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SENATOR CAMPBELL: The Children's Behavioral Health Oversight Committee and the Committee on Health and Human Services met at 9:00 p.m. on Friday, August 26, 2011, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a joint public hearing. Senators present: Kathy Campbell, Chairperson; Bill Avery; Dave Bloomfield; Colby Coash; Tanya Cook; Annette Dubas; Gwen Howard; Bob Krist; Amanda McGill; Jeremy Nordquist; Pete Pirsch; and Norm Wallman. Senators absent: Mike Gloor; and Tom Hansen. []

SENATOR CAMPBELL: Good morning. Good. I heard a couple of people, I know you're out there. We are going to convene a joint meeting of the LB603 Oversight Committee, and most of the committee members for that are on my right, and then a joint...the other partner in this is the Health and Human Services Committee, and most of those folks are seated on my left. We are still expecting several senators but we are on a very tight schedule this morning because we're trying to cover a lot of ground and a lot of material, so with that, as is our tradition on the Health and Human Services Committee, we'll have the senators introduce themselves and we'll start to my far right. []

SENATOR AVERY: I'm Bill Avery, District 28 here in Lincoln. []

SENATOR NORDQUIST: Chairman Nordquist, District 7, downtown and south Omaha. []

SENATOR McGILL: Amanda McGill, District 26, northeast Lincoln. []

SENATOR PIRSCH: Pete Pirsch, District 4 in Omaha. []

SENATOR COASH: Colby Coash, District 27 here in Lincoln. []

SENATOR CAMPBELL: Kathy Campbell, District 25, Lincoln and Lancaster County. []

SENATOR COOK: I'm Tanya Cook from District 13 in Omaha and Douglas County. []

SENATOR KRIST: Bob Krist from District 10, and it's Omaha and Douglas County. []

SENATOR BLOOMFIELD: Dave Bloomfield, District 17, made up of Wayne, Thurston, and Dakota Counties. []

SENATOR WALLMAN: Norm Wallman, District 30, south of here, Gage and part of Lancaster. []

SENATOR CAMPBELL: And entering the room is Senator Dubas from Fullerton and many parts around that. Welcome. []

SENATOR DUBAS: Thank you. []

SENATOR CAMPBELL: This morning the meeting is divided into two segments and the first segment is really an update for us on the different components of LB603. And the second half of this will be a briefing on the Medicaid residential treatment changes that are proposed and have been put into place and for which we are receiving a lot of information. So we'll start with the overview of what's happening in LB603 and want to welcome all of you to this. It's great to see so many people at the hearing today and so many who have an interest in children's welfare as well as their mental health, so thank you. We'll start out this morning with general comments from the Division of Behavioral Health. Good morning. []

SCOT ADAMS: Good morning. Thank you so much. []

SENATOR CAMPBELL: As Director Adams is getting prepared, remember to turn your cell phone to vibrate or off so we're not bothering our neighbors today. []

SCOT ADAMS: Okay. []

SENATOR CAMPBELL: Good morning. []

SCOT ADAMS: (Exhibits 1 and 2) Good morning again. Good day, members of the Health and Human Services Committee and also the LB603 Oversight Committee. I'm happy to be here. My name is Scot Adams, S-c-o-t A-d-a-m-s. I have the honor and privilege of serving as the director of the Division of Behavioral Health in the Department of Health and Human Services. Given the long schedule of speakers, I will try to provide very brief and sort of syncopated comments with regard to an overview this morning, but I will stick around if you'd like to have me comment or have other questions that you might have at a later point. About six points I would like to make this morning. First of all, national context. Over the past three years ending June 30, 2011, $2.2 billion or 17.5 percent of the funding has been taken out of all states across the nation's mental health systems, $2.2 billion, 17.5 percent reduction across all states; specifically, approximately 8.6 in this last fiscal year ending June 30, 5 percent the year before, and 3.6 percent the year before that. In substance abuse that's been a little bit less, a total of 7.8 percent, with a range of 3.6 to 1.2 percent the last three years--still a significant sum of money. In Nebraska the picture is different. Over the past three years expenditures in the Division of Behavioral Health have risen 3.7 percent in '08-09; 5.5 percent, '09-10; and 3 percent last year. Appropriations grew in that same time by 5.5 percent to the Division of Behavioral Health services and community-based services. On the Medicaid side, provider rates grew .5 percent last year and 1.5 percent the year before. With the beginning of this current fiscal year we're in, there is a rate reduction of 2.5 percent. All in all, while behavioral health services are being cut across this nation, we've done...we've held our own better than most. The second point here, you'll hear, shortly, about the Family Navigator and the Family Helpline from Boys Town and the Federation of Families. I'm not going to steal their thunder but I do want you to hear from me that we changed the nature of those contracts in this coming year in hopes of providing an increase of continuity of support to help families. Specifically we intend greater integration between the Helpline and longer term services, as well as the crisis services and as well as suicide prevention and other services in the community. So that was our intention with regard to changes of the contracts. As you know, LB603 also provided for evaluation of these services conducted by Hornby Zeller, and their final work product will be due on October 15. We'll make sure that you receive copies of that report. Today I have the fourth quarter report to be able to hand out to you for your information, and that is here and I'll do that at the end then. With regard to the Helpline and Family Navigator services, the Helpline receives about 320 calls per month on average--a number we have come to expect as sort of a baseline number. Family Navigator services were offered to 686 families in 2011, and 460 of those were accepted for services. Notably both the Helpline and Navigator come in about a half-million dollars under our original projections for need for services, so this is a project that has come in under budget and is doing really quite well in many respects. These new programs available statewide provide much needed support to families with children experiencing behavioral health challenges, often successfully preventing further system involvement or custody relinquishment. Another point I'd like to make with regard to LB603 that added funding to the regional behavioral health authorities to increase services to children and specifically to expand the Professional Partner Program which is a wraparound service around families. And then a creative new partnership to families is the Region 6 mobile crisis response service. This collaboration has been extremely successful in providing immediate care to families in need and eliminating the use of protective custody, minimizing trauma for youth and other siblings in the family. And both Regions 5 and 6 have created a new successful short-term partner programs aimed at deterring families away from custody relinquishments. Regions 1 through 4 also have done good work in expanding protective custody in Professional Partner services and being able to serve additional youth and levy those dollars for additional training or to do small pilot projects. Consumer surveys are things that are done by the Division of Behavioral Health on all customers and consumers of services during the prior year. So we survey everybody. That survey with regard to services for children, because it divides into adults and kids, showed that about 89 percent of those surveyed responded positively to questions related to quality and appropriateness of service. So those are the people who have been in the system the past year and were asked that question, seemed satisfied with the overall arrange of service. Finally, a recent federal report from SAMHSA on Nebraska's mental health system, adults and children, identified 41 particular and specific strengths of the system, no serious deficiencies--a change from about three years ago, and 10 opportunities to improve should we want to do that. That report would be available if you're interested in that. So Nebraska continues to improve its behavioral health system, day by day, piece by piece, best we can in light of very challenging times. With that, I'd be happy to respond to questions. I do have the chart, if you like the color version, of the numbers with regard to funding and then the Hornby Zeller Fourth Quarter Report for distribution. []

SENATOR CAMPBELL: We'll have the pages distribute those. []

SCOT ADAMS: Sure. []

SENATOR CAMPBELL: Questions? Senator Avery. []

SENATOR AVERY: Thank you, Madam Chair. I'm looking at item 6 here on your testimony. []

SCOT ADAMS: Uh-huh. []

SENATOR AVERY: Have you done these consumer surveys for previous years? []

SCOT ADAMS: Yeah. Yep. []

SENATOR AVERY: How do the results of...? Eighty-nine percent is pretty high. How do these results compare to the past? []

SCOT ADAMS: The last year's survey is actually a bit higher than they have been, but they've all been in the 80's range. There are about seven different particular categories of service, and questions cluster to the category, and so you can go by question or you can go by the cluster. The worst one, the highest is with regard to cultural sensitivity as one of the domains that we measure, and that's in the 90's in terms of satisfaction. The worst number as I recall off the top of my head--and I'd be happy to get you a copy of the survey--is somewhere in the three-quarter range, about 70 to 75 percent. []

SENATOR AVERY: So we had a reason for this committee,... []

SCOT ADAMS: Yep. []

SENATOR AVERY: ...and it was because we were being absolutely inundated with complaints from the public. How do you explain these high numbers in your consumer satisfaction survey with the complaints my office and others here were getting about the services being provided? []

SCOT ADAMS: Well, I think you have the...first of all, one response is the difference between systemwide impact and individual situations and stories of deep need. Clearly this is a system that works okay for most of the folks most of the time but is not one that covers every need absolutely perfectly. []

SENATOR AVERY: Well, we wouldn't have this committee if there hadn't been a crisis. We don't just, you know, form special committees because we enjoy meeting. So I'm really puzzled by this. []

SCOT ADAMS: I'll be happy to send you a copy of the reports conducted by the university and so is independently leveraged. You'll understand the nature of survey research. But it's been done for multiple years, and I'd be happy to talk further with you. []

SENATOR AVERY: And you do have the over time...? []

SCOT ADAMS: Yep. []

SENATOR AVERY: Okay. I'd like to see that. Thank you. []

SCOT ADAMS: Yeah. You bet. []

SENATOR CAMPBELL: Senator Nordquist. []

SENATOR NORDQUIST: Thank you, Senator Campbell, and thank you, Director Adams, for being here. Just real quick on the Helpline. We made a reduction in the budget to that for the current fiscal year,... []

SCOT ADAMS: Yes. []

SENATOR NORDQUIST: ...and just want to see that reduction. Did that have any impact on the number of people being served by the Helpline and are we still, with that reduced amount, able to meet the ultimate intended goal that Helpline was set out to do? []

SCOT ADAMS: You know, Boys Town will speak at a later point. They can certainly offer their perspective. But the process by which we came to this reduction was a collaborative process involving them in the discussion about need, because we didn't want to short need, and yet we, of course, we were all faced with the need to be able to reduce expenditures. In my opinion, we came to the point where we felt that this was not going to be hurtful to the services. We had had, at that point, about a year, year and a half, of operations in terms of the number of people being served consistently came in less than original expectations. That's why that 320 number is sort of important because it sort of seems like that's our baseline for Nebraska, less than we had anticipated--another point, Senator Avery, with regard to some of that as well, by the way. And also then the idea that together we thought we could continue to do that. We are up over some of the initial inertia of awareness and some of the promotional items. There are still promotional elements to the funding that go into this, in addition to the on-line operations, so that we're trying to stir awareness through various media approaches as well. So while it was a serious reduction, we felt that it was one that could be done in a way that continued to deliver an important service. []

SENATOR NORDQUIST: Okay. Thank you. []

SENATOR CAMPBELL: Okay. Director Adams, would you be here for the second half? You will be, won't you? []

SCOT ADAMS: I'll stick around. Sure. []

SENATOR CAMPBELL: That would be great. Thank you. Our next report comes from the Family Navigator program, and Ms. Candy Kennedy is reporting to the committee from the Nebraska Federation of Families for Children's Mental Health. And we should indicate that this is part of what the director was talking about. We have the advisory committee to the Helpline. We can add another chair. []

CANDY KENNEDY-GOERGEN: That would be helpful. []

SENATOR CAMPBELL: Do we have another chair to add? Maybe, maybe not. []

CANDY KENNEDY-GOERGEN: No? We'll take turns sitting up here, how's that? []

SENATOR CAMPBELL: All right, that would be great. We'll keep looking for a chair. And this allowed so that if someone came into the Navigator program, that...and that was meant as sort of short term and then they would transition to someone different, this kind of is a more seamless approach. Is that a correct analogy? []

CANDY KENNEDY-GOERGEN: Yes. And I actually speak to that a little bit. []

SENATOR CAMPBELL: Good. []

CANDY KENNEDY-GOERGEN: I thought that would be helpful to explain. []

SENATOR CAMPBELL: I won't steal your talk. Thanks, and welcome today. []

