time how many people do you employ, if I can ask, how many people do you employ and how many of them are going to turnover in a year's time? []

ROGER STORTENBECKER: We employ around 450. Every day it's a little bit different. We rely a lot of college age students because we do support a number of people who have aggressive behaviors, old guys like me are just going to get hurt if we're working in that environment. So we need people who are healthy, fit and able to work with some of those folks. Our turnover rate two years ago was about 80 percent. []

SENATOR LATHROP: Was what? []

ROGER STORTENBECKER: Eighty percent. []

SENATOR LATHROP: Eight-oh? []

ROGER STORTENBECKER: Eight-oh, um-hum. []

SENATOR LATHROP: And is that of all 400 people? []

ROGER STORTENBECKER: Yes. []

SENATOR LATHROP: So two years ago you had to replace 80 percent of the 400 people. []

ROGER STORTENBECKER: Yeah, yeah, yeah. The way that we talk to our area directors and their coordinators that are really tenants was that we're going to have to step-up our onsight supervision and modeling, and we're going to have to do it on nights and weekends and overnights because what we have, literally, are locations that chances are best that if an employee has a question, eight out of ten times they're going to ask somebody who's just as green as they are, what should I do. Now, last year we improved that by quite a bit. We are probably, although I haven't seen the numbers yet, we are probably closer to a 50 percent turnover. []

SENATOR LATHROP: Are...community-based programs typically have a higher turnover rate than Beatrice? []

ROGER STORTENBECKER: I don't know the answer to that. I don't know what Beatrice's turnover is. []

SENATOR LATHROP: You said that you use college students, fit people to do this work because it can be physical and in some cases involve a confrontation. []

ROGER STORTENBECKER: Um-hum, yes. []

SENATOR LATHROP: So are you recruiting people that have it as...it seems to me that when I look at the folks that are working at Beatrice and stick around they are people who find it a rewarding experience to work with the developmentally disabled. Are you looking for a different crowd when you're trying to staff community-based programs? []

ROGER STORTENBECKER: No, no. We're looking for the same kinds of things that BSDC would be looking for. If we were to hire someone who is fit and able to work in a confrontational setting, if they were confrontational themselves or that's what they were about, that would be horrible. []

SENATOR LATHROP: Yeah, they are gone. []

ROGER STORTENBECKER: Yeah, well they don't get through the door. Out of...out of those several hundred people that we hire in our recruitment strategies, currently, about half the people who apply actually get an interview. Out of the people who actually get an interview only about half of those get a job. And of the ones who get a job, some smaller number, I apologize I don't know off the top of my head, some smaller number actually get all the way through our training. []

SENATOR LATHROP: Well, at 50 percent, that's a very high turnover rate. []

ROGER STORTENBECKER: Yeah, it is. []

SENATOR LATHROP: And I've seen some numbers, that's higher than Beatrice... []

ROGER STORTENBECKER: Yeah. []

SENATOR LATHROP: ...Development Center. What do you attribute the turnover rate to, your 50 percent turnover rate, because it really affects the continuity of care doesn't it? []

ROGER STORTENBECKER: Yes it does, yes it does. Well, I think, it probably has something to do with what we're paying, where we are and the availability of competition for other jobs. When we're out there starting people off on average about $9 an hour, there's a lot of jobs out there that pay $9 an hour. Unfortunately when the economy's bad and other business closes, that's when we get a lot of applications. But you know when Verizon moves into town, they've got some glitzy glossy billboards, come work for us, with some great looking people on it and we pay you great and there's good benefits. That's pretty attractive to a lot of people that we employ. So I think it has a lot to do with the challenges of the work, with the hours--we're 24 hours a day, 365 days a year. It has a lot to do with the wages. We do offer a pretty good benefits program, but people who are 25 and younger don't really care about our IRA, that kind of...health insurance. A lot of them are still on mom and dad's plan if they're at the universities. They really don't care about that. So it really comes down to how much cash in their pocket and it's difficult for us to compete. I don't know what Beatrice pays, but I heard that it was considerably more than that. So that... []

SENATOR LATHROP: It's all relative, isn't it? []

ROGER STORTENBECKER: Yeah, yeah. []

SENATOR LATHROP: Considerably more may be $1.50 (laughter). []

ROGER STORTENBECKER: Yeah, that's right. []

SENATOR LATHROP: Okay. Well, I appreciate your coming down here today. Senator Wallman. []

SENATOR WALLMAN: Thank you, Senator Lathrop. Yeah, another question, please. How many of these direct care providers are providing for a child of their own or a sibling or a brother and sister, you know? []

ROGER STORTENBECKER: Oh, my goodness. []

SENATOR WALLMAN: Do you have an idea? []

ROGER STORTENBECKER: No, I really don't, several. []

SENATOR WALLMAN: They would probably stay on board. That would probably be... []

ROGER STORTENBECKER: In fact we even tried to target that group for our recruitment. What we thought was if we could find families, two-income families with kids, what we could offer is while one of the parents is working during the day, one parent could stay home and watch the child and that other parent could come work for us on a night or a weekend and the other parent could watch. It really didn't seem good to me, but my kids are older and I don't have to worry about that anymore. But it just really didn't stick, it didn't work as well. But there are a number of people who have their own kids, they work for us, and they work other jobs. []

SENATOR WALLMAN: Okay. Thanks. []

ROGER STORTENBECKER: Yeah. []

SENATOR LATHROP: Senator Cornett. []

SENATOR CORNETT: I guess the thing that concerns me the most is this committee is meeting on Beatrice and part of the problem at Beatrice is the staffing problems. And if you have even a 50 percent turnover, the heart of the matter is that's worse than Beatrice in the way of staffing turnover. What are your other staffing issues? How is your overtime? How many people do you have on suspension at any given time because of complaints? I believe at the last hearing they had--what was it--almost a third of the employees at any given time on suspension for investigation of complaints. How do you compare? How do you handle complaints? How many people percentagewise do you have suspended? How much overtime do you run annually or monthly? And what are your provisions if people call in? I mean... []

ROGER STORTENBECKER: Yeah. See if I can knock those out in the order that you asked them. Fifty percent turnover rate is DSN's approximate experience. It might not be the experience of Region I, II, III, IV, V or any of the other providers. []

SENATOR CORNETT: Okay. I understand that. []

ROGER STORTENBECKER: Okay. If there's an allegation of abuse/neglect, we are required, just as every community-based provider is, to complete an internal investigation. We put the employee who is accused of abuse/neglect on suspension immediately pending the outcome of that investigation. []

SENATOR CORNETT: Suspension with pay or without pay? []

ROGER STORTENBECKER: Well, it is suspension without pay and that the employee is cleared, than if they would have worked a shift in that time that we were conducting the investigation, we'll pay them for those hours that they lost. Due to the nature of the shift work, what we try to do when we do an investigation is we'll put the person on suspension, we'll try and get them interviewed and wrap it up before their next shift

would come around. Doesn't always work like that. If we determine, we don't even wait for Protection and Safety to make their determination because we report all of our investigations to Protection and Safety, and then that goes on to the DD system and Regulation, Licensure, if we determine that employee didn't act according to our policy and procedure or if we determine that it was abusive or neglectful, we separate them immediately. All those come past me. I see all those investigations. I'm the guy that watches for the system's issue: Is this a second or third one I've seen from a location? Has it come from a certain area program? Is it coming from a certain residential manager or a vocational or a coordinator? With regard to vacancy, I've been at BSN for six years and I think I'm accurate in saying there's probably not been a single month where we've claimed every intervention unit that was available to be delivered. Now, I don't know that that's unusual. When we built the system several years ago, we knew that there would be vacancy days where somebody was out of services or they might not have wanted to participate or there might have been some other circumstance that would have prevented all of the units from getting delivered. So we wrote the rules and regulations that you can claim up to the authorized or the actual, whichever's less. So I don't think it's unusual to say we don't claim all the intervention units. With regard to overtime, we have excessive overtime. There are certain times when we just have to bite the bullet. There might not be intervention units that there to pay for a staff person who's supporting a person who's having a significant behavioral episode. But in order for us to be successful, for that person to be successful, we still have to staff it. So every month we run intervention reports, and it bounces around what percent of our total payroll goes to overtime. Our policy is zero overtime unless the area director approves it personally. I can tell you every payroll there's considerable overtime. []

SENATOR CORNETT: Is that overtime because patients needs significant intervention as you just said, or is it because of a staffing shortage? []

ROGER STORTENBECKER: It's both. []

SENATOR CORNETT: Both. Have you ever considered yourself fully staffed? []

ROGER STORTENBECKER: No. []

SENATOR CORNETT: Okay. Thank you. []

SENATOR LATHROP: I think that's it. []

ROGER STORTENBECKER: Okay. Thank you very much. []

SENATOR LATHROP: Thank you very much for coming down here and for your testimony and your insight. []

ROGER STORTENBECKER: Thank you. []

ALAN ZAVODNY: (Exhibit 5) Senator Lathrop, members of the committee, let me be the first to bid you good afternoon. My name is Alan Zavodny, A-l-a-n Z-a-v-o-d-n-y, and I'm the chief executive officer of NorthStar Services, and I'm also testifying as the president of the Nebraska Association of Service Providers. NorthStar provides supports to people in 22 counties in northeastern Nebraska. We have roughly 540 employees and support 330 people. We have area programs in Bloomfield, Columbus, Norfolk, Oakland, O'Neill, South Sioux City, Wayne, we get the Valentine issues, and Fremont. In the prepared testimony that's been handed to you, I talked a little bit about the background of developmental disabilities services. I won't go over that. You can read that at your leisure. I would like to follow up on a few things that have come up in previous testimony. Our turnover rate runs roughly 36 percent. In some of our communities, like Bloomfield and O'Neill, it's sometimes as low as 12 percent or 9 percent. Again, I think Senator Lathrop was on the right track, it's relative. In Bloomfield, we're one of the best employers going; Norfolk, not so much. So those things do factor into how successful you are in those areas. And to address overtime, we have a