CANDY KENNEDY-GOERGEN: Thank you. Good morning, Senators. My name is Candy Kennedy-Goergen, C-a-n-d-y K-e-n-n-e-d-y G-o-e-r-g-e-n, and the G-o-e-r-g-e-n has been added in the last three weeks. Yeah. (Laughter) I am the executive director of the Nebraska Federation of Families for Children's Mental Health. The federation also consists of six affiliate family organizations around the state of Nebraska which is Nebraska Family Support Network, Families Inspiring Families, Parent to Parent, Families CARE, Voices 4 Families, and S.P.E.A.K.O.U.T. And we also have a very strong partnership with the NFAPA, the Nebraska Family Foster Adoptive Parent Association. First, I want to thank you guys for the very hard work that you're doing and the commitment and the continued passionate support of our children and families that struggle with behavioral health challenges in Nebraska. The impact from your dedication and work is very great. It's important. Thank you very much. I am here today to speak of our recent contract and work with the Family Navigator Peer Support services in conjunction with the Nebraska Family Helpline and Right Turn. In May 2009, LB603 was passed authorizing the creation of the children's behavioral Helpline and the Family Navigator services. The children's behavioral Helpline and Family Navigator services was initiated by an RFP through a contract with Boys Town, which established the Helpline and Navigator services. Separate from this initiative, the state had contracts with local family organizations to provide longer term Family Peer Support services. While both programs have demonstrated successes, both hosted by different vendors in many areas, causing a disruption in service continuity for the families if referred from, like Senator Campbell was speaking, for the short-term Navigator services to those long-term Peer Support services. Simultaneously, the state operated an evaluation process pertaining to the services. One recommendation from the process was to consider quality efficiency improvements, which included a recommendation to review the families' express concerns about the disruption of support services while being transferred from one service to the other. So the current contracts seeks to continue the Navigator services as well as the long-term Peer Support services operated by the same vendors to ensure consistency and continuity in services delivered for the benefit of the youth and families. So just to continue there's no disruption with those same relationships. No matter if you're receiving the short term or long term, you can continue with that. These current services provide continuity of advocacy and support from the Navigator, the Peer Support. This would include the enhancement of the Peer Support model through data collection, contract management, quality improvement, and fidelity measures. Consistency in family connection. The family tells the story once and has the benefit of the long-term relationship building with the advocate. Long-term outcome track--and we have the ability to track data across systems and services, so no matter what system or service, where that family is, we can continue collecting that data and really truly looking at the picture of what the family looks like. We have the ability to track and assist with safety planning and interventions regardless of the involvement of the formal systems. We have a dynamic new database we call "flip the pyramid," so we have the ability to report data across the systems, and we are looking at including CFS data as well now. This allows for comparing apples to apples so we can really get that true picture of same questions. We have the ability for instant reports, outcome measures, quality reviews statewide in one location, so everyone is not collecting their own data. It's all together. Contract monitoring tools and performance indications by organization so we can look at the organization or the service area to see what those individual data looks like as well as just the statewide. We have community-based connections so we connect to the individual cultures within each behavioral health region in the state. We have key stakeholders, agencies and partners within each region with their specialized knowledge and relationship to the specific region connected to the organization allows for stronger connections and sustainability, what works within their community. Community connections assist in that comfort factor for the families' true long-term informal supports. So what we build and what we help and the resources stay there, and it allows better integration into each region's local system of care, so that true connection with that. We have developed a localized clinical consultation, linkages to mental health practitioners acting as clinical consultants within each region. Clinicians specialize in specific regional cultures. Clinicians provide individualized training and skill development related to the needs of each organization working hand in hand. It enhances the unique knowledge and skill base with the Peer Support and Navigators through its ongoing education related to behavioral health symptomology, interventions, and safety planning, so working with that clinician to get their perspective and their knowledge base along with that unique peer support focus. So we also have connections to local...we're developing connections with local colleges in counseling programs for consultation and local growth in rural mental health field development, so it's an opportunity to share education. The clinicians are educating the Peer Support; as well, Peer Support is educating our clinical education process, as well, so they understand that and so we can value each other's perspectives. Partnerships with communities across the state and with key agencies including Boys Town, for the Helpline, continually sharing responsibility to maintain an updated resource depository with input from each community. So really getting those new resources from each region updated by those in the community, including family providers and the family organization to ensure complete, accurate, and up-to-date information as it changes. As we all know, that changes quite often--so to make sure that we're staying up-to-date on what that resources for the families truly looks like in that community. The resource database includes resources not commonly known by statewide but by small communities in the...you know, small groups in the communities. Our marketing efforts, we're doing social marketing with each region including county fairs, events with small communities, parades, whatever those local activities are that are involved, the organizations, because the family organizations are there and have those connections and know the people and know the families. We're using marketing tools such as Take a Second, Make a Difference from the Search Institute, and the Above and Beyond Award, localized public service announcements, connections with schools, hospitals, therapist providers, the whole system teams, but most importantly word of mouth--families talking to other families sharing their experiences. Model creation was based upon evidence-based practice. We are now having an opportunity to be part of the development of a national Peer Support system model. We are bringing in support entities such as SAMHSA, the Nation Federation, Copeland Center, and the Search Institute. We do evidence-based practice, promising practice, and best practice trainings--okay, my time is getting tight here. (Laugh) Opportunities for our advocates, so new training and to really understand and utilize both our evidence-based practice. Some examples of that are the 40 developmental assets, WRAP planning, standardized tools, such as caregiver strain, satisfaction surveys, family-centered practice, the CSAP strategies, and the creation of a model to allow the family-run organization sustainability and multiple funding sources at the same time creating a standardized process. No matter where our families may live or relocate in Nebraska, they can receive the same quality advocacy. And of course, last but not least, contract accountability. We have the availability to have one main entity responsible for the statewide contract with the individuality and diversity of six different affiliate family organizations. We work together to create a unified family voice and at the same time have the unique opportunity to stay true to the community culture. Performance accountability of family organizations through quality assurance reviews, administrative reviews, as well as peer reviews. Diverse planning and growth in connecting. We have great connections with the Division of Behavioral Health as well as Child and Family Services, so. And with that I would like to introduce my program manager to talk about...oh, if you have any questions, first, and then we were going to do data. []

SENATOR CAMPBELL: Let's do that. Senator Krist. []

SENATOR KRIST: Thank you. Thanks, Candy, for your testimony. []

CANDY KENNEDY-GOERGEN: Uh-huh. []

SENATOR KRIST: And congratulations. []

CANDY KENNEDY-GOERGEN: Thanks. []

SENATOR KRIST: How much...you talked about the database being built. []

CANDY KENNEDY-GOERGEN: Um-hum. []

SENATOR KRIST: Do you interface with N-FOCUS? []

CANDY KENNEDY-GOERGEN: No. No, we are not at this time. []

SENATOR KRIST: Why not? []

CANDY KENNEDY-GOERGEN: It's just a different system. With the previous contract, they were doing some with N-FOCUS. We are collecting some same datas. But it was very, very time-consuming. We're talking about N-FOCUS, you would have to go through many, many, you know, screens to add just a limited amount of information. This way we can collect the same information within a very short period of time and continue the work that we're doing. []

SENATOR KRIST: Sounds to me like we've recreated a database that was already in place. []

CANDY KENNEDY-GOERGEN: No. No, not...what was put or initially in N-FOCUS was very limited. It was more statistics about the families such as one of the big things was the Social Security numbers. So there was already another database that was being utilized with the contract with Boys Town had the database. So we have the ability...it really is not replication. []

SENATOR KRIST: So if the contractors that are out there, let's say the primes in another area are having behavioral or health problems that relate within a family structure. How many databases would they have to go through to track a child who had an issue or a family that had an issue within the state? []

CANDY KENNEDY-GOERGEN: Through...for the advocacy services is all I can speak to: one. I can't speak to all of, you know, what....if you're...it would depend on if you're in children's behavioral health, child welfare, you know, the rest of those, what those look like. But for... []

SENATOR KRIST: Would you entertain a notion that we really continue to stovepipe what we're doing here rather than horizontally planning for the care of a family or a child? []

CANDY KENNEDY-GOERGEN: For the big picture I can see that perspective, absolutely for the work that we're doing and the ability that we have, we're creating, so we can track across systems, so there is no...from...only for the efficacy piece, no siloing, so that you can actually have that data no matter where the family is. But I do understand what you're saying and it is a challenge. But that was one of the reasons to do this, so we didn't have to go to this system or that system or, so. []

SENATOR KRIST: Okay. Thank you. []

CANDY KENNEDY-GOERGEN: Um-hum. []

SENATOR CAMPBELL: Senator Dubas. []

SENATOR DUBAS: Thank you, Candy, for being here. I'll kind of pick up where Senator Krist left off. You're referencing and what you're dealing with is just the Navigator portion. []

CANDY KENNEDY-GOERGEN: Absolutely. Yes. []

SENATOR DUBAS: Okay. And the answer to the question I'm about to ask is probably fairly obvious, but I want to make sure that we're connecting the dots for the record. []

CANDY KENNEDY-GOERGEN: Right. []

SENATOR DUBAS: So where we were before Family Navigator to where we are today, to where hopefully we continue to go. So before Family Navigator, did any of this exist in any way, shape, or form--the services? []

CANDY KENNEDY-GOERGEN: No. No, it did not. []

SENATOR DUBAS: And we put Family Navigator in place... []

CANDY KENNEDY-GOERGEN: Yes. []

SENATOR DUBAS: ...because there was just that wandering in the desert for these families and... []

CANDY KENNEDY-GOERGEN: Yes, absolutely. And now they have a new resource, a number to pick up, and then the follow-through with that, so. []

SENATOR DUBAS: And so you've been able to collect this data, create this advocacy for these families and these children, pulling everybody together. So while I too understand where Senator Krist is going... []

CANDY KENNEDY-GOERGEN: I do as well. Yeah. []

SENATOR DUBAS: ...with the big picture. But when we're looking at specifically what LB603 tried to put together and what we heard from families as far as I didn't even know... []

CANDY KENNEDY-GOERGEN: Who was where? (Laugh) []

SENATOR DUBAS: I could pick up a phone but I didn't even know where to start. []

CANDY KENNEDY-GOERGEN: Exactly. []

SENATOR DUBAS: We've made some huge strides. []

CANDY KENNEDY-GOERGEN: Absolutely. And a lot of this has to do with the evaluation piece as well, because a lot of that data is collected per the evaluation process and like that. []

SENATOR DUBAS: And I'm going to assume we still have strides to make, and hopefully... []

CANDY KENNEDY-GOERGEN: Absolutely. []

SENATOR DUBAS: ...with everything that's put in place, the state will recognize what your portion has done and will continue to build on that. []

CANDY KENNEDY-GOERGEN: Yes. Yep. []

SENATOR DUBAS: Thank you very much. []

SENATOR CAMPBELL: Candy, my question sort of comes to tying these two together in the sense that many of the families you work with and the effort that goes into Navigators and the hotline is to keep children, youth, and families out of the system. []

CANDY KENNEDY-GOERGEN: Absolutely. []

SENATOR CAMPBELL: And that was really our hope and goal as I look at the LB603 half of the committee here. That was really our hope and goal that those families and those youth wouldn't even have to get into the system, that we could find services and help and support for them. []

CANDY KENNEDY-GOERGEN: And I am fairly confident that our long-term data...I'll remind everyone we've been doing this for 45 days, so it's new, but I am confident that the data that we'll show long-term is the effectiveness and how we've been able to keep the families out of the system, those unneeded. []

SENATOR CAMPBELL: And I think what's really neat here is to see that we've now gone to the next step of trying to ensure that you don't have one person for a Navigator and then you have to move. Because for a family that's very...at least from all the calls that we took, that was very disruptive for the family. So it's good to see the family organization step in and have a longer term effort with the families. []

CANDY KENNEDY-GOERGEN: You know, this may be a part of the family's life that is...they're in crisis. It's the biggest crisis they've ever experienced. And to build relationships, to build trust, and to share that story and be able to communicate that is a very difficult thing to do and a big accomplishment. And to actually do that and then have to move on and do it all over again is disruptive and frustrating and, fortunately, unnecessary now. []

SENATOR CAMPBELL: Senator Krist, I think, has a follow-up question here. []

SENATOR KRIST: Actually I do. I didn't mean to attack your success. I meant to point out that if we continue to build stovepipes of success and we don't go horizontal in these plans then we will be wasting our effort. []

CANDY KENNEDY-GOERGEN: I completely agree. []

SENATOR KRIST: And if that database is good enough, then that child and that family has been...has gone through the Spanish Inquisition once. []

CANDY KENNEDY-GOERGEN: Um-hum. []

SENATOR KRIST: They shouldn't have to go through it five more times to be entered into common database systems that are accessible. []

CANDY KENNEDY-GOERGEN: I agree. []

SENATOR KRIST: And that's one of our problems. So I make that point to say I congratulate you and the LB603 process and the efforts that's done. But take notice: These standalone stovepipes of success need to be woven together into a fabric that takes care of families and children. []

CANDY KENNEDY-GOERGEN: Absolutely. And I think that's even a national conversation about system sharing and you should be able to...it would be great to have an opportunity to look at a family, long term, and see what that looks like, and. []

SENATOR CAMPBELL: I want to take one more quick question for Ms. Kennedy and I thought I had...I thought, Senator McGill, you had one. []

SENATOR McGILL: No. []

SENATOR CAMPBELL: Okay. Senator Nordquist. []

SENATOR NORDQUIST: I don't know how quick it is. But just any challenges making the referrals and to the challenges of obtaining the services after you...as you are helping the families through the system? []

CANDY KENNEDY-GOERGEN: No, just sometimes that initial connection. And again that's because of the, you know, the situation and where the family is at and to allow someone else into their business and their home to actually, you know, do that initial... []

SENATOR NORDQUIST: So the barrier is more on the family side as opposed to the services being available? []

CANDY KENNEDY-GOERGEN: Yes. []

SENATOR NORDQUIST: Okay. []

CANDY KENNEDY-GOERGEN: And if it would be all right, I would like to take a moment and introduce Sara and share the numbers--are again, 45-day numbers, so. (Laugh) []

SENATOR CAMPBELL: Because the Boys Town people have got the statistics prior to that. []

CANDY KENNEDY-GOERGEN: Yes. Absolutely. And that's another point too, is we...as we did that transition, there was no...data remains the same. There was no gap in data or changes, so the transition was pretty transparent and flawless. Knock on wood. (Laugh) []

SENATOR CAMPBELL: And we'll need your name and spelling for the record. []

SARA NICHOLSON: Sara Nicholson, S-a-r-a N-i-c-h-o-l-s-o-n. Good morning. I will keep this very brief. We just have some, just a little bit of data so far in our first 45 days. We're looking forward to having a data management system that allows us more comprehensive data. But I just wanted to share a few of the little basic pieces to give you an idea of where we're at in these first 45 days. As of the twenty-third, we had 56 referrals from the Helpline from Family Navigation cases. And we had one family that transitioned over from previous navigation services to our navigation services of those. We've had...previously we had the Families Mentoring Families grant where we served families in a very similar way that we now are with Family Peer Support, and we had 125 families transitioned over from that contract into Family Peer Support services. We have since July 1 received 24 new referrals for Family Peer Support. And what we've seen as far as some trends is that more referrals are coming in, in the Omaha area. That's where our biggest population of referrals have come, followed shortly behind by Lincoln and Kearney area or the Central and Eastern service area. We have not received any referrals in Region 1 and minimal referrals in Regions 4 and 2 at this point. But we do in those areas have a higher population of the Family Peer Support cases. We have a lot of families that will walk directly into those offices and want to access services, so we're able to hook them up that way instead of sending them back through the Helpline. Okay. We have had three discharges to date, which is wonderful, because we can serve families, you know, approximately eight hours or no more than 90 days. At this point we can't give you an average number of days that we can serve them because again we're at 45 days. But in the 45 days, we've had those three discharges. We've had some interesting dynamics with some of those discharges that I'd just like to share. With those three discharges we've had one of them--actually two of them, one of them has not discharged yet--came in to the Helpline. Were transferred over to Family Navigation services, but the same day that they called the Helpline they also called the CFS hotline. And so one of those cases has closed from our services because they went over to CFS. That's something that we're tracking because we again are very cognizant of the need to keep families out of the more formal system when we can. We've had 20 Family Peer Support discharges since July 1, which is wonderful. We're really starting to put some parameters in place and some transition plans for families so that we don't keep them in a formalized service for too long and we're able to transition them to informal supports, which is one of the outcomes. And that's all I have for data. Do you guys have any questions? []

SENATOR CAMPBELL: Okay. Thank you so much for coming today. Our next report will come from the postadoption/postguardianship: Jessyca Vandercoy. And Jessyca is the director of Right Turn. Good morning. []

JESSYCA VANDERCOY: Good morning. []

SENATOR CAMPBELL: The page will...and would you state your name for the record and spell it, please? []

JESSYCA VANDERCOY: (Exhibits 3 and 4) Absolutely. My name is Jessyca Vandercoy, J-e-s-s-y-c-a V-a-n-d-e-r-c-o-y, and I am program director for Right Turn, which is a program collaboration between Lutheran Family Services and Nebraska Children's Home. And I am very excited to be here, as usual. I love reporting all the nice outcomes that we've had and really to be a part of postadoption services in Nebraska, which prior to Right Turn hadn't legitimately, in my opinion, been around for families. So I also want to thank all of you for being part of the decision to extend the funding into a new contract period for postadoption services. I think it is a validation or recognition of the hard work and the success Right Turn has had for families, but it's also really a testament of Nebraska values and supporting that. So I appreciate that. I have passed around a folder with a couple of different handouts that I'll go quickly over. I know I only have 15 minutes which is probably the thing that makes me the most nervous because I have... []

SENATOR CAMPBELL: And we're going to try and shorten that just a little bit. []

JESSYCA VANDERCOY: I have, okay, 12--maybe?--minutes. []

SENATOR CAMPBELL: (Laugh) You and I are always negotiating on the time. I love that. []

JESSYCA VANDERCOY: I know we are. (Laugh) I will push the envelope as much as I can. But so what you have in there is just really a quick overview or quick facts that I thought were interesting. It also goes over our outcomes. First being that, you know, in the first 18 months of the program we've served 353 families in a case management capacity. We've served an additional 65 families that were not eligible for the program but were adoptive families. We do that through a partner relationship through Nebraska Children's Home who has postadoption services. I'll address this a little bit later, more specifically, but approximately 12 percent of the families that we've served have asked for an extension of service, so their issues really haven't been resolved to a place where we feel permanency is absolutely stable at the end of that 90 days, and so they have requested an additional amount of time. We have lots of service referrals that happen in cooperation with Hornby Zeller, the evaluators, their reporting as well as consistent with our data, that approximately 75 percent of families who experience Right Turn are reporting that their needs are met through that level of service, which I think is positive and I will talk about what our solutions have been to that. We've served families in 19 states including Nebraska. We've been in 45 different counties across the state of Nebraska. And just to give you a quick look at the family: 62 percent of the parents that call are married or in a married family; 19 percent are single parents. So I thought that was significant. On the second page you'll find really our...how referrals have come in over the last year. As you can see, we don't have a real idea of why they come in when they do. It's sort of all over the place. And then the second is just a breakdown of where the families are coming from across the state. Again we continue to serve more adoptive families than guardianship families. It's pretty consistently, since the beginning of the program, then about an 80/20 split. On the third page you'll find, because mental health has been such a significant piece of this, 73 percent of the families that call know or report that they know their child's diagnosis or know that their child has previously been in mental health treatment. So at the time of intake we do collect information as to what their child has been diagnosed with. So there you'll find the most common diagnosis is ADHD or ADD. You'll notice that the second highest, at 38 percent of the Right Turn families, are parenting a child that has been prenatally exposed to drugs or alcohol; 33 percent of Right Turn families are reporting that they are parenting a child that falls in the reactive attachment spectrum; and 17 percent of families report that their child has a mood disorder; and 11 percent account for developmental disabilities or children who fall on the autism spectrum. Then on the last page, which is really where things get fun because it's our program outcomes, and I'm very, very happy with how things have turned out and really happy to report that in January, from January 2011 until today's date, we have not had any families that have dissolved or relinquished their commitment to the child. Let me clarify by saying we have had children...parents who have chosen to make their children wards of the state for the purposes of accessing treatment which I'll go into a little bit, but we do not have any parents that have said "I'm done with my parenting commitment; I'm going to turn my child over to Health and Human Services and I don't want to be contacted again," which I think is absolutely awesome because not only is it a testament of how committed these parents are but that this service is making families feel hopeful that in fact there are some solutions. Unfortunately, and I don't know if this is, you know, an issue of how our state functions or how services are accessed, there have been families that are forced into having to use the child welfare system to access services for their children. So since January we've had six of those families: one being to access specific mental health treatment;

two to access developmental disability service that they were not able to get for quite some time--years actually--and were really forced into that; and then another three through status offense of the children, what they were committing, so the Office of Juvenile Services had taken over. So that absolutely is excellent news and hopefully is supportive of the reasons why this committee was developed, and the idea of keeping children out of foster care or out of the system I do believe is working through what we have to offer. So the other outcomes that we were required to report on are families being able to identify community resources. One hundred percent of families report that they are now able to find resources that they didn't...weren't able to find prior to service. Seventy-seven percent, after our service, say that they were able to find the resources they need to keep their family together and healthy--and that's compared to prior to Right Turn, 11 percent of families. So at intake, 11 percent of families report that they're not quite sure where to go; at post service, 77 percent of families report that they do know where to go. So that is a nice increase of 66 percent. Families are satisfied with the service. They have reported that to both Hornby Zeller and during our satisfaction survey that we have afterwards, and that they are better able to manage or to respond to the adoption and guardianship issues that children will face over the course of their entire life; that parents are better equipped to respond to that. So kind of just a quick overview. The second part of this, I'd really like to talk about what we have learned in the first 18 months, which I think is really important because it is a framework of how we're moving forward and what we hope to be able to offer to families. I'd like to commend all of you for also extending the funding to Hornby Zeller, the evaluators. In that first 18 months we have learned quite a bit through their evaluation and what they have been able to discover, as well as what we have discovered. And a couple of those things that have come out of that, and I have been caught saying a couple times that the amount of money that was paid to them I believe was well worth it in really only one statistic that they came up with in a Quarter Five report, which was not this last report but the previous. And the Health and Human Services opened up access to their N-FOCUS data, so Hornby Zeller was able to take Right Turn families and be able to compare the Right Turn family back to that child's case file prior to adoption. And what they found was that 90 percent of families that are contacting Right Turn, so the families that are in need, that are in crisis and are needing that support, are parenting children that have more removals, more foster care placements, and spend a longer time in foster care. Now that fact alone and that data to be able to support that says a lot of things about what we need to do to move forward, but it also says a lot about our system, which is it absolutely does matter what happens preadoption and it absolutely does matter what happens in our foster care experience, because seven years postadoption, these families are still struggling to respond to their children's mental health needs and help their children heal from the trauma and loss that they've experienced. This may seem as...you know, the mental health issues that, you know, 73 percent of families who contact us have children with mental health diagnoses. That's way over what the average population has experienced, and it's not random. It's caused by abuse and neglect and it's caused by the experience that children have in foster care. So I think the implication that we see from that is that we need to do it better on the front end because it will make it easier on the other end and it will be a surefire way to have greater permanency stability for children once they've been adopted or are in guardianships. So I think that's really important. Last time Hornby Zeller was here they had a PowerPoint and they talked about 20 percent to 25 percent of families that are...their needs are not able to be met by a Right Turn level of service. And I think I've referenced before, you know, a level A service, a level B, and a level C being out-of-home or not in the family home, that B being that community-based level of service and A being an in-home support. We took that very seriously. They're continuing to report that about 25 percent of families that experience Right Turn are not...it's not an intense enough of service. So what we have done is, the parent-child relationship and attachment, which I'm sure you hear an awful lot about and I'm going to try to explain it a little differently in what we're doing... []

SENATOR CAMPBELL: And you'll need to... []

JESSYCA VANDERCOY: It will be 120 seconds. []

SENATOR CAMPBELL: Okay. []

JESSYCA VANDERCOY: Okay. So... (Laughter) []

SENATOR CAMPBELL: Note the 120. We just...that seems to be a figure. It's just because I have to get to the other folks too. []

JESSYCA VANDERCOY: This is really interesting and it corresponds with the article that you have in your folders. So attachment and the parent-child relationship, what we've noticed is that 20 percent, you know, although mental health and therapy services are absolutely important and need to be continued to be funded, we know that that cannot solve absolutely everything for this 20 percent that is needing a more intense service. These families really struggle with the trauma and loss the child has experienced and then building an effective relationship with that child. If you look at there being the attachment disorder and how many of our children have been diagnosed with that, we became...really needed to respond to the need of helping parents build skills to be able to improve relationships with children and help them create a new attachment. An attachment is a memory, so attachment is an experience. If I tell you if a child says "cats bark"--okay?--and you hear through your childhood, this is your memory, "cats bark, cats bark, cats bark," you grow up and you believe cats bark. Now it is not as simple to be able to say, "No, no, honey, I'm going to bring in a dog and I'm going to show you dogs bark, cats meow." Right? And so what ends up happening is we do that and we do it through therapy, we do it as a parent through behavior modification. We say, "No, honey, this is...you know--a cat meows, a cat meows, a cat meows. Well, in the experience of relationships and the memory of attachment, the memory of the trauma and the loss that that child has experienced, it takes more than that. It takes a parent who understands that it's going to need to be repetitive, it's going to need to be ongoing, it's going to need to be in a nurturing and skillful way of being able to rework a brain or rework the child's memory of what that experience has been. So you'll see in your folders that there is a handout on A Step Further which is a program that we have begun to intensify our case management services within Right Turn to be able to help parents do this with their children, because we believe that's a level B service, that we are teaching parents how to have improved parent-child relationships and rework that memory, rework the trauma and the loss. []

SENATOR CAMPBELL: And I'm going to stop there because Senator Pirsch is trying to get in a question. []

JESSYCA VANDERCOY: Okay. []

SENATOR PIRSCH: Yeah, and I'll be brief. I know we're pressed for time. Thank you very much for your testimony here today. Right Turn families, you indicated that commonly what you're experiencing is 80 percent/20 percent split, 80 percent being adoptive families and 20 percent being guardianship. Is that reflective of the overall raw numbers in terms of guardianships and adoptions in the state of Nebraska? It doesn't seem to be fairly reflective, does it? []

JESSYCA VANDERCOY: No, it's not reflective. []

SENATOR PIRSCH: Does that indicate perhaps that more outreach needs to be done on some level to guardianship--perhaps--families? Well maybe even adoptive families. But the more...what... []

JESSYCA VANDERCOY: You know, I'm not sure. All of our marketing is geared towards adoptive families and guardianship families. It's one and the same on all of our marketing materials. So I'm not really quite sure why that is. It will be interesting to see as the...the change. You know, the Foster Care Review Board had a recent report out that talked about the decreased number of adoptions that have happened since the privatization, going from 577 to 360 about. And that does impact us because those families are then going to be eligible for Right Turn, and that's, you know, a decreased number. So it will be interesting to see if guardianship numbers go up because in the privatization there may be lead agencies who are doing more guardianships than adoptions. I'm not sure why the number has dropped so significantly, but, you know, we'll have to wait and see I think what the fallout is of that. []

SENATOR CAMPBELL: And we can follow up on that. []

SENATOR PIRSCH: Okay. Yes, I will. Yeah. []

SENATOR CAMPBELL: I mean because that's a great question. We should...I'm making a list of the follow-ups beginning with Senator Avery's comment about the annual report. Any other questions? Thank you so much... []

JESSYCA VANDERCOY: Absolutely. []

SENATOR CAMPBELL: ...for bringing a lot of good information for us today. []

JESSYCA VANDERCOY: It's was great to see all of you. []

SENATOR CAMPBELL: The next presenter is Shellie Gomes. Shellie is here from Boys Town and will cover the children and family hotline. []

SHELLIE GOMES: (Exhibit 5) Good morning. My name is Shellie Gomes. I'm the program manager for the Nebraska Family Helpline. Shellie is S-h-e-l-l-i-e G-o-m-e-s. All right. Well, thank you for the opportunity to present, and I will provide kind of an overview of the last 18 months of this initial contract. And as we've heard this morning, that contract has shifted a little bit in going forward for the next two years. We will be focusing just primarily on the Nebraska Family Helpline, while the Federation for Families has the Family Navigator program. So within your folder, on the left-hand side, will be kind of just the talking points that I'll work through. On the right-hand side is some additional data and details that you can look through later. All right. So looking from January 1, 2010, when the Helpline began, through June 30, 2011, that 18-month contract period, the Nebraska Family Helpline received over 5,300 phone calls serving nearly 4,000 unique families across the state of Nebraska. Also during that time nearly 650 families were referred to the Family Navigator program. We also identified very early on within the Helpline that one of the value-add services that we could provide to families was the outbound follow-up calls, and that wasn't something initially brought into the Helpline contract, but we identified that there was great value in taking the time to call those families back. So they may call into the Helpline or receive some assistance, some information, some referrals to services, and we really implemented a follow-up call within a short period of time, generally two or three days, to follow up with those families, and we did about 3,200 of those phone calls as well during that 18-month contract period. Again, consistent with what Candy and Sara presented this morning, the majority of calls and Family Navigator referrals occurred in the Region 6 area, which is primarily that Omaha area. And with that, we went ahead and pulled some population figures statewide. So looking at the population figures of children under 18 across the state, we did identify that that Region 6 area was generally overrepresented with calls and Family Navigator referrals, with Regions 1, 2, and 4, generally being underrepresented; 3 and 5 were pretty consistent based on population. And I would like to note that I do think having those family organizations now located in each of those regions providing that Family Navigator service really could have an impact. As Sara mentioned, you know, people generally walk into those offices sometimes in the smaller communities. That's a better way to do that outreach. So I'm hopeful and I look forward to seeing those numbers to see if that does balance out a little bit over time. Some of the demographics across this 18-month period: 74 percent of callers identified themselves as parents; the median age of callers was about 40; and only 4 percent of our calls came from children under the age of 18--so definitely more parents, family members, or other caregivers making those phone calls. Eighty-one percent of the callers were female, with 75 of them identifying themselves as single parents. As for the identified child that prompted that phone call, 58 percent were male, with 42 percent being female. And parents most often called about children between the ages of 13 and 16. And within your chart you'll be able to see the other age breakdown, so you'll have the ability to take a look at that as well. The most common issues reported when parents called the Helpline were children not following family rules or not following rules within the home, aggression, arguing with parents and other authority figures. Other common issues that we heard were conflicts with school, poor grades, not attending school, running away, depression, substance abuse. During that time, the 18-month period, the Helpline and Family Navigators provided families with over 8,500 agency referrals, representing over 10,000 different services within that. And data from the Family Navigator program indicated that after a few months and closure, 75 percent of families had utilized at least one referral, while 50 percent of families had utilized at least two referrals that were provided for them. So keeping in mind the role of the Nebraska Family Helpline and Family Navigator service was really to be that one stop, that initial phone call that families could make that connection--no longer be kind of out there wandering on their own and start finding out their means of accessing services--so it was definitely successful for many families. The most common referral types were for outpatient counseling and therapy, as well as mental health evaluations--that initial mental health evaluation, and then residential treatment programs. This information includes both referrals that were requested by family members and those provided by our Helpline counselors and Family Navigators, and we've talked about that in the past. There are times where parents have called, clearly identifying that "I've tried therapy before; we've tried other things; those don't work; I'm specifically looking for a residential treatment program." So we try to take the time to educate parents on the balance of what needs to occur before a child would get to that level and maybe other options that are available before they would be looking at placing the child outside of their home. Are there any questions on that? That sometimes is a little confusing. []

SENATOR CAMPBELL: And at this point, Shellie, I do want to get to the questions because I know Senator Coash has a question. []

SHELLIE GOMES: Okay. []

SENATOR CAMPBELL: But go ahead and give us a highlight on the second page. []