significant amount in Norfolk, other areas not so much. Some of the reasons for that might be if someone's in the hospital, a lot of times we will eat the cost and have a staff with them just for the familiarity of someone, a familiar face there at their bedside when you have tubes and people coming in and doing things. Something we're not able to be funded for, but we think is the right thing to do. And then, you know, we have staff that go on maternity leave, those kinds of things, so overtime does occur. What I have experienced and I've listened to the testimonies over the several hearings that you have held, not to take away from anyone who's testified whatsoever, but it's been a little frustrating because I hear what the issues are. Let me tell you what all the problems are, but it's been a little short on solutions. I'm going to get myself in a lot of trouble today because I'm going to give you solutions and that's not going to make everybody happy, but someone's going to have to step up here already and say, here's what we're going to do. Okay. So if they start throwing things at me, just ignore that. It could happen. The first is funding methodology. That's a formula that was designed by Deloitte Touche, as you've heard, then it was Touche Ross. That was early in the 1990's. And I think I should probably state here, I've been doing this for 27 years. June 15, 1981, I was really skinny and I had hair (laugh). So obviously I've changed a little since then. Don't be giggling over there, Senator Stuthman. I know what you're thinking. But that document, the methodology was a formula designed to assign cost for doing business, if you will. It had the staffing component which was based on 90 percent of a Tech I at Beatrice. And as you've heard, Beatrice can't even really hire the Tech I except for some substitutes because the pay is too low on what we're asking people to do is very difficult work for that kind of pay. You will also probably note, and this was according to Sandy Sostad's testimony which I thought was very helpful, that methodology needs currently about 95.5 percent of that 90 percent or it would take about $3.5 million to fund you at that Tech I rate. So even funding that wouldn't get you to probably a really good competitive raise. And we are also fighting the issues of increased costs in a lot of areas, worker's comp, insurance, property and liability, natural gas keeps going up, electricity, all those things, fuel obviously. You've all had to fill your cars to get here today. So the current reality is the reimbursement rates really don't

have much of a margin for the cost of our doing business. My recommendations would be it is way overdue to study the costs of providing services in the community. It's crucial that an effort be made to revisit the situation soon. I would suggest a zero-based approach, it costs what it costs. And then we can make the decisions we need to make of how much we're willing to commit to have these services provided. While increases have been appreciated, we have to deal with the reality that developmental disability services have not been a priority. When the state has enjoyed large reserves, we've been told that we need to give money back to the taxpayer, which I certainly understand. When times are more difficult, the message is we can't afford it this year. What you learn from that is it's never a good time. The ultimate political challenge we get is soon to follow: Tell us who we should cut so you can get your money. I would respectfully suggest that the premise of that premise of that question is flawed. So we need a funding system that's based on the Tech II position at BSDC and we need a formula that recognizes increases in operating expenses which are the costs of doing business. Issue number two is the objective assessment process or the ICAP tool you've heard some about. In theory that's an idea that's long overdue and it's needed. And what that essentially does is it assures that a person with similar needs in Omaha gets the same level of services as the same person in Scottsbluff. But understand that it is proportionate based on available resources, it's not truly based on what the person needs; it's based on their allocation of the pie that's there. Whether it's not enough to fill you up is a totally different question. Recommendation on that would be we need a system based on staff intensity needed for people. We would be much better served to evaluate the amount of staff intervention a person needs and base it on a ratio for 24-hour, at least, assisted services. Issue number three, BSDC. It's been my personal observation...I've been there a few times and I was area director in Fairbury, Nebraska, for around five years from 1991 to 1996, so I got to Beatrice quite a bit more often. And I would say in my recent visits, the morale is low. I had people asking me for jobs until they were found out we were pretty far away and certainly they lived in that area. And the reasons are probably more complicated than I can address, but I can tell you some of the things that I heard was what the CMS investigations, Department of Justice

investigations, and running about 100 open shifts, it's a pretty tough place to work, and the overtime has been well documented. I know I have an opinion that puts me at odds with some people, but I think BSDC is necessary but it's not sustainable at its current size. Beatrice is a community of about 12,000 people. We provide supports to about 100 more people spread out over 22 counties, and we provide services in all the communities I mentioned earlier and it's difficult for us to recruit enough staff to do everything we need to do. As a matter of fact, we've been contracting because residential services really haven't had a formula that brings people into those since Governor Nelson's blueprint in 1996. Services were made...people were entitled to day services and so what we have done is slowly...if it's not being paid for, you see it shrink, and that's what we're seeing in our residential. So we are going the opposite direction of what you're looking for as far as capacity, and I think that should be something that would probably be concerning to you as you look at these issues. My recommendation would be to expend the ITS program at Beatrice. It's a valuable resource. There are people there who are used to working with some high intense behaviors. One of the problems we run into is if you have someone in the community and you have an emergency protective custody issue, we are a lot of times having a very difficult time finding anywhere to go with that person, and local law enforcement is wanting transport. They figure if it's a person with developmental disability, that's you as an agency's responsibility to do. So what we do is we get a driver and a person on each side of someone in a backseat of a little Ford Taurus and we hope that Norfolk can take us or maybe there's another opening at Omaha or somewhere and we make some long trips. It's not a good situation. Sometimes we've had the only opening in the whole state's in Scottsbluff. That's not a really good way to do this. The other thing that I think is a monumental problem is we talked about what are the limitations of community-based. I think safety that Senator Cornett mentioned is a really big thing. You want to never get off the front page is let someone burn down a city block in Bloomfield, Nebraska. You'll never get your reputation back. And a lot of times the referrals we're getting are people who have issues of setting fires. There may be sexual offenders, and we are really careful in making sure we don't make promises we can't keep. The worst thing we could

do is try to say we think we can do something, then have a bad outcome because you never overcome that. You also have some people with violent behavior that chew up your staff, meaning you get a reputation, nobody's going to want to come work for you or the staff keeps saying, I'm going somewhere else for a buck less because I'm not going to get my glasses broken and bruises and that kind of thing. That's a reality in what we do. And so I hate to be as blunt about that, but I think you need to realize that's part of what you're up against too. The other thing that I think Beatrice absolutely needs to do is probably get a panel of I would recommend maybe nine. I don't know what the number is, but of people to evaluate every single person there, from 1 to 275, if that's still the number they're at, and say this person is best served in Beatrice. The number one person who is best served here is number one. And you go down to 275 really could be in the community very easily and it's able to do. The problem is do we have the political will to do that because now you're not really giving people the choice of Beatrice. You're going to have to say, look, Olmstead says you have the opportunity to have the least restrictive, but it doesn't guarantee you a placement necessarily exactly where you want to if you don't make Beatrice an option. That's the problem you're running unless you prioritized in some manner, you will never get Beatrice low enough to what you need to do. The referrals we're getting, and I don't want you to misunderstand, I don't want someone to come around later and say community-based isn't our answer because they're saying no to everyone. We're saying no to the people that we don't believe we can provide supports to. There are many people at Beatrice who could do extremely well in the community. The other thing that's happening is we're getting people with needs and the service units that are assigned to them don't seem to match that need level, so you've got to be really careful. In assisted settings, you're required for 24 hours a day, 365 days a year. If you accept someone, no matter what those units are, the expectation is 24-hour of continual care and supervision. If someone has very little units and high need, it's very difficult to make that work in many ways. BSDC must change its culture and must reinvent itself. And that's easy for me to sit here and say, doing it would be a lot harder, but there are ways that that could be done. The waiver, I think this is something that I would really like to see our state look

at. My recommendation for that is we're due for a rewrite. I'd really like to see us focus on outcomes rather than the habilitation because what the habilitation does, and you do what you're paid for, so that's what you're going to go out and spend the most time focusing on. The problem is we're measuring what we're doing with people every minute of the day which doesn't have much impact on what their outcome in life is. Someone many years ago much smarter than I told me if you want to see what somebody's quality of life is, see how they spend their money. Are they going bowling? Are they doing leisure things? Do they take trips? Do they spend...where do they spend the money? Follow the money and you'll see what kind of life a person has. It's something where we're so concerned as providers of being sure we can account for what a person's doing every minute that we're losing sight of the bigger picture and I think that's problematic. What is paid for becomes the most important thing. Contracts, they become cumbersome. They have been used in the past to circumvent regulations and policies because they are a path of least resistance. This should not be used to replace the process to impose rules. And I would recommend that we have actual contract negotiations as opposed to the department saying here's your contract, take it or leave it, you're agreeing to all these things whether you want to or not. Services coordination, those are the people that are in our programs every day. Now, Helen testified of what reg and licensure does, but I want you to understand that through the DDD division, there are state employees who are there every day monitoring, looking what going on, and following people throughout their journey in our services. I would like to see...and I understand there are issues with the state union and needing to right performance standards, but I would recommend a choice in services coordination. You could have a state system, but I have a problem with the funder also being one of the people who monitor. There's an inherent conflict of interest. I would like to see services coordination be a choice people can make. We talk about choice all the time, maybe they would like someone other than the state of Nebraska being that person who coordinates their services. Finally, regulations, we have a lot of them. Roger provided to you what they are. But we need to simply them. To give you a brief history on regulations, they've tried to work on them several times. I think we ran into some turf battles to be quite honest

sometimes. And when we started this about 1998, several people have had name changes since then because it's taken so long, people have been married, not married, those kinds of things. People who have started this process have gone through a lot of changes and we're still sitting with no movement on the regs. It's taken us 30-plus years to get to this point. It's unrealistic to believe the solutions are simple and can be done quickly. We must start, however, because we have totally lost our way. The answer is not to throw money at the problem, but I think some reallocation might certainly help. We must establish capacity. We need to learn from the LB1083, which was when we were talking about people coming out of the regional centers and we didn't build a community capacity. We need to be smarter and not let history repeat itself by making the same mistake. Without community-based being ready, we are shifting a problem from Beatrice to the communities, and that would be shame on us if we allowed that to happen. We are down...I'd just like to say, the system is not stable as it currently is, and that's obvious from the reports. You've heard from Nebraska Advocacy Services, the Auditor of Public Accounts, CMS, Department of Justice, and others demonstrate the major flaws in the system. I will tell you that I don't think we'll have residential services to speak of within ten years in this state if we don't do something quickly because all of the providers are continuing to contract because people are coming into the residential services. And it gets hard, we have a lot of aging parents, the baby boomers, the people who have lived at home their whole lives because parents felt that obligation to take care of them. They're going to be coming into the system and where are they going to go if they don't have a place to live and we're contracting? We are providing, NorthStar, 37,000 fewer units in the last year than we did the year before. That's roughly $740,000 reduction in our revenue. And I would just close by saying I think it's incumbant to bundle all this to work together to find what the solutions are, but we need to get going. []

SENATOR LATHROP: Thanks. It's good to have somebody come in and start the dialogue on the solutions because I think that's going to be our next focus. But Senator Cornett. []

SENATOR CORNETT: Alan, why...we keep hearing testimony that community-based...there's a trend moving toward community-based services. If that is the case, why are the community-based programs contracting? Why do you have $3 quarters of a million less than you did last year? []

ALAN ZAVODNY: That's a really good question. []

SENATOR CORNETT: Where is the money going? Where are the people going? []