SHELLIE GOMES: Perfect. I'll keep going. All right. And I think, again back to that point, is that families most often will call us having reported that their child maybe does have a mental health evaluation or they've been evaluated in the past or they have had some access to services. So we do get that handful of phone calls from individuals who are saying "This is just starting in our house, this is new; I'm not sure what is going on, where do I start?" We also have those parents who are calling, who are at a very different level of frustration where they feel like they've tried services and what they've tried hasn't seemed to work or hasn't seemed to be effective for those children and their family. And oftentimes at that point is when a parent kind of reports being a little bit at their wit's end, saying, "I need a residential program; I need, you know, my child out of my house." And we know that our goal is not to go that way. Oftentimes parents have to make their child a state ward in order to access some of those residential services or those out-of-home placements. And our goal is really to keep these nonsystem families as just that, nonsystem, and try to catch them on the front end before they would (inaudible) them. So another great collaboration that I want to make sure that I can talk about really briefly is, since January 2011, so just the first part of this year, the Nebraska Family Helpline has partnered with Region 6 and their crisis response team. And this has really fit a very needed gap for families that we've identified, and we really look forward to having the opportunity to maybe partner with other crisis response teams in other regions. That crisis response team is generally available very short term. So although we have the Helpline, we have the ability to make a referral to Family Navigation services within, you know, 24 hours that navigator would make contact. This crisis response connection gives the families the immediate intervention. So that opportunity, instead of staying, you know, "My child is acting out, it's not a safe situation in my home," we don't necessarily need to call the police, who in many times would go to the home. But really no laws have been violated or something...you know, does it require a true police intervention? The crisis response team can be to that family's home typically within an hour. It's a licensed therapist who arrives at that home and really will help the family immediately de-escalate that situation, which seems to have, like I said, fit a very important need and fill the great gap for many families. So that's been a great service. Back to some implications that we have kind of seen over time and some of the trends. With so many families that we see requesting residential treatment, we really identified a need for kind of a mid-level service similar to what Jessyca was saying. We have those families who maybe say " We've tried therapy, we've tried some medication. We haven't really seen that be effective and now we're looking at residential." And we have really identified, to a degree, the gap that occurs in the middle there. Some sort of a more intensive in-home family service-type program was what we had in mind. And that is a service that is very readily available to system families, those families who are currently involved with child welfare system. That's a service they have access to. However, it's not typically available to those nonsystem families. But looking at the data of who's calling the Helpline within the last 18 months, we see many similar comparisons. They are really kind of knocking on that door to enter into the state system. It just quite...you know, hasn't quite happened yet; it hasn't moved that far. So with that in mind, Boys Town went ahead and decided, you know, let's try to pilot this program. So we put into place an in-home family service pilot program with the mind-set of serving 20 families. So these would be families that contacted the Helpline, met some established criteria of there's conflict within the home. The parents are expressing some frustration in services they've previously tried; they'd potentially be asking for residential or out-of-home placement. There are multiple siblings in the home, so really an intervention that could affect not only that identified child but other children within the home and, you know, the parents who are willing to accept help. They've called the Helpline; they're looking for answers. And so that's really kind of what we looked at in order to serve those families. The pilot intended to set out to serve 20 families, two to four hours a week, over an 8-12 week period, so a little bit more time-intensive type service that would occur right there within the family home. We ended up, due to capacity, serving ten families. Eight of those families were actually served and engaged fully in the service. One family did not engage and one actually moved into the child welfare system during that time period. So that really to me was a very good indicator of we are in many ways having conversations about the exact same families overall. So this could be a very important intervention to prevent those families or those children from moving into the state system. During that pilot program, our in-home family consultants met with families on an average of 27 hours over ten weeks, so approximately three hours a week. So it really fit within what we viewed as our pilot program. During that time, families demonstrated achievement or progress toward 95 percent of their goals. Eleven...overall, 11 goals were identified as fully achieved; ten goals identified as making progress. So, you know, although it's a very small sample and a very small pilot, it shows that this is a service that may very well benefit many of these families who are contacting the Helpline. []

SENATOR CAMPBELL: And I want to get to Senator Coash's question. []

SHELLIE GOMES: Okay. []

SENATOR COASH: Thank you for being here today. My question has to do with utilization of the Helpline, compared to when we set this up we thought it would be a little bit higher than we've actually experienced. Can you just talk a little bit about do you have any data as far as what we planned on, what we're seeing as far as accessing the Helpline services? []

SHELLIE GOMES: Absolutely. Well, I do think, as Director Adams mentioned, early on the Helpline was established and the Family Navigator program were established really as a result of a pretty public outcry related to safe haven. It was very highlighted. It was definitely brought to the forefront. And so I do think, you know, in that time it was important to (inaudible) numbers high, to identify that there may be a very significant need out there. And we were able to budget for that, which was excellent. I do think over time, although we continue to market the program, it's one of those programs that it's a Helpline and there are very various Helplines out there across the state, and although we can market it and draw people's attention to it, is it is probably more often going to be readily used when people hear about it and they hear families having some success or getting some valuable information. And I do think the word of mouth piece is going to be significant. But I also believe we're at a point now, which is why we are able to look at the budget reduction as mentioned earlier, that we probably have met a baseline need where we're going to see some changes, and I think our time going forward, being able to compare different months over various years. We tend to see a spike this time of year with school starting back, that transition maybe not always going well, and also sometimes during the summer months when maybe activities or days aren't as structured, seeing some of those increased problems. []

SENATOR COASH: Does the department market for you? In other words, you know, families in crisis may end up just calling HHS? []

SHELLIE GOMES: Yes. []

SENATOR COASH: We get that out of the blue pages. They're not in the system but they call HHS. Do you get a referral...do you get families who the department has said, well, you know, your child's not an immediate risk so we're not...you know, there's no allegations of abuse but you are in crisis; call them. Do you get referrals of that nature? []

SHELLIE GOMES: We do. We do get referrals where families identify DHHS as a referral resource. Also families who have called Child Protective Services on their own and then have been given referrals to the Helpline as well. []

SENATOR COASH: Is that a significant number of your referrals, coming through the department, or a small number? []

SHELLIE GOMES: I would say a smaller number. Definitely noteworthy. I mean it falls within probably that list of top eight referral resources that we have. Our main marketing is obviously TV and radio, and then just our own outreach where we are kind of getting out and talking to schools and different community centers and that type of thing. []

SENATOR COASH: Thank you. []

SENATOR CAMPBELL: Okay. Senator McGill. []

SENATOR McGILL: Thank you, Senator Campbell. My question is really to ask you to talk about the follow-up survey data... []

SHELLIE GOMES: Okay. []

SENATOR McGILL: ...and how those families were originally chosen. It looks like only 32 participated. Some of these statistics are sort of, like,... []

SHELLIE GOMES: Yes. []

SENATOR McGILL: ...unpleasant to me, but then it's only 32. And so can you... []

SHELLIE GOMES: Right. []

SENATOR McGILL: ...expand a little bit on what you're doing there? []

SHELLIE GOMES: Yep. And that 60-day follow-up survey is what Senator McGill is looking at, and it was done as a way for us to track those families while we were doing both the Helpline and Family Navigator service. We knew we were going to get very good data from the Navigator program as it related to families accessing services and connecting to resources within their community. We also knew we had this kind of pool of individuals that we were going to lose information from because they might contact the Helpline once. We may do a follow-up call with them but we really wouldn't have an idea of how that moved forward or what implications their initial Helpline call had later on for their family. So the identified pool of that are those individuals that contacted the Helpline. We gathered information relating to their identified child, some of the parenting concerns that they were experiencing but they did not get referred to Family Navigator, or we made a referral but, you know, oftentimes we would offer Family Navigator services and families would say, "No, thank you, I want to try to do this on my own," or whatever it might be. So the pool of that is a little bit smaller because there were families who were not referred to Family Navigator and families who also had to consent to that 60-day follow-up call from us, and then we had to obviously be able to reach them 60 days later, so. []

SENATOR McGILL: Some of these numbers are...show that parents haven't been able to fulfill...well, that they weren't able to get the services for their family to improve. []

SHELLIE GOMES: Right. []

SENATOR McGILL: But if they weren't in Family Navigators and so. []

SHELLIE GOMES: Yes. []

SENATOR McGILL: And on one of the later pages it says that it's going to be made available now to all callers. Is that because they are no longer with specifically connected to Family Navigators? []

SHELLIE GOMES: Yep. Absolutely. So we're going to move that outcome survey more to probably a 90-day survey and try to make connections with all families that have contacted the Helpline, and in many cases those families that would have been referred to Family Navigator would likely have completed it within that 90 days and so we can still make that connection and try to gather that outcome information. []

SENATOR McGILL: I think that will have a lot better information for us then. Thanks. []

SENATOR CAMPBELL: It is true though, Shellie, that the police officer does go with the mobile response... []

SHELLIE GOMES: Yes. []

SENATOR CAMPBELL: ...in the Omaha area. []

SHELLIE GOMES: Yep. []

SENATOR CAMPBELL: The police officer is there with them. []

SHELLIE GOMES: With them. Yep. []

SENATOR CAMPBELL: The second thing, and just a statement and that is for the senators, Shellie has touched on the intensive family support in-home that they are seeing from their pilot project. And I want you to keep that in mind because that is going to surface as a need and a gap in the second half of today's discussion. So that project is raising...I mean while it's a microcosm of a small, it is a raising a much larger issue border to border. And part of the thing is, is that, yes, in the Omaha area we do have the resources of that, but what you're going to hear statewide is where...what is the availability of that as we go across the state. So keep that in mind. Nice segue, Shellie. I appreciate that very much. []

SHELLIE GOMES: And I do want to add that's a pilot program that we'd like to continue during the next contract period. So I think, you know, if we can establish that opportunity and continue to make that available. Obviously ten families is a small number but if we could add to that and really provide that outcome data, I think it would be valuable. []

SENATOR CAMPBELL: Yeah. It's identified a gap that's for sure. Thank you very much. []

SHELLIE GOMES: Thank you. []

SENATOR CAMPBELL: Our next report is on the Behavioral Health Education Center of Nebraska from Dr. Boust who is the director. Good morning. []

SUSAN BOUST: (Exhibits 6 and 7) Good morning, Senators. My name is Susan S-u-s-a-n, Boust B-o-u-s-t, and I'm the director of the Nebraska Behavioral Health Education Center, which we fondly call BHECN. You're getting some handouts as they come around, and there are two of them. One is a rather long document that gives you our update on activities. But I'm going to talk from the Executive Summary which will just summarize those. The vision for BHECN is that everyone in Nebraska will have timely access to comprehensive, effective, and efficient behavioral healthcare by 2015. Our mission is to support the recruitment, retention, and competency of the behavioral health work force, and we have three areas in which we focus providing education and training and evidence-based practice, interprofessional collaboration, and the use of telehealth. So those are on the Update Activity. And I'm going to go to the Executive Summary. Now you know that BHECN was created when the state made the decision to move the location and philosophy of care out-of-state institutions into community-based service. It's been very good for me to listen to the other people who have come before me on LB603 and looking at all of the places where we do interface with education, with outreach, with collaboration. This has been a very big growth year for us. We have five staff now. The team has made substantial headway in planning and executing the activities of BHECN under a strategic plan that exactly reflects the legislation. Our section of the legislation was probably the most complex and had five basic sections that we had to address. We've had a significant increase in the interprofessional training and rural training, and one of the modules that we developed won a national teaching award in psychiatry. Our five sections are outlined in the summary then and we are to develop regional sites in every area of the state. I hear that one of our colleagues back here is also working on that and look forward to a way to collaborate with them. Our intention is that everything that's available in Omaha becomes available to the rest of the state. And as we go around the state and are working with our more rural partners, we are hearing their biggest concern with retaining their behavioral health work force is burnout. We're just burning out these people. Either they leave because the jobs go away or they lead with their heart, they try their best, and they just can't do it anymore. They're facing crises in the levels of care that they're trying to provide which is outside their scope of practice which they're not trained for. They don't have anybody else to rely on. My chairman and I are always saying, you know, if this was a patient with a heart attack we wouldn't be wondering how to deal with it in Broken Bow. There would be referral places they could go. But in Broken Bow, if it's a family that's broken or a child that's having a mental health or substance abuse problem, it's the primary care doctor and the local community that just continues to struggle and struggle and struggle. Our telehealth development, we do have telehealth now for psychiatry going to Scottsbluff, Wayne, and Columbus, and hope to expand that further. We do have an annual summit where we bring together everyone across the state interested in expanding telehealth to meet services, and our next one is November 4, which is a daylong one. We bring together everybody with interest and look at ways to deal with the barriers. Inteprofessional education is our largest section and we have a six-month-long training for 32 primary care doctors, pediatricians, APRNs, and physician assistants who are not specialist. These are the primary care work force trying to help them deal with how to prescribe medication for children and adolescents. We know nationally that when the FDA put the black box warning on antidepressants for children and adolescents, the primary care doctors were uncomfortable prescribing them any longer and quit prescribing them, and we saw a huge increase in suicide in this country. And so we can't fix the black box warning but we want to train those doctors so they feel comfortable again and eventually make sure that they have access to psychiatric care if that's needed. We're also collaborating with the Department of Family Medicine and put together a depression module which will be covering depression in adolescents and children, which should be...it's completed; it's just not on our Web site yet. We're doing community-based participatory research with the Department of Family Medicine. This is Dave Robinson who's been going out to the those communities. His focus is on communities under 5,000 people in the state, and he goes in with a team of researchers, gets the community at the table before they ever decide what they're going to look at for their research, involves the consumers and family members, first in a focus group and then at the table with the rest of the community, and does a yearlong activity to pull together all the resources under the belief that it's really at the community level where you are going to find the solution to the highest quality, lowest cost care. Dave put out a call for other family practice doctors in the rest of the state who would be interested in hosting such an activity. He got 103 positive responses. So BHECN is funding another four of those this year, hopefully to go for a large federal grant that will roll this out across the entire state. And then finally PhotoVoice which is an activity that allows consumers of service to find a way to voice their concerns about what's happening to them. This is a very well known activity that lets them take pictures, put the words with the pictures, and then disseminate those to people. And we will be back here sometime after the first of the year with a set of pictures from consumers explaining what it's like to like to live with these illnesses. And then finally...oh, residents and students. This is one of our biggest funding issues. We do have four psychiatry residents added to the Creighton Nebraska Department of Psychiatry training program. We are doing rural work. They're doing that community-based participatory research. We have one of our partners in Ogallala has offered to have them come out there to the Dismal River Golf Course for their annual retreat, getting them more and more rural and teaching them how to do telehealth so that when they leave the training program they can meet the needs of the entire state, not just the community therein. And then finally our work force analysis which is supposed to be completed by September 15. Actually I got the final rework yesterday and it should be on the Web site by Monday, and that looks at, by county, all of the licensed behavioral health professionals in the state. And we are woefully inadequate in many of them and critically inadequate, particularly with child psychiatrists. Around the country we know that we are never going to meet the need for child psychiatrists just by training more. They don't make enough money. The training takes too long. And so we're going to have to do something else, and whether that's team-based care, increased use of telehealth, we have to do something to make child psychiatry more available to the rest of the state. We had a provider in one of our contract partners who was a nurse who was providing...prescribing for an agency--and she killed herself this year, and that's tragic. I got on-line and tried to cover her patients for awhile over telehealth, and half of them were children and adolescents. And I said, holy moly--and they were really sick. I said, you know, this is a woman with very minimal training. So I've been successful in that situation in getting the UNMC Department of Psychiatry child psychiatrists to take over that telehealth service. But we've got to meet those needs better. I'm a psychiatrist, and these were over my head and she was out there just struggling away the best she could, so. I want to remind you there is no health without mental health. We're doing tremendous look at how we're going to solve the problems in this country to provide healthcare at a cost we can all afford. We have several pilot projects in Nebraska looking at the medical home model, and they're just getting up and running enough that they're starting to scratch their heads and say, holy moly, we don't know what to do with the behavioral health problems. There is no health without mental health. So thank you for your time. I will do my final reminder again that this was a four-year budget for the Behavioral Health Education Center, and in order to continue with the plan to add two more residents for the next two years and to increase our rural sites by the three more to six, we're short $500,000, so. Thank you. []