ALAN ZAVODNY: Well, and there are multiply answers to that. People are moving, they get older, they might need to go to nursing homes. That happens. We have people that have been in...after the Horacek decision in the early seventies, people came to us in their 30s, a lot of those people are passing on, sometimes there are medical issue. So those things are happening, but the bigger issue of why residential is contracting is the only way to get residential services right now is to be what's called a "priority one," which means you're in imminent danger of being homeless or physical danger. And there aren't very many of those, at least coming to us in the rural parts of the state because parents are taking care of people at home and stuff, and the state is only funding students transitioning out of the schools for day services. We can go help them find jobs. We can work on interview skills, those kinds of things. But they're not funding people to come move into those CDD capacities that Helen talked about. Those capacities are great, but I don't think we could even hire enough people if we totally went to capacities. []

SENATOR CORNETT: So I just want to make sure I'm clear on this, it is a component on it that is basically attrition, they're moving to nursing homes, they're passing away. But people are still being born since the seventies when this...with developmental disabilities. Are we not providing the services that we once did and we're not expecting the family members more and more to keep their children at home for longer and longer

period, which brings us to the question of the waiting list. []

ALAN ZAVODNY: That's exactly it. That is exactly it. The reason you have the waiting list you do is if a person is living at home with their parents and they're safe, they have food and they have shelter, we're not providing those services. []

SENATOR CORNETT: And they only come into immediate danger when those parents are no longer physically able to care for them. []

ALAN ZAVODNY: Mom dies and dad's ready to go to the nursing home. []

SENATOR CORNETT: So regardless of the quality of life that the parents have then and/or the child had, we're not providing services. []

ALAN ZAVODNY: We are not. []

SENATOR CORNETT: Thank you. []

SENATOR LATHROP: That's it. []

ALAN ZAVODNY: Thanks. []

SENATOR LATHROP: Thank you very much for your testimony. Can I see a show of hands? I ran us through the lunch hour. I thought we were going to have four people. Are we...okay. Three more. It's close. []

TAMMY WESTFALL: (Exhibit 6) Senator Lathrop and members of the committee, my name is Tammy Westfall, W-e-s-t-f-a-l-l, and I am the regional vice president of Mosaic Services here in Nebraska. I appreciate the opportunity to provide testimony today, and we hope that this testimony will help guide the state's future in providing appropriate

services to all citizens with developmental disabilities. I am here today to provide an overview of our services. And today what I plan on doing is not talking about community-based services that we provide because that's already been done and we're part of the trade association, but to talk about our three ICF facilities. Mosaic was formed on July 1, 2003, by the consolidation of Nebraska-born Lutheran ministries. Bethphage began in 1913 in Axtell, Nebraska, and Martin Lutheran Homes began in 1925 in Sterling, Nebraska. Our national headquarters is located in Omaha, Nebraska, and we currently provide services to over 800 people here in Nebraska across 12 communities, and to over 3,000 individuals across the United States. Mosaic operates the only three private ICF/MRs in Nebraska: the Beatrice campus, Bethphage village in Axtell, and our nine-bed facility in Grand Island. These three facilities serve 245 people. Almost 98 percent of our funding is based...comes from Medicaid. The funding methodology has been based upon prior year facility cost reports which contain caps on certain costs, plus an add-on inflation factor. In recent years, there has been no methodology for establishing the add-on inflation factor. The appropriations for these services have not been adequate to cover the inflationary costs such as utilities, food, fuel, personal care supplies, several of the things that Alan mentioned earlier, not to mention wage increases. Without a significant increase in funding, Mosaic is unable to increase our starting wages for direct support staff. Due to the limited funding increases, Mosaic's starting wages have not increased for over six years. And remember, I'm talking strictly about our ICFs right now. The average starting wage is $8.15, $8.15 an hour. These low wages and the current economy have led to increases in staff shortages. The staffing shortages are placing a greater burden on our current staff to cover our open positions. The services for 245 people with severe disabilities are in jeopardy unless the issue is addressed. Mosaic's ICFs are regulated and monitored by Centers for Medicaid and Medicare and also the state of Nebraska, and I won't go into that in any more detail because Helen mentioned all of that earlier today. We also hold a two-year network certification by the Council on Quality and Leadership. The council focuses on quality through the use of basic assurances and personal outcome measures. Within the past two years, we have seen changes in the interpretations of

the regulations. The interpretation and enforcement have created greater expectations and a drain on our limited resources. We will continue to support the state's plan in transitioning people from BSDC into our community and ICF settings, and we will work with the state to develop a system of care and supports for people with developmental disabilities. In order to meet the needs of our current population and support the transition to community-based services, the funding methodology should ensure adequate appropriations to allow pay adjustment for staff that is competitive to the market and to cover the recent inflationary costs. Estimated increase in appropriation requested is $6 million. The state's portion is approximately $2.4 million. This would allow us to bring our starting wages up to $11 and hour, and to cover the recent inflationary costs. We recognize that $2.4 million is a lot of money to request, but we feel it is an investment the state needs to make to maintain to provide quality services for the 245 people that we are committed to providing services and supports to in our ICFs. We would like to thank you for the opportunity and time to consider our testimony today. Mosaic is committed to partnering with the state to improve services for all Nebraska citizens, and we would like to encourage you to visit our facilities so that you have a better understanding of the services that we provide. And we would also be happy to provide you with any further information that you may need. []

SENATOR LATHROP: Very good. []

TAMMY WESTFALL: Thank you. []

SENATOR LATHROP: Thank you. Senator Wallman. []

SENATOR WALLMAN: Thank you, Senator Lathrop. Thank you for coming here. I enjoyed your comments and investment and we consider cost all the time. I think it is an investment in our people in what we would be doing. Thank you. []

SENATOR LATHROP: I think...oh, Senator Gay. []

SENATOR GAY: Quick question maybe. When you talked about the funding and Medicaid, earlier we talked about Medicaid as a, you know, you ask for the money and you get a portion and that's always our problem. But is there a private pay that you also get on your budget strictly based on Medicaid or do you get private pay? Do you get donations? Do you get...how... []

TAMMY WESTFALL: Three percent. We get a variety of money comes in for most if it. We only have one private pay in all of our three ICFs, so the rest of that could be from donations from the community. []

SENATOR GAY: So it's all...so 99 percent of your funding is Medicaid funding only? []

TAMMY WESTFALL: Um-hum. []

SENATOR GAY: Okay. That's what I wondered. Thank you. []

TAMMY WESTFALL: Um-hum. []

SENATOR LATHROP: Senator Adams. []

SENATOR ADAMS: Do you think that even at $11 an hour, given labor shortage across the state, that you're going to have the people that you need? []

TAMMY WESTFALL: You know, right now to be honest with you, Senator Adams, we're...I'm going to use Axtell as an example. We too right now are using temporary staff to backfill the positions that we have open right now. So even if we were at $11 an hour, because when you look at our Axtell community and we've got what we've got a community-based setting out in Holdrege, there's staff shortages. They're just...because of what the economy and the gas prices and stuff...because you know we're pulling our

population of employees from surrounding communities and they can't afford, when you get the younger kids and they're driving to and from a great distance, they can't afford even gas in their vehicles to get to work. []

SENATOR ADAMS: But what about in rural Nebraska your ability to find psychologists, psychiatrists, that kind of help? []

TAMMY WESTFALL: That's a huge struggle. Even in our community-based settings we struggle. We cannot get, you know, the medical or behavioral health support out into those areas, and what Alan was talking about earlier is when you do have somebody is in a crisis, you do. You load them up, you transport them yourself, and hope that there's a hospital that will take then to get them through their crisis. And unfortunately it's strictly a quick fix because it's getting them through a real quick crisis and then they come back and you've got to be able to deal with that. So yeah, the behavioral health supports and the mental health supports are very limited when you get out into rural Nebraska. []

SENATOR ADAMS: So if you have a client with severe behavioral problem at any moment in time, you would handle that similar than to law enforcement in the area that was called into a situation. You have to find a place for them. []

TAMMY WESTFALL: Right because as Alan mentioned, the police will not do any transporting for us and so we either...now, we have obviously, we end up, you know, you hope for the best like I said that you can get somebody into a hospital setting. But anymore that's harder and harder to find because it's limited. There's only so many slots even in the hospital for mental health crisis. []

SENATOR ADAMS: Are we finding--if you don't mind--are you finding that are there any of these critical access hospitals in rural areas that are designating bed space for this kind of thing or is it just not in the financials to make it happen? []

TAMMY WESTFALL: No, they don't designate for our population in particular, but for mental...just strictly there's so many mental health beds. But there's not that many, and there's only so many of the hospitals that even serve youth. I mean that's even limited in and of itself, you know, because we ran into a crisis out in our Axtell campus in December of 2007 and we had a huge time in getting that individual the services that they needed. And what it did is we ended up...all of the providers ended up clashing with one another because everybody would say it was all ended up being about money because there was not the financial resources, you know, to provide this person the supports that they needed. And fortunately we were able to get the individual into the IDIS program at BSDC for a 30-day eval. []

SENATOR ADAMS: Okay. []

SENATOR LATHROP: Senator Gay. []

SENATOR GAY: Do you have the TeleHealth in Axtell? []

TAMMY WESTFALL: We're looking at that in Axtell right now to do that. []

SENATOR GAY: I was in Kearney last week and they have that with a psychiatrist on duty 24/7 at Richard Young. I mean, it's a different scenario, but they deal with youth and adults and that population. And I was under the impression it's not being used as much as it could be, so I think that might be something you should look into a little. They flat out said it's not being used probably as much as we could utilize these tools we have, technology. So it might be a solution to look at in the future. []

TAMMY WESTFALL: And we did, Senator Gay, here, oh it's probably been maybe now close to six months ago, we have been working with a lot of Region III providers out in that area with service coordination, the hospitals, both Richard Young, Mary Laning you know to try to come up with some solutions. And that's one thing that we did discuss

and that's why Mosaic Axtell is currently going to look at that. Yeah. []

SENATOR GAY: Okay. []

SENATOR LATHROP: Very good. Thank you for your testimony. []

TAMMY WESTFALL: Thank you. []

SENATOR LATHROP: I think we're down to one more person. []

MONICA BREITINGER: You know, I'm not a provider, I'm a parent. Okay. []

SENATOR LATHROP: We'll hear from you. []

MONICA BREITINGER: I'll be less than ten minutes. I didn't come to testify today, but what I hear is frightening to me as a parent of a child at BSDC because he may be on that frontline to get discharged. Just tell you a little bit about him and tell you what I know. He's 35. He's been their 12 years. []

SENATOR LATHROP: Ma'am, why don't we have you tell us your name first so we know who's talking to us today. []