SENATOR CAMPBELL: That's quite all right to have the commercial. (Laughter) Senator Pirsch and then Senator Dubas. []

SENATOR PIRSCH: Almost born of necessity, we're relying on...or we're looking at telehealth as a large part of the solution. Have any...and I don't know this but your background would certainly be...have any studies been completed about the efficacy of telehealth as opposed to other alternative types of... []

SUSAN BOUST: Actually they're going beyond that to some computer assisted therapy that they can demonstrate that in noncomplicated cases people can do it even without the therapist. I don't propose that for complicated cases. But what's been found nationwide is that patients and family members have no problem adopting telehealth. It's the providers. I'm not having trouble at all with patients accepting it. It's the providers that are uncomfortable. So it works. []

SENATOR PIRSCH: Okay. Thank you for that. []

SUSAN BOUST: Um-hum. []

SENATOR CAMPBELL: Senator Dubas. []

SENATOR DUBAS: Thank you very much, Senator Campbell. Thank you, Doctor. My question is in no means a criticism of professionals who are out there especially in the rural parts of the state trying to do this work. But you referenced the nurse who ultimately ended up taking her life. Is there enough being done to offer support to these professionals? I mean I'm assuming there's a certain degree of professional pride. I'm sure this nurse felt like, I'm a trained professional; I should be able to handle these things. But obviously they were beyond her ability to handle. Is there a feeling among those professionals that there's someone they can turn to, to help them alleviate their own stress if not help them find solutions for the people they are caring for? []

SUSAN BOUST: Our methodology with working with that is through our contracts with our rural partners. We have two of them right now which are ahead of schedule. We plan on having two more this year. And we see that really as needing to be a much more local solution than BHECN can provide for a statewide situation. It's very community dependent. For instance, in our work force analysis we found that programs in Grand Island have difficulty hiring master's level counselors, where programs in Kearney do not. That's because they train master's level counselors in Kearney. So even that little distance can make a difference. We are planning to do trauma informed care for providers as a stress relief tool, and we've been doing that around the state now. Plan on bringing that in as a train-the-trainers model into the Lincoln area and into the Omaha area. But our strategy will be to work with a local contracted partner who's responsible for knowing what's going on in their area and then we would like to bring in some things like that. But ultimately you can't relieve stress if somebody is trying to take care of twice as many people as they can take care of. []

SENATOR DUBAS: Thank you. []

SENATOR CAMPBELL: I want to draw attention again to the senators, and boy, I didn't even pay all of you this and you're putting great segues in. I want to draw the attention of the senators to the report of the child psychiatrists across the state of the concern by Dr. Boust about that because as we go into the next segment you will hear that one of the requirements that has changed is that the form must be signed by a psychiatrist, and I think that we all need to pay very close attention to that element when we discuss it in the second segment. It's always a pleasure to have you, and thank you very much for the work and for all of the presenters today. This is great to know that what we envisioned in LB603 in great part is happening for families before they get to the system, which was certainly the Legislature's goal. Next presenter is Liz Hruska, and I know Liz is such an on-target person. []

LIZ HRUSKA: I can either just give you the handout or... []

SENATOR CAMPBELL: No, we want to hear. No, no, you can't get out of it, Liz. Come on. We're running a little bit behind but it's important for us to know where we are for our guests in the room and for the senators. The LB603 committee has not only followed programmatically but has had a fiscal status report as we have gone along to let us know how we're spending the money. So Liz. []

LIZ HRUSKA: (Exhibit 8) Basically the report that is being passed out is an update from last year, and you've already heard from most of the programs so I will be very brief. LB603 had five bills in it. One was LB136 by Senator Avery, and that increased the Children's Health Insurance Program from 185 percent of poverty to 200 percent of poverty. I forgot to introduce myself. Liz Hruska, L-i-z and the last name is H-r-u-s-k-a. And in the CHIP program the increase in total number of children served since the passage or the implementation of the bill is 5,800. We are now at 29,365 children eligible for CHIP as of July, just this last month. When we originally passed the bill we expected an increase of about 5,400, so we're probably on target although the 5,800 increase in eligibles is a combination of the eligibility increase and also the economic impact of the recession that we just went through. We no longer track the expenditures for the eligibility increase. It's just part of our budget base. So I mean they're just counted in like any other child that's eligible for CHIP, so I don't really have a breakout for that. You've already heard from Scot, the hotline expenditure was reduced and that was based as I understand it on usage, as was the Family Navigator program. And both of those are a combination of experience in tweaking programs so that we get the best amount for budget dollars. And the postadoption/postguardianship services are currently funded at over $2 million in the current year and the next year of the biennium. And the regions, as I think Scot had mentioned, originally the additional appropriation for children's behavioral health services was a half-million dollars. That was increased to $1 million last year and that's continued into this biennium at the same level. Senator Nordquist's bill, LB601, had two components. One was budget neutral and that was to prevent the department from eliminating a coverage for voluntary commitments. The department had notified the Legislature they were going to do that. Senator Nordquist's bill prevented that from happening, so there really was no budget impact. The other was requiring secured residential services to be covered by Medicaid. The plan was approved last year but it wasn't until this past July that those services are now being reimbursed, and that was because our department had some clarifications they wanted to get from CMS. And since Vivianne is following me, I think if you have any additional concerns or questions about that, she would probably be a more appropriate resource. And the Behavioral Health Workforce Act, which you just heard a presentation from Dr. Boust, did take a cut from the original appropriation in the November 2009 session of $420,000. But in spite of that reduction, they have really continued to work towards the requirements in the bill. And in this past fiscal year they spent just over $1.4 million, and in the current fiscal year their budget hasn't been approved yet but they're looking at $1,563,000. The evaluation was mentioned a couple of times. We did provide $150,000 in the first two years of '10 and '11. In the current biennium, the evaluation money was continued only in the current year at $150,000. So I've been a fiscal analyst nearly 28 years and I said this to you last year and I'll repeat it again: I think you are getting what you expected for these dollars, if not more. I mean I think this was a well-thought-out package to address the issues. []

SENATOR CAMPBELL: Questions for Liz? []

__________: If Liz says it's okay, it's okay. []

SENATOR CAMPBELL: If Liz--we're just talking--if Liz says it's okay. (Laughter). Thanks, Liz. We just appreciate this and it's been very helpful to follow the money along with the programs, which has been a great part of the LB603 package. So thank you. As promised, we will take a brief break, not the whole 15 minutes but let's take about 5 minutes and take a break and we'll try to get this set up. []

BREAK []

SENATOR CAMPBELL: I think we finally got the chair situation worked out. I'll say good morning again and remind everyone, because I know many of you might have rushed out to check your e-mail and phone messages, so make sure that your phone is on silent or turned off. And again we welcome all of you. The second session today is a briefing to give the senators an explanation on Medicaid and the new proposed regulations having to do with group homes, therapeutic group homes, IMDs, all the acronyms which I always have difficulty with, because I have to go P-R-T-F and I always get them mixed up, and somebody in the audience then always corrects me. So I'm very careful about trying to make sure I get that one correct. I do want to frame the issue somewhat so that you have some background. The Health and Human Services Committee's side of the panel has had I believe two briefings from the director, Director Chaumont, and Director Reckling I believe was with us to give the committee some idea of what was coming down from CMS and the department's plan for bringing Nebraska into compliance. In that time, I know that the director has visited a number of providers and had meetings across that to try to answer questions. The object today is to try to brief the senators, give them a picture, and to also identify where we think there may be some problem areas and how we're going to go about looking at them. The providers have given to us, some of us at least, some of the issues that they are framing in their questions and discussion with the department. One of them has to do with the access of care: How will youth access that care across the state? Is the path clear in terms of how they would, children and youth, would come into that system? The other concern that has been expressed is that we are going from five levels to three, and the director may want to describe how those are different, but in the state we've generally had a system where we could have youth step from one to the other as their needs have been met and then gone through. And so one of the questions that has been raised is, do we have some kind of step down? We do know that in some cases the youth will return to their home and an expectation of how would we serve them, and I believe that we heard somewhat of that in the reports in the first session: Do we have the kinds of intensive care framework across the state that will be there for children? The other is, and I think the director, and Director Reckling, who I hope is going to be joining us there at that chair...please come forward. We had planned on you taking the third chair because Director Chaumont kept looking at that chair like, who is supposed to be sitting in that chair? Because one of the concerns that has been expressed is as we...and I think both the directors were very clear, to the Health Committee at least, that if the care was not covered or could not be covered under the new process under Medicaid that those costs would then be picked up by the child welfare side. And that is a critical issue for everybody sitting here and some of the concerns that have been expressed. So with that I'm going to go ahead and allow the two directors to make whatever comments they want to make to begin with and then we'll go to questions from the senators, because this is an area that we need a lot of education on, so thank you very much for coming. And then I want to add thanks to Mary for being here from Magellan, so. []

SUE MIMICK: Sue Mimick. []

SENATOR CAMPBELL: Sue. Why did I say Mary? I want you to be Mary today maybe. Director Chaumont, are you going to start us off this afternoon? []

VIVIANNE CHAUMONT: I am. []

SENATOR CAMPBELL: Okay. []

VIVIANNE CHAUMONT: (Exhibit 9) Before I start you off though, based on your remarks...my name is Vivianne Chaumont. I'm the division director for Medicaid and Long-Term Care at the Department of Health and Human Services. And I think before I start the presentation, which gives you a status update of where we are on this issue, maybe I should provide a brief explanation of what the issue is for Medicaid, because I know that members of the HHS Committee have been briefed and perhaps the members of the LB603 committee are not as familiar with the issue. So forgive me for not having that in my presentation, and I'm just going to...this is a complicated issue. I'm going to try to simplify it as much as I can. The Medicaid program--we're starting at the base. The Medicaid program signs a state plan with the federal government, with the Centers for Medicare and Medicaid Services, known as CMS, which is the basis. It's like the contract between the federal government and the state on what the Medicaid agency will do and what the federal government will pay for, and it has in there who we'll cover, what we'll pay, what we'll pay. All of those types of issues have all to be approved by the federal government. So sometime before July '10, before July of 2010, and I don't remember the date--probably in April or March--we had submitted a state plan amendment that didn't have anything to do with the issues as they came in. It had to do with some rates I believe; I don't remember what the issue was. But as they were reviewing that state plan amendment, CMS looked at surrounding pages of the state plan regarding children's behavioral health issues. And they...what the state does in the state plan is, for many things, it just has to say to CMS: We assure that we doing this, this way. We assure you that we are not paying for this. We assure that we are paying for that. So as they were reviewing the state plan, they sent us a letter that said: Please provide us with assurances that you are not paying for children's treatment in institutes for mental disease. We could not provide that assurance because, in fact, Nebraska Medicaid was paying for children who were residing in institutes for mental disease, an IMD. And an IMD is basically a facility, an institution that has more than 16 beds, that's providing where 51 percent, basically, of the patients in that have a behavioral health...are there for behavioral health reasons. If Medicaid pays for someone under 65 who is in an IMD, the person retains their Medicaid eligibility but Medicaid can't pay for any services for that person. So the bottom line is...I mean, in fact, the result is that the person isn't Medicaid-eligible. So if a child lives in an IMD and Medicaid can't pay for anything. It can't pay for the behavioral health treatment, can't pay for a physician, can't pay for a dentist. Just plain old simple, can't pay for anything. So when we couldn't provide that assurance, we had to do a state plan--a corrected action plan--and that's what I'm going to be talking about. And the corrective action plan is basically to come back into compliance with federal requirements. When CMS finds that the state is not in compliance with federal requirements, CMS can go back and collect all of the money, the federal share of the money that the state spent paying for something that it shouldn't have paid for. And in this case that would have been millions and millions of dollars, and generally they go back five years. So it was important for us to come into compliance so that they would not go backwards and so that we wouldn't put current and future dollars at risk. So one exception for children under 19 to the IMD rule is if they are in a PRTF--Senator Campbell's favorite facility--psychiatric residential treatment facility--and PRTF, just so you know, is basically one tiny step down from inpatient hospitalization, psychiatric hospitalization. So that's a facility. That's doesn't matter if it's more than 16 beds, it doesn't matter if 100 percent of the kids are...so long as they're children and it's a PRTF, then Medicaid can pay all of the costs, with some exceptions. They can pay all of the costs in the treatment plan, so that's the issue you might have heard, that you can have a child in a PRTF; Medicaid can pay for everything in the active treatment plan, and if the child breaks an arm, you know, has to go to the hospital for an appendectomy, Medicaid cannot pay for the additional Medicaid expenditures. This is...just so you know, these are federal requirements. The IMD rule was first adopted in Title XIX, which is a federal chapter of the Social Security Act, in 1965. This is not new stuff. It is new being enforced by CMS. So we have been out of compliance for many years along with many states. Nebraska is not alone in this. We have states that have been called on the carpet with CMS. Big states: New York, Texas; littler states: Colorado, Kansas. Every state that has challenged the IMD rule and the PRTF rule has lost and have had to pay back millions and millions of dollars. Imagine what kind of money that would be in New York and Texas. Millions of dollars have had to be repaid. In Kansas, what we hear is that Kansas child welfare kind of told CMS that they didn't agree and they weren't going to do it, and Kansas got slammed with a huge disallowance. The interesting thing about Kansas...everybody says, well, let's go change it at the federal level. I think on a fairly regular basis states have attempted to get the IMD rule changed, the statute--it's statute so it has to be changed--probably since 1966, and it has failed. And the reason basically is that...the reason it was put in, in the first place, was the federal government didn't want to take responsibility for psychiatric hospitals like the regional center that states run. But it's much, much broader than that. And all of the states that have had the cases and have lost millions of dollars were all during the prior administration, federal administration, where fiscal accountability was the key. And so with the new administration, some people were hopeful that the new administration would change its mind. Kansas briefed their governor when the case went to the Departmental Appeals Board, which is the federal adjudicated body that rules on disallowances. They briefed Governor Sebelius before...while she was Governor Sebelius. Kansas thought, oh, we have an in here; we're going to get this taken care of. The DAB, the board, had not ruled yet. They briefed the governor. The governor, as you know, is Secretary Sebelius of the federal Department of Health and Human Services. She went to D.C., and the DAB came down and slammed Kansas. So this isn't something that we're doing just because we woke up one morning and decided we wanted to save Medicaid dollars. This is something that we are required to do to protect dollars here. Because while the new process creates, you know, shows hardships, I don't think that that it is the hardship...we would have the hardship plus having to pay back millions and millions of dollars out of the system if we didn't comply with the federal government. With that said, I'll start where we are...(laugh). []