MONICA BREITINGER: Oh, okay. Monica Breitinger, B-r-e-i-t-i-n-g-e-r. He's lived there 12 years. He lived in community one year. When he went to BSDC, he was on five psychotropic medicines. Those were in the glory years. They took him off everything. They said you can't learn rules, you can't follow directions if you're on all those meds. When he went to community, then his behavior was not so good and the first thing they wanted to do was to put him back on meds again. And you know that's just an uphill more meds, more meds, more meds. That's not really living. I could see that the care was deteriorating at BSDC, and you know we parents went to the administration there

and here and the message we got we were told try and get along. So we saw things through that weren't right. Yes, we came here and they said try and get along. At one time I was ARC review person in Omaha, and this has been a while back. But some of the things that I saw is that if you have a small group home and there's two people there supervising, they become friends. And what I saw in that situation only one person would come to work and they would cover for the other person. Other person never came to work, nobody ever knew that there weren't two people there. So we did point it out to Encore and I think they took steps to correct it. But that's what happens in those small group homes, those people become good friends and they cover for each other. So they're not likely to report anything that goes on in those homes because that person is their friend. Also one day we went on a picnic with a staff. You know, we have vehicles at BSDC. You can't use your private vehicles, but they do in the community. The vehicle that one of the staff members used to transport clients was so old it didn't have seat belts. So these kinds of things are scary to a person that knows what goes on or used to go on in a community. I know what's different about BSDC and the community. It's the long-term employees. That is the key. It's the DT IIIs who can anticipate a problem. They worked there long enough they can anticipate a problem and they can smooth it over. They know what to do. Even some of the long-term employees aren't very good, but somehow BSDC has picked out key people. And on my son's unit, when things were getting bad...you know I live in BSDC. I'm there five out of seven days a week. I go in the morning, sometimes in the afternoon, sometimes at night. I'm around there a lot. And so even though sometimes I go and I wouldn't know any of the staff people on his unit, and I think this is not good. But in my mind I think the next staff, there's going to be somebody who knows what's going on, and maybe when things are going right they can correct it. But in the community with people who are not experienced in shift after shift, I think they're just asking for trouble. And I want to know how the state arrived at 170 people. I don't know if they pull numbers out of the air or if there's some reason or some scientific that that's what they're going to reduce to. I don't know. I've never heard how they arrive at numbers. Mystery. Somebody mentioned suspensions. Well, I told you, you know, when you have three people in a house and

the people that are working there are friends, there's probably not going to be a whole lot or suspensions because they're not going to report on each other. And you mention the police coming in someplace. Well, at BSDC what I've witnessed is sometimes a client is way out of control, running or whatever, and there probably will be...and then after a while it's like maybe four staff just kind of gather around this person, talk him down, quiet him down, and there's no...they don't call the police. Of course they don't have to because they have the staff, but I see them just quietly talk, talk, talk, talk, but still ready to intervene in case something else happens. You mention, Senator Cornett, less people. You know, 90 percent of Down's syndrome children are aborted now. So there are less. []

SENATOR CORNETT: Actually I was asking a question, are there less coming in. []

MONICA BREITINGER: Oh, but that would be part of the reason too is they're not around. I have nothing else to say. []

SENATOR LATHROP: Well, I appreciate your thoughts and your contrast for us between the different programs. Senator Stuthman. []

SENATOR STUTHMAN: Thank you, Senator Lathrop. Monica, do you feel that since your son was overmedicated, do you think there's an abuse of overmedication in the whole system part of it? []

MONICA BREITINGER: You know, I don't see that of BSDC. I don't...except the ones...I'm on a committee to human and legal rights, and I see a lot of clients that have to come into legal and human rights. The ones that I see that are sedated are the ones with severe, severe seizures that are almost uncontrolled by medication. Those people are sleepy, but those are the only ones I see. In the community, I don't know any more. They wouldn't have many tools to use except to sedate or call the police. []

SENATOR STUTHMAN: Okay. Thank you. []

MONICA BREITINGER: Um-hum. []

SENATOR LATHROP: I think that's it. Thank you for your testimony. Do we have...looks like we do have one more, a repeat guest. []

JACK NICHOLS: Yes. My name is Jack Nichols. I live in Omaha. We have a son in BSDC. I wasn't going to say anything. I always told my children, my older children if you're not prepared, you don't know what you're talking about, don't speak. But I'll try not to let it show too much. The two ladies that was here this morning I thought did a wonderful job being as they were contracted by Medicare, I guess, that they didn't go too far into it. But I got out of between the lines at their feeling that possibly their inspections were adequate, CMS wanted more. And I totally believe in my own mind that it's attribute to our administrations vindictive, whatever, to save money and they probably are told to find something wrong with these units. I think if you go through, check and see how many states have downsized, got rid of complete state-run mental institutions, I think you'll find there's very few left. I'm of course in the center of the woods and the trees are in the way, but I can tell you what I see. We have experienced enough, don't want to hash over it too much, but this community-based units, the closest one that would take our son was Kearney. And it lasted for a while but the police and the rescue squads and of course the neighborhood group got together and said we want these people out of here, so they moved them in town. And it wasn't very long after that they sent him to Richard Young, they went and put a mental against him and they sent him to Norfolk just because it was too much of an overload for them. We're real lucky to get into BSDC. It's been the greatest. My wife and I are scared to death that he'll be pushed into a community someplace, and like in Kearney. They'll do it for a year, the funding changes, they'll dismiss him. And where's he go there if there's no place to go? It's a real problem. We can't do it at home. In the community-based unit, our experience is if you don't feel good in the morning, you don't want to get up, you feel