SENATOR CAMPBELL: We'll stop there... []

VIVIANNE CHAUMONT: Okay. []

SENATOR CAMPBELL: ...just to make sure that if there's a question about that background. Senator Krist. []

SENATOR KRIST: It should be stated for the record, because I don't know that we've ever, ever, ever stated it for the record, this has nothing to do with the reform, privatization, outsource, resourcing that we're doing in the reformation that Director Reckling was involved with. Nothing. []

VIVIANNE CHAUMONT: You are absolutely correct, sir. And thank you so much for bringing that up. This aid doesn't have anything to do with the child welfare reform and where I thought you were going, because, you know, it's always all about Medicaid. It also has absolutely nothing to do with the Medicaid reform. []

SENATOR KRIST: Right. []

VIVIANNE CHAUMONT: This is not about Medicaid...this is not a cost-saving issue that Medicaid came up with. []

SENATOR KRIST: Okay. Then my follow-up question to you, and I don't really expect an answer to it today: I'm hearing from people out there in my travels over the last few months that we are going overboard complying. I am hearing that we don't have to do all the things that we are doing and we're going to kill the private sector and the services that are provided. I'd like to talk to you about that off-line. I'd like to get that to the committee if we could, because there are people out there that we have heard from that are smart, smarter than I am,... []

VIVIANNE CHAUMONT: Um-hum. []

SENATOR KRIST: ...and they're saying, yeah but. And I'd like to discuss those yeah-buts because they're...if there's wiggle room, if there's something that we can do, I think we need to lean forward and do that. If it's clear-cut, black and white, and it's no interpretive value, it is clearly this is the way it is, then I want to be able to answer that question when I go out and talk to my constituents, and I think we need to be able to answer that question across the board. []

VIVIANNE CHAUMONT: I appreciate that, Senator Krist, and I can...and I'd be happy to meet with you and provide more information. I can tell you that we are wiggling as much as can. So that...I think there is a lot of misunderstanding, you know, after many, many meetings. I mean this is a shock to some people but we are not applying anything more strictly than we need to. []

SENATOR KRIST: Okay. []

VIVIANNE CHAUMONT: And if we are and someone can give me a specific, I'd be more than happy to look at that specific and see if we can wiggle some more. []

SENATOR KRIST: That's where we need to go. Thank you so much. []

SENATOR CAMPBELL: And I think we come back to that, perhaps later, because Senator Krist I think has raised a valid question that a number of us have heard. So I think we come back to that. But let's go ahead and unless there's a question on the overall briefing, we'll go ahead with the presentation. []

VIVIANNE CHAUMONT: Okay. So...and when the federal government said, please provide us an assurance that you're not doing this, and I couldn't in good faith provide that assurance, what we said was: Please work with us, we'd like to do a corrective action plan. And we submitted a corrective action plan and the corrective plan basically said that we agreed that by July 1, 2011--so this last July 1--that we would be in compliance. That the department would be in compliance with the regulations regarding IMDs and PRTFs, and that we would submit a state plan saying that we would unbundle the children's services that they had problems with our payment methodology. And then we also asked them if by July 1, 2012, that all providers could be in compliance with the plan. When we submitted that plan, I was not particularly optimistic that CMS was going to give us almost two years to come into compliance. What we did was we wrote to them a letter that I think has been provided, at least to the HHS Committee, that explained to them that these changes were going to have serious impact on the child welfare system as it existed in Nebraska, and that we wanted to have plenty of transition time because we didn't want kids to be, you know, adversely impacted by the change. So they agreed to provide us that time period. So by July 1, providers were supposed to give us proposals for their new treatment services that met federal requirements. We enrolled existing residential treatment providers for the new treatment services, and Magellan conditionally approved those providers and is working with them to do...will be working with them to develop compliance plans so that the providers can be in compliance by July 1, 2012. And I'm thinking that if you're not intimately familiar with this, as unfortunately I've had to and my staff have had to be in the last 12 months, this might not be real clear. For us being in compliance meant that we had told the providers what they needed to do. We changed the state plan and we were proceeding in compliance. For providers to be in compliance, we asked for that extra year, and what that meant was there are some more intense requirements for a facility to be a PRTF. You have to have a psychiatrist, have to have some things. So if a facility said we are working towards being a PRTF and we just need to hire a psychiatrist or to develop our protocols and things like that, that they...we wouldn't, you know, July 1, 2011, say, you know, you're out, we're not paying you. We would pay them as they tried to achieve compliance, and then by July 1, 2012, they need to be there in order to continue funding. Or, for instance, you might have...I forgot to mention...I think I mentioned that a facility has, if it's 17 beds or above. So if it's 16 beds or below, the IMD rule doesn't apply. So you might have a facility with 20 beds who is saying, you know what? We want to go to 16 because we don't want to mess with any of this. And but, you know, they have 19 kids in there and they're not just going to kick them out July 1, 2011. So let them downsize. You know, finish out the kid's treatment and downsize and arrange for other care so the child is not adversely impacted. That's the difference between us being in compliance by July 1, 2011. You know, our paperwork has to be in compliance, the payment methodology, all of that has to be in compliance and providers having to be in compliance. So that's what the July 1, 2011, is. And during this time we've updated the claims system--no small task--to pay providers for the new services so that they're paid, hopefully accurately and in a timely fashion. Magellan developed a 90-day transition plan to transition kids from existing treatment services to the new services, and we've had no disruption of services. Kids have continued to receive the medically necessary treatment services that Medicaid pays for--and don't ever forget that Medicaid only pays for medically necessary treatment services. And that is not a new requirement either. That is a 1965 requirement. Medicaid is an insurance company.

Health insurance companies only pay for medically necessary treatment. So all the child welfare group homes have submitted their compliance plans to Medicaid outlining how they will come into compliance. They are then providing us more detailed plans, I believe by September 1, but they all need to be in compliance July 1, 2012. And all of these actions have maintained the availability of federal matching funds. The feds have continued to provide their share while we are coming into compliance and have heard not a peep about going backwards for five years. Okay. So a PRTF is basically an inpatient level of care in a hospital or a freestanding psychiatric facility under the direction of a psychiatrist, and it's really to provide, basically, acute mental health services. It really is just a tiny step down from inpatient hospital. And so the criteria for kids to go into a PRTF is fairly stringent. Kids with less acute mental health and substance abuse disorders will receive mental health and substance abuse treatment services in the community. And I might just point out, you know, I'd mentioned that the prior federal administration was really into accountability, fiscal accountability: We're not supposed to be paying for this; we're going to stop it and we're going to take all our money back. This administration shares that fiscal accountability. In addition to that fiscal accountability that we're getting from them that, you know, we shouldn't be paying for things that we're not authorized to pay for, they are also as a matter of policy saying they do not want children institutionalized. And so a lot of their going after states for this is to reduce institutionalization and get kids in the community where they believe, and we believe, that kids are better served. So although the administration has changed and the emphasis has changed a little bit, they are both still in agreement that we need to come into compliance and for policy reasons as well as the fiscal part of it. So we also had to unbundle community-based treatment services and we have new regulations that will make the community-based treatment services more flexible and user-friendly so that we can ensure access to the community treatment as an alternative to inpatient psychiatric treatment services, which is basically what a PRTF is. And unbundling rates, what that means is I think some of you might have been involved in it when we did the community support. You can't pay a monthly, you know, a monthly fee. You have to break it down into services provided by professionals, and that is what we had to do rather than monthly units. So the future expectations for us is that we will need additional community-based treatment services and we will have fewer residential treatment providers and services because we will not need them and because we won't need the residential and because the focus is to treat children in the community. And if you have residential, they are very short-term residential stays. And so we are continuing to work with providers to get them into compliance so we don't put federal funds at risk and we continue to provide the best care that we can for our children in the system. []

SENATOR CAMPBELL: (Exhibits 10 and 11) And thank you, Director. That was very brief and to the point. Before we start on the questions, there have been two sets of information that come to the committee and I'll ask the pages to hand it out. The first is a memorandum that's come to us for some information from the Ombudsman's Office on this issue that we thought you should have, and they ask that it be in the record. And the second set...and so, Emily, we'll have you do the second set. And I know that this information has been sent to, at least the letter that came to me was sent to Mr. Winterer and Director Chaumont and Director Reckling. And it came from providers from Alegent, Epworth Village, Boys Town, and Uta Halee, and I know that they've put together some information which you've seen the initial letter, I think. []

VIVIANNE CHAUMONT: I'd just like to say that we got that at 10 p.m last night, so we didn't actually see it until this morning, and I have not had a chance to give it any kind of extensive review. []

SENATOR CAMPBELL: And we got it late yesterday in the afternoon also, Director, but the information has come to the committee and asked that it be in the record. We'll go ahead and start with questions and discussion while those two pieces of information are being distributed. Questions? We'll start with Senator Krist and then we'll move around this way. []

SENATOR KRIST: Define community. []

VIVIANNE CHAUMONT: I think a community is...community service is a service that isn't done in an institution. []

SENATOR KRIST: So it can be publicly funded, it can be nonprofit funded, it can be extension services of any... []

VIVIANNE CHAUMONT: The funding doesn't have anything to do with it. I think the bottom line is that we believe that kids are best served in their families with services wrapped around them. You know, kids need to function in their families and they need to function in the community. They need to function in their public school, they need to function in their regular way that they do. And to take them out of that, of where they need to function, and put them someplace else in an institution away from all that, they might learn to function in that institution but that doesn't teach them how to function back in their community, in their family, in their schools. []

SENATOR KRIST: Well, we...in an ideal world, I guess we intervened at an early point. We treat the child or a young person and we inject them back into the family as soon as we possibly can, and nirvana is reached. But in some trouble cases, we have some folks who, at least within certain models, they're taken out, they're put into proper treatment. The family is treated at the same time. There is that treatment that needs to go on with where the problem actually started, to begin with, and then it's reinjected back. []

VIVIANNE CHAUMONT: Um-hum. []

SENATOR KRIST: To me--and I make this comment. It's not a question,... []

VIVIANNE CHAUMONT: Um-hum. []

SENATOR KRIST: ...there's a lot of databases out there that are all running in silos. We have a lot of information about a lot of kids, about a lot of families. And one of the things that this process did and what we're seeing in HHS is N-FOCUS needs to interface or at least some of that data needs to interface. And you get the point. []

VIVIANNE CHAUMONT: Um-hum. []

SENATOR KRIST: I mean it's a point at which if you're going to intervene at the root of the problem and treat the entire problem, it's a family problem. And individual needs to be treated, reinjected if safety permits. That is a database that is across the board on a horizontal treatment platform, in my opinion, and that's what I'm hearing. So I guess we're not...we're getting there. We have a lot of neat programs that are doing neat things, and we need to take the neat and weave it into a fabric. And you weren't here this morning so this is a repeat of what I said earlier today. Anyway. []

VIVIANNE CHAUMONT: Thank you. I can't disagree with that. []

SENATOR CAMPBELL: Senator Wallman, and then we'll come back around this way. []

SENATOR WALLMAN: Thank you, Chairman. Yeah, thanks. And mine is in the future expectations, you know, mental health issues. How do you...who does...does CMS check on these, how do you evaluate these? []

VIVIANNE CHAUMONT: We will be evaluating the providers' plans that they give us to make sure that they are in compliance with federal law. And yes, the OIG or CMS can do an audit any time and make sure that we are doing our job. []

SENATOR CAMPBELL: Okay, Senator...oh, did you have a follow-up, Senator Wallman? []

SENATOR WALLMAN: No. []

SENATOR CAMPBELL: Okay. Senator Dubas. []

SENATOR DUBAS: Thank you, Senator Campbell, and thank you, Director, for your comments. I'll probably make more comments than questions, but I would like your feedback on them. I won't disagree with a single thing you said as far as community-based care, and we need to keep kids as close to home as possible and make sure their family is being treated as well as the children are. But we heard this morning, and I know from firsthand knowledge that, especially as you get into the more rural areas of the state, community-based care is almost nonexistent in some places and stretched to its limits in others. And so if this is where we're going, which again I don't disagree with, but we can have a chicken-and-egg thing here. Do we need to get the services in place first and then bring them to the kids, or is there...does there have to be some kind of transition going in there? I hear the frustration of my providers out in the rural areas. I hear the frustration of my families out in rural areas. I know in many instances your department's hands are tied because, like what we do from the state level pushing down to the local, you're getting the push from the federal level. And so I think we have a lot of just confusion, where do we go, how do we make community-based care successful in those areas of our state where it is very challenging? []

VIVIANNE CHAUMONT: Well, I can't disagree with anything you've said either. (Laugh) []

SENATOR DUBAS: (Laugh) We're in agreement on some things. []

VIVIANNE CHAUMONT: I know. Well, come on, we've agreed a couple of times before. You're absolutely right, and it's that transition as we shift resources from residential treatment to being able to get them to community providers. But that is something that perhaps Magellan can address a little bit later. But you're absolutely right, that's the issue and that transition is the difficult part. []

SENATOR DUBAS: Thank you. []

SENATOR CAMPBELL: Okay. Senator Nordquist. []

SENATOR NORDQUIST: Thank you, Senator Campbell. And Director Chaumont, thank you for being here. You mentioned in getting into compliance with CMS's ruling that we allowed for the most wiggle room or we had a significant amount of wiggle room in that interpretation. Do you think we have the same wiggle room in our definition of medical necessity? []

VIVIANNE CHAUMONT: No. I would be happy to consider any and all suggestions regarding the medical necessity criteria. The medical...I think that's medical...I think that clearly defines what's medically necessary. And by the way, we got that, most of that definition, I'm told, and I checked my own plan and that is almost word-for-word the definition of medical necessity in Blue Cross Blue Shield. So this isn't something that we've, you know, just... []

SENATOR NORDQUIST: How often do we review...or there was a change in that about a year ago, is that right? []

VIVIANNE CHAUMONT: No, there hasn't been a change that I'm aware of in the medical necessity. The new rules for the behavioral health have it in there, but that definition has been in part of Medicaid rules for years. []

SENATOR NORDQUIST: Okay. And that is left up to each state, though,... []

VIVIANNE CHAUMONT: To define. []

SENATOR NORDQUIST: ...to define that? []

VIVIANNE CHAUMONT: I think medical necessity is determined. Those are guidelines that we have in the rules. Whether a particular service is necessary for a particular individual at a particular time is always an individual medical judgment. []

SENATOR NORDQUIST: Sure. Okay. Just for a...are there any...and maybe I'm wrong on the physical health side, too, but maybe network adequacy isn't the right word. But requirement of access to services? Isn't there something like that on the physical health side that we have to ensure that services are available? []

VIVIANNE CHAUMONT: We have to...yeah, a Medicaid program needs to have an, you know, adequate network of services. And that is a kind of a standard Medicaid issue, but that doesn't mean that the Medicaid program has to graduate doctors or build hospitals or hire nurses. It just means that it has to have sufficient reimbursement, sufficient to attract providers. The issue of behavioral health in rural Nebraska is a Medicaid issue but it is not just a Medicaid issue. It's a private health insurance issue, it's a provider issue, it's an issue that many other rural states are just as familiar with. []

SENATOR NORDQUIST: Is it sufficient on that, too, if we don't have services available to provide service...I mean, provides services out of the state? Does that meet that as long as the services are available? []

VIVIANNE CHAUMONT: Yes. Yes, but we don't like to do that. []

SENATOR NORDQUIST: Yeah. Sure, sure. []

VIVIANNE CHAUMONT: But if...and that happens. Let's say on the physical health side it happens actually frequently. Someone will need a transplant that is not...the technology or whatever is not available in Nebraska, and we might pay for them to go out of state and do something. And there are many Medicaid programs that pay for their clients to come to UNMC for some transplants and things, so. []

SENATOR NORDQUIST: Okay. And one more quick one on the...back to the medical necessity. The additional or the signature--now--requirement by a psychiatrist versus what was previously just...was that a Magellan psychiatrist that could sign off and now you have to have an additional signature? []

VIVIANNE CHAUMONT: No. I think that's a misunderstanding that I'm glad you raised so that we can correct it. It's always the child's treating physician, treating whatever, that determines, that recommends, that says this child needs this. And then in a managed care system, that's reviewed, prior authorized by the contractor, whoever that may be, that determines, yes, we agree; no, we don't agree. The change is that the federal...for PRTF. Don't forget that prior to July 1, 2011, we didn't have PRTFs in this state. We had any number of other institutions that didn't...that shouldn't have been getting federal funding. In order to get federal funding, we have a PRTF, and the CMS rules say that it has to be a psychiatrist or a physician with a psychiatric education. []

SENATOR NORDQUIST: Okay. Great. Thank you. []

SENATOR CAMPBELL: Senator McGill. []

SENATOR McGILL: Thank you, Senator Campbell. I know you said you just received these letters, and this is the first I've seen of them, too, and I've been trying to read through them while listening. You know, it looks like the analysis of the Ombudsman's Office concludes that there is a...one of the deficiencies, anyway, is the presence of coexisting conditions of mental illness and cognitive intellectual disability that impedes the treatment of the illness. So some of the people who are most at need because they have the dual diagnosis are the people who are falling through the cracks right now. And they said the impact of that is that 159 Nebraska children are right now in out-of-state care. And the other letter talks about how that means that that treatment is paid for with state dollars and the state doesn't receive the Medicaid match, so it is costing us more to send these kids of out of state. Do you see that as a problem? The other letter also says they think this is an all-time high. And either of you can answer this, but the implications of sending people out of state, I mean there are a lot of negative implications associated with that, not just financially but just for the family, because it's the opposite of the community care we want. Can you talk a little bit about that? []

VIVIANNE CHAUMONT: Well, my data shows that we have... []

SUE MIMICK: Nine. []

VIVIANNE CHAUMONT: Nine? []

SUE MIMICK: Nine. []

VIVIANNE CHAUMONT: Nine Medicaid kids out of state... []

SUE MIMICK: Receiving medically necessary... []

VIVIANNE CHAUMONT: ...receiving medically necessary services out of state. But those are...Todd can address the ... []

SENATOR McGILL: Yeah, what the 159 is. []

TODD RECKLING: Senator, if I could, when I get to my presentation I'll talk to a little bit about the out-of-state issue. []

SENATOR McGILL: Okay. []

TODD RECKLING: And I believe there are 159 children that you're referring to actually through the child welfare/juvenile services... []

SENATOR McGILL: Okay. []

TODD RECKLING: And I can talk a little bit more about that. []

SENATOR McGILL: Okay. []

SENATOR CAMPBELL: Just to clarify, Director, is that where the number 159 comes from then? []

TODD RECKLING: That's a point in time from our database. Yes. []

SENATOR CAMPBELL: Okay. Okay. Other questions? Okay, we'll come back around this way. We'll do Senator Howard. Senator Krist, you have a question, too, don't you? Okay. []

SENATOR HOWARD: Thanks, Senator Campbell. I'm going to echo what Senator Dubas has said. In all the years that I worked in Health and Human Services and, obviously I worked in Omaha, many, many children came in from western Nebraska, and they were court-ordered into treatment because there was no treatment in western Nebraska in the areas that they served. So what I'd really like to know is, what is actually being done to develop services out in those areas if that's the model you're going to? You've got to have providers. You can't just say this is the best idea. There's got to be something in place, and you know that as well as I do. So what's happening? []

SUE MIMICK: Senator Howard, maybe I can address. Magellan has continued to recruit programs and providers in rural Nebraska. We also feel that there is a lack of community providers and it is very difficult to do community-based services. We do the best we can by wrapping what is there around the kids. But it's...we have many more resources available in Lincoln and Omaha than we do in western Nebraska. []

SENATOR HOWARD: Always been the way. []

SUE MIMICK: Yes. Our experience has been is that we will go out and we will talk a provider into bringing up an IOP program or a day treatment program or something like that. They will open it up, and shortly after opening it up they don't have enough referrals to make it economically feasible, and they come back down. So that is our experience. And, you know, we continue to do that. We haven't stopped. We haven't given up. But I think there's an opportunity now to do a much better job of that. []

SENATOR HOWARD: Well, this really begs the question of, how are we going to shift to this model with the problem? []

VIVIANNE CHAUMONT: Well, but I think it also means that we have to shift. I mean if we develop an intensive outpatient IOP provider and we don't get any kids into the intensive outpatient because they're all being sent to residential care in Omaha, then what we need to do is stop sending kids in the, you know, to residential care, you know, in Omaha and Lincoln. []

SENATOR HOWARD: So what work has been done with the judges in that respect? []

VIVIANNE CHAUMONT: Well, I think Todd will be talking about that one. []

SENATOR CAMPBELL: Senator Krist. []

SENATOR KRIST: Well, I have a question, but I'm going to comment on Senator Howard's point. You know, God love him, when Father Flanagan put the whole thing together it was the place that, not just Omaha, not just Nebraska, but all over the world, because they were the best at what they did. Now what we're saying is because we're being told to do something, that child in Scottsbluff, we can't send him to Omaha where he can get the best treatment that he can get because we want to keep him in his community. When I asked you for a definition of community, I was leading right down that track. It may be Nebraska is the community that he's being treated in and not Scottsbluff. We're duplicating efforts all over. I'm hearing from providers--and this is going to overlap with Director Reckling--but I'm hearing from providers that Magellan is telling them that they have to treat five times a week rather than two times a week, and they've got to transport the family back. That's $200 a trip every time they come back. They don't have the money to do that on any program combined. So when you take the family program and you take the problem kid and you try to treat the kid...again, I know it's more complicated than just this stovepipe and this stovepipe, and I hate using that analogy, but let's get out of the silos. Let's start treating the family and the kids the way we need to. And if the best facility is Boys and Girls Home in Sioux City or Sioux City, Iowa, you know, I mean I don't understand. I guess I understand that we can't pay for it out of that pot of money, but there are going to have to be...there's going to have to be a clearing house where we say the kid is the most important thing or the family is the most important thing, and we move on from there--and that's just my soapbox. But the question that I have that I wanted to ask is those same providers are saying that they've been asking for how to go about...how to move on to what needs to happen. They've been asking for a public hearing date or those kind of dates where they can come in. They've been telling me that they're calling and they get bits and pieces of information. Are you planning on having a public hearing for providers to come in and public briefings in places, or is that already happening in some places and some people are falling through the crack? []

VIVIANNE CHAUMONT: We have had numerous meetings and webinars about this issue with providers on numerous...so if...and with the associations. I mean we've had a lot of meetings and a lot of explanations. We have gone out to each and every single provider and sat down and talked with them at least on one occasion. So there's been a lot of information out there. The rules will go out for public hearing, here shortly, and then there will be another public hearing on that. []

SENATOR KRIST: Okay. And do we have an idea of when that date is going to come up, or...? []

VIVIANNE CHAUMONT: I don't. []

SENATOR KRIST: Okay. Thank you. []

SENATOR CAMPBELL: I'm going to interject a follow-up question here, Director. And you're saying the rules are going to come out. Is that all under Chapter 32? []

VIVIANNE CHAUMONT: Yes. []

SENATOR CAMPBELL: Because we keep hearing Chapter 32. And so we're moving...we're saying to people we're going to have to comply but we haven't finalized the rules in Chapter 32 yet. []

VIVIANNE CHAUMONT: Correct. []

SENATOR CAMPBELL: Would that be correct? []

VIVIANNE CHAUMONT: Correct. []

SENATOR CAMPBELL: So there would be a public hearing. Based on that public hearing, would there be any change that we would make to what we've told them? []

VIVIANNE CHAUMONT: I mean we always accept input, and if there are things that can be changed that we believe are correct, we change them after the public hearing. []

SENATOR CAMPBELL: So going back to Senator Nordquist's point that, on the definition or...you know, if there's anything that could be found in Senator Krist's--oh, what shall we call it?--the weasel room here, that may surface when you do the hearing on rule 32? []

VIVIANNE CHAUMONT: I don't think he said weasel. (Laughter) []

SENATOR NORDQUIST: Wiggle. Wiggle room. (Laughter) []

VIVIANNE CHAUMONT: I kind of resent that. (Laugh) He said wiggle. []

SENATOR CAMPBELL: He said wiggle. Let the record and our audience out there...sorry, Senator Nordquist, I would never want to imply... []

SENATOR NORDQUIST: If I did, it was a Freudian slip. []

SENATOR CAMPBELL: I want to get this right for you, but...so that's where we could look at...if anybody has any suggestions, obviously that may be a place to come forward. []

VIVIANNE CHAUMONT: You know, that comment that our medical necessity requirement is too strict has been out there, and the other states have less stringent...has been out there for at least a year. I have continuously asked providers to tell me what state, show me the rule, we'd be more than happy to look at it--and I've never gotten anything. So yes, I think it would be very interesting to see what they bring. []

SENATOR CAMPBELL: Okay. And I have received some information just in the last couple days and not had a chance to thoroughly review it but would be glad to send it on. []

VIVIANNE CHAUMONT: And the other thing is, we have to make sure that the information is coming from states who are not at risk of a CMS audit regarding their IMDs. []

SENATOR CAMPBELL: Okay. We'll go back around. Senator Pirsch. []

SENATOR PIRSCH: Is that...and maybe this question would be most appropriately addressed to Ms. Boust and Magellan, which is, as Magellan is approving and denying claims, is it based solely and exclusively upon, then, interpretation of Medicaid, the rules coming out of...the federal rules coming out of D.C.? Or is there some interplay in terms of policy that's...state policy, as well, infused with it? []

SUE MIMICK: Well, there are medical necessity guidelines that when you get my materials you will see some examples of, and they are not part of Chapter 32. We...they're developed on the basis of scientific evidence and psychiatrists' feedback. And we have provided those to all of the residential providers in draft form for comments, and have received some comments. It's very limited however. And so we made some changes on the results of the comments that we've received and...but not all were changed. []

SENATOR PIRSCH: With respect to the certain court-ordered services. I'm talking with respect to the juvenile court, for instance, that youth are...where youth are involved and in terms of treatment. And where they have been denied, then the state will...and yet the court has ordered the department to make those services available. Do we have an understanding...or can we...have we quantified those in the aggregate? Do we know how much court-ordered services over the...? []

SUE MIMICK: Yes. And I have some of those numbers in my presentation. []

SENATOR PIRSCH: Okay. Yeah, and I... []

SUE MIMICK: And Todd has additional information in his. []

SENATOR PIRSCH: Okay. Thank you. []

SENATOR CAMPBELL: Is your presentation, Sue, going to cover the number of applications... []

SUE MIMICK: It certainly is. []

SENATOR CAMPBELL: ...and the... []

SUE MIMICK: I've got all the numbers you could ever want. []

SENATOR CAMPBELL: You have everything you've ever...so at this point the compensation, the compensation--I just want to be really clear about this--the compensation to Magellan at this point is not based on...I mean you're paid to provide that service. []

SUE MIMICK: We are paid... []

SENATOR CAMPBELL: Not the denials or the number of acceptances. []

SUE MIMICK: We are paid the same amount. We're paid on a per member basis. So as the Medicaid membership increases, our payments increase. That's the only variation in our contract with the state as to what would drive payment. []

SENATOR CAMPBELL: Okay. And so is there any variation then? And this was...I think this was asked over here, but I just want to clarify. There's a variation. []

SUE MIMICK: Oh, can I (inaudible)? []

SENATOR CAMPBELL: And a managed care. []

SUE MIMICK: Pardon. I'm sorry. Go ahead. []

SENATOR CAMPBELL: If Magellan should undertake a managed care portion of this, but it might be a different financial setup. []

VIVIANNE CHAUMONT: Okay. []

SUE MIMICK: It would be a different financial arrangement. []

VIVIANNE CHAUMONT: Yeah. There is at-risk managed care which is a model where the managed care company gets paid per member, per month, and they are responsible for providing the care, for paying for the care. We don't have that model at this time. And then there is what we have at this time which is an administrative services organization, which is we pay the contractor, Magellan, a per member, per month, but we pay for the services on a fee-for-service basis. And they basically are managing, you know, the prior authorization and that type of thing. []