like you're sick, that don't make any difference. You get up and you get out of here because there's nobody in this house during the day. You go to wherever you go. They send them to volunteer work at Salvation Army, Goodwill. They do pretty good. But a situation comes up there, they're not equipped to handle it. I'm not saying all of them are that way because some of the staff was excellent. But the general run of the mill, they couldn't handle the situation. And these situations will pop up and if you're not experienced...I'm not 100 percent experienced, but for 30 years I can kind of see when a situation is coming up when he's getting aggravated. Our experience is they would start pushing their ideas, you do this, you do that, do it our way or the highway, and pretty soon it's the police way. Other than that, like I say, we're just scared to death that it's going to close. And what we're doing now is the situation is getting bad down there at BSDC because some of the guys that have come in years ago have mellowed out. These were a peer group my son could relate to. The community group picks and chooses and both these guys said that that's what they do because what they can handle. What's happening when the unit gets low, they start bringing in other people from I suppose different units, and then we've got to get acquainted again and build a peer group and it just doesn't work like you're in high school. These people are pretty much on a even keel. Once they get comfortable with something, things work a lot better. But then when the apple cart gets messed up, they start getting anxious. We've had three incidents here in the last month where we've went ten months without any incidents. But it's coming up. So I guess that's all. []

SENATOR LATHROP: Okay. Well, thanks, Jack. We appreciate hearing from you again. I just want to make one thing clear, when you were talking about the administration, you were talking about the President and not the Governor when you said it seems to be a vindictive thing with CMS. []

JACK NICHOLS: I used the wrong work, vindictive. Escape, maybe, plan to eliminate state-funded or Medicare-funded agencies run by a state, and our Governor also, in the communications I've done with him, is looking forward to community assignments too.

And we drive 100 miles from Omaha to Beatrice, no less every two weeks, sometimes more, a lot more. It's worth that to us to drive that far to know that the security and the care that our son's getting is that good. []

SENATOR LATHROP: Okay. []

JACK NICHOLS: All right. []

SENATOR LATHROP: Good. Thanks. []

JACK NICHOLS: Thank you. []

SENATOR LATHROP: Any questions? Nope. All right, thanks, Jack. []

JACK NICHOLS: Thanks. Thank you. []

PATTY SMITH: Do you guys have a couple of minutes? []

SENATOR LATHROP: A couple of minutes, Patty. []

PATTY SMITH: A couple minutes. I didn't bring notes this time, but there's a couple of things that might be helpful to you so I would try. My name is Patricia Smith, S-m-i-t-h, is my last name. I'm from Omaha. I am past president of the ARC and I'm a parent and a grandparent of a son with disabilities. I just want to give a couple of answers that might be helpful. The question was asked earlier in the day if other states have closed institutions. We know that at least nine states have no state institutions. We know that 147 state institutions have closed in some 41 states and the District of Columbia and Puerto Rico. We need to know that there is a great deal of effort that has been done that could be instructive to all of you if you try to work through this. The salaries at BSDC the last two years because of a deal that came about because of the union,

which I'm not complaining about, but the staff salaries were raised 7.5 percent each year. So in two years, it's a 15 percent increase on the salary amount. In the community-based, it was only 2 percent for the two years. There's an extraordinary...there's always been a change there, and as I understand, Beatrice is able to hire people at the second level when they even first start. So when they're talking to you about $9 an hour and the different amount of money in the community, that's part of the problem. So that's another one. The overtime, I do not believe there's overtime budgets for most of the community-based services. That is what I have been told. They do not have overtime in their budget. At one time, Beatrice had a budget item of $1 million for overtime. I saw it with my own eyes. That's one's done. Folks need to take...oh, the money following the person. The only thing I'm concerned about as you move people out of Beatrice, I've heard from service providers that they are concerned that after a period of time they will not have as much financial support as they get in the beginning. This is worrisome and as a group trying to figure this out, you need to look at that because if it costs $200,000 a person at Beatrice right now and you can serve a person for $90,000 in the community, they have real high needs. But if six months later somebody says, oh, we're going to cut it down to $60,000, that's a problem. The thing about the service coordinators was explained to you quite well. The service coordinators do serve a function of trying to keep track of what's happening in the community. The aging parent list. I'll find the figure, but the figure is extraordinary how many parents there are over 65 years of age in the state of Nebraska who will, as has been testified earlier, are going to want more support than they're getting. It's another factor that it seems like everything you factor in is more people are going to cost more money. And this is whey we're getting to my last one. Rebalance the monies because that is what is not happened. That is what the people in Washington, D.C., have begged every state to do is to rebalance their monies and to use the monies in a better way. So if the state of Nebraska is not successful at appealing the amount of money that Medicaid is going to withhold, that means then, and you guys already know this, that you're going to have to pay another $20, $30 million to keep Beatrice open because there isn't going to be Medicaid money there if they refuse that appeal. But if the people go into the community

they would then be able to use their Medicaid monies. In other words, you could rebalance that money so it wouldn't be so hurtful to your budgets. The bottom line is the state of Nebraska has not come up to bat, and you as senators have been learning painfully that they have not kept even places just to keep the money going to take care of the people no matter where it was. That's it. []

SENATOR LATHROP: All right. Thanks, Patty. []

PATTY SMITH: I don't think you want question. []

SENATOR LATHROP: Doesn't look like it. []

PATTY SMITH: They're hungry. []

SENATOR LATHROP: They're hungry. []

PATTY SMITH: Thank you very much. []

SENATOR LATHROP: Thank you very much and thank you all for coming here today and we'll have hearings probably next month and we'll get the notice out to you so you can appear if you like. Thank you. []