SUE MIMICK: So the easy way to understand it is that the amount we get paid today is very small. It's an administrative...it's to cover our administrative charges only. If we were an at-risk contract, we would get paid for the services and administration in the fee, and then it would be our job manage within that amount. []

SENATOR CAMPBELL: Good. Okay, so there's two different models. []

SUE MIMICK: Right. []

VIVIANNE CHAUMONT: Um-hum. []

SENATOR CAMPBELL: But as we go to the changes, we're not talking about a change in the model. We're still staying with the current model and contract that we have with Magellan? []

VIVIANNE CHAUMONT: Well...no. And we are currently discussing with providers going to an at-risk model for managed care because we've just talked to you about the children's IMD issue, but a few months ago I got a letter from the federal government saying, please provide assurance that you are not paying for any adults that live in an IMD, and I could not provide that assurance. So we are going to be submitting a corrective action plan on September 15 for the adult part of that. One of the things that we are talking with providers and working with providers on is going to an at-risk model for behavioral health. []

SENATOR CAMPBELL: So when would that decision be made, whether we would change models? []

VIVIANNE CHAUMONT: Probably in the next six months. []

SENATOR CAMPBELL: So is that tied to our being in compliance and ready in 2012? []

VIVIANNE CHAUMONT: No. For the kids? No. []

SENATOR CAMPBELL: So it's a totally separate issue. []

VIVIANNE CHAUMONT: Yes. []

SENATOR CAMPBELL: It's not tied to how this is working. []

VIVIANNE CHAUMONT: Correct. But I...when you asked me are we thinking about going to at-risk managed care, I felt like I had to answer. []

SENATOR CAMPBELL: Yeah. No, no, no. I appreciate that but I couldn't figure out whether it was tied to this or tied to this. []

VIVIANNE CHAUMONT: No. []

SENATOR CAMPBELL: And I'm going to ask one other question so then we'll get to your presentations, and that goes back to what...and you all might not have heard that, but we heard a presentation this morning from Dr. Boust about the scarcity of child psychiatrists in the state of Nebraska, and yet we're moving to a point at which you're going to have to have a psychiatrist sign off. Are we...I mean I can't but help think that this is going to prolong this. And we have a chart in here, in the letter and in the material that you probably got, a chart about Johnny, and I think it was prepared by Voices for Children. But it shows that, now, how quickly you could go through to get this to Magellan and do this, and how much longer it may take if we have to go through a psychiatrist. And to me that's a critical access question when it comes to children. So maybe I'm leading into Sue's report, but. []

VIVIANNE CHAUMONT: I have briefly looked at that chart and I'm not prepared to say that I agree with their representations made in that chart. But I just want you to know that, yes, those are the requirements, the federal requirements for PRTFs. There are states that do not have residential psychiatric services or residential services for their kids at all. They do everything in the community. So there is more than one way to approach the issue. []

SENATOR CAMPBELL: Okay. And we may want to come back. Sue, why don't you go ahead with yours and then we'll do Director Reckling, or if one is the other. I don't know who is supposed to go first. []

VIVIANNE CHAUMONT: Sue. []

SENATOR CAMPBELL: She is? Okay. []

SUE MIMICK: Just a comment about the shortage of psychiatrists. I don't have it in my presentation but the shortage of psychiatrists is much more severe in rural Nebraska than it is Omaha and Lincoln. And I don't have the numbers with me today but my...I'm going to guess that 85-90 percent of the admissions into residential care are from Omaha and Lincoln. So, you know, it is an issue. I'm not saying that it's not, but I think it is not as much of an issue in Omaha and Lincoln as it is in rural Nebraska. []

SENATOR CAMPBELL: And the reason I raise it, though, is that that issue in and of itself creates an even greater potential barrier. []

SUE MIMICK: You know, we have not heard...we've been meeting with the residential providers since the first week in May and we've had weekly meetings with them. Last night's e-mail was the first time I have heard that the shortage of psychiatrists are causing a barrier, but we will certainly look into it. []

SENATOR CAMPBELL: Okay. I interrupted. You go right ahead, Sue. []

SUE MIMICK: So we are getting way over time so I'm going to try to (inaudible). []

SENATOR CAMPBELL: Well, and we know we're going to have to extend it. We'll keep going and as long as there's questions. []

SUE MIMICK: Okay. So the first slide here, the...it's a more extensive description of the levels of care. The PRTF, psychiatric residential treatment facilities: They are only available for accredited facilities. They do have to be under the direction of a psychiatrist. It is a 24-hour inpatient care level of care, highly structured, closely supervised. Psychiatrists must attest to medical need, and that's just what you were just saying. It includes a treating clinician statement of clinical need for every provider currently working the with client. So we ran into some...this was a suggestion made by our physician advisory group that we were running into situations where a kid was winding up in a residential facility, and the psychiatrist that had been treating them didn't even know that they were going there. So, you know, we needed to correct that pretty quickly, just for continuity of care if for no other reason. Therapeutic group home: They are limited to 16 beds. They're not IMDs. The 16 beds were grandfathered. The new programs will have eight beds at a maximum. This is intended to be community-based treatment. We are hoping that eventually these therapeutic groups homes will start cropping up in rural Nebraska. We don't have any applications for them yet but it is still a hope. This is run by psychiatrists or a psychologist, and also it includes the treating clinician statement of need. The next slide, the professional resource family care: This is a new level of care. It's not the same level of care as our old treatment foster care. This is family-focused and it's intended to be a short length of stay, three weeks to three months, and it's intended to focus on teaching the parents how to be better parents. So it's really focused on the parenting. So clearly the participating parents have to agree to participate in the treatment and they have to agree to bring the child home after discharge. New medical necessity criteria: In your packet you have examples of three of the criteria. There are many more criteria than I printed off for you, because I didn't want to kill a tree. But each level, each specialty level of care has different medical necessity criteria. For example, there's medical necessity criteria for substance abusing PRTFs; there's different medical criteria for sexual offending PRTFs; and also for mentally handicapped children. So this is an excerpt from the PRTF criteria and so it's requiring that they have some significant issues that less restrictive treatment programs suddenly had failed or inappropriate, and it is those patient's symptoms are not primarily due to the things that are listed here. []

SENATOR CAMPBELL: Can I ask a question? []

SUE MIMICK: Sure. []

SENATOR CAMPBELL: Isn't part of the concern, and I realize that we...I understand the definition that's coming down. But isn't part of our concern here that you're going to have someone in the patient symptoms and those categories there that also may have part of the ones that are in the top. What is going to happen to them? I think that was alluded to over here. That's a real concern, because we've had, like, five levels in the state and now we're going to three. What if somebody falls in between there? What is going to happen to that young person? []

SUE MIMICK: Well, this is only one model of care. There are other levels of care and they don't all have the same criteria. Therapy group home criteria would be significantly different than this from the first bullet. []

SENATOR CAMPBELL: Okay. []

SUE MIMICK: But the other two bullets would be the same because it's a residential level of care. The second bullet says, you know, basically they're getting the right care at the right level. The third bullet says that kids with, for example, conduct disorder, scientific evidenced primarily shows that they do not benefit from (inaudible) from congregate care. []

SENATOR CAMPBELL: Okay. I'll go ahead and let you finish. []

SUE MIMICK: So that leaves...I've used...I've shown this matrix before that (inaudible) this is our matrix of care and it gives you some idea of how the intensity of the services, how much safety, and restrictiveness and those kinds of things. So I'm not going to spend any time going through it. This is there for you reference if you'd like. It has staffing ratios, etcetera. The next slide: So what we did is we asked all of the residential facilities that existed to choose a new level of care. And so what...showing the before and after, so prior to 7/1 and after 7/1. We had 557 beds prior to 7/1. Of those, 68 were treatment foster care that I have to remove from the number to compare it to the after, because we don't have the number of beds for a PRFC. So overall, if you remove the treatment foster care from the equation, instead of 557 we had 489, and that includes Cooper Village, which closed on 5/30, and they had 34 beds. So we lost 40 beds; 34 were accounted for by Cooper, so total net loss of six beds and doing the transition from the new to the old. Under the current number of beds that are available, there are two facilities in this chart that we believe will be coming down. We did get a resignation this morning from a therapy group home with 8 beds, and although we haven't been officially notified of it, OMNI Columbus has 11 beds that they terminated, so that takes the 92 therapeutic group homes down to 73. Now the other two homes, the occupied beds: So the first column shows available beds, the second column shows occupied beds. So every week the providers send us a census and they say, of all of the beds that we say we have, how many have kids in them, how many are full. So prior to 7/1 we had 291 occupied beds. Today or the latest report, we have 233 beds. Of the occupied beds, how many are Medicaid funded? We had 196 Medicaid-funded beds prior to 7/1; today we have 140. The difference between the occupied beds and the Medicaid beds are beds that are funded by other payers, which includes CFS--I'm sorry for the abbreviation here--but it's on a letter of agreement. And so that's primarily what they're due to. So you have 95 CFS beds primarily funded by CFS before 7/1; you had 93 after 7/1. Okay? We do look at...we do quite a bit of research on what all is happening in here with our denials, and we have been doing them quite some time as I think you know from prior presentations. We did look at all of the letters of agreement that resulted from a Magellan denial. And 100 percent of them didn't meet the medical necessity criteria because the diagnosis was conduct disorder, ADHD, or ODD--oppositional defiant disorder. So that's our problem: conduct disorder, oppositional defiant disorder, and ADHD. So talking about application: Applications are indeed down. The three months prior to 7/1 we averaged 97 (inaudible) individual applications a month. In July, we received 41. And so they're down by 58 percent. The...in August, so far, by last Wednesday, we had had 41 applications. So we're estimating that the August numbers will be up. They'll be up over 50. So at this point I don't know what it's going to level out at, but we think it will be certainly higher than what we experienced in July. []

SENATOR CAMPBELL: And Sue, how many of the applications did we approve? []

SUE MIMICK: I have those numbers. In July, we approved a total of 34 percent of the applications. Of the kids with the primary diagnosis of conduct disorder, we approved none. Of the kids with a secondary or further down the chain diagnosis of conduct disorder, we approved 32 percent. And of the kids with no conduct disorder, we approved 64 percent. So again we have an issue with...and I'm saying conduct disorder here and I'm including in that all of the related behaviors, so it would be conduct disorder, ODD, intermittent explosive disorder, disruptive behavior, and impulse control. So all those kind of aggression kinds of... []

SENATOR CAMPBELL: Okay. All that. So the question I raised earlier, you're grouping all of those together. []

SUE MIMICK: Right. Yes. []

SENATOR CAMPBELL: Okay. []

SUE MIMICK: So in August we denied a total of 58 percent of the applications so far. I mean we have some that are still pending. And again the numbers are 18 percent approval rates for the kids with a primary diagnosis of conduct disorder; 50 percent of the kids with a secondary or later diagnosis of conduct disorder; and 82 percent approval rate for the kids with no conduct disorder, so. Things are changing pretty rapidly. []

SENATOR CAMPBELL: Thank you. []

SUE MIMICK: We have...at the bottom of this slide...can you go back one? We have nine children in out-of-state treatment services. We said this before, and this gets confused very often with treatment versus placement. So CFS might place a kid in a group home out of state that is not done for treatment services or is court-ordered for some other reason, but only nine of those come from medically necessary Magellan-approved services. That's the lowest in many years. You know, a couple years ago we had a total of nearly 100, and we're down to nine and we're very proud of that. We worked really hard to bring all those kids back in state. We've admitted...people keep asking us...so we've admitted one youth to out-of-state residential care since 7/1 and there are two pending. One of the three required services not available in Nebraska. The other two have been primarily not accepted by Nebraska providers because they're too acute for...they feel that they're too acute for their programs. We checked to make sure with this reduction in applications and the reduction in approval rates and all of those things to make sure that that wasn't resulting in another issue which was an increase in inpatient care. And in fact, it's not. Our inpatient days are down pretty significantly as well, a decline of 36 percent. There's been no change to inpatient services. Some months ago I talked to you about starting to do outcomes measurements, and we have started to do that. We are...it's called the CANS program--Child and Adolescent Strength and Needs Assessments. It was implemented in December 201l. It has six domains, and where the assessment is conducted and to if the kinds who are in our...we require this assessment for all residential providers for every child, and they're assessed at intake. Every 90 days they would discharge against the scale that's noted here, a strength--a watchful waiting, act, or act now. And so far we've conducted 1,092 assessments. So we're starting to get some overall outcome reporting on the CANS resident care. And I only have one domain; it's the strength domain. And on this domain the primary reason or the primary...the percentage of kids...the highest percentage of kids that have either an act or act now dimension on the CANS is level of involvement in his or her community. So the kids have those needs. They're coming into the residential centers without those needs and there were only 20 percent of the kids that were involved in their community that came into a residential setting. At discharge, and the number are much lower at discharge, 15 percent of those kids had improved in that dimension. Okay? So this goes down. The next one is well-being which is the strengths that the youth has developed, including both the ability to enjoy a positive life experience and manage negative life experiences. So it's pretty interesting that involvement in the community is a higher need than the strength around well-being. I'm not going to go through all the rest of these. They're there if you would like to read them. And we'll continue to bring data here as we get more robust on it. So conclusions on residential care: Some scientific evidence. I was corrected yesterday by a provider that says there is scientific evidence that residential care does work, and so I've changed this to some. But including the U.S. Surgeon General's report shows that residential care is not helpful and many times detrimental to children with conduct disorders. So I'm focusing in on conduct disorder because that clearly appears to be the place where are not approving the residential care and that the kids are having to seek other services. Our own data in Nebraska supports this. We have a readmission rate of 30 percent at nine months following discharge. Baseline CANS data shows that limited improvement is being made in residential care, and--I'm sorry for the typo--many children seem to have some sort of conduct diagnosis--75 percent of the applications since 7/1 have some sort of a conduct disorder diagnosis. Evidence-based practices show community-based multi-systemic therapy and functional family therapy is extremely helpful. We do have some of those programs. They are somewhat limited. We'd like to see many, many more of those programs, but at this point it is what it is. We need a package for community services for disruptive disorder diagnoses is my conclusion. So it's a place where we really need to focus some efforts. []

SENATOR CAMPBELL: And that we keep coming back to that. []

SUE MIMICK: Best practice for community-based treatments available to kids with disruptive disorders. The source of this is a NAMI publication that it's a national NAMI publication and I've included the source here. But some of the things that we have available to kids in our system includes parent training through CFS; strategic family therapy, etcetera; and then we have some nontreatment services examples. The children's--going on to the next line--the children-based...oh, I'm switching now off of residential into we did this unbundling on IOP and day treatment, so I'm switching gears on you now. (Laugh) Children-based community service programs: Prior to 7/1 we had 49 programs and they're listed here by type. There were 11 programs discontinued but only one program with two children had any active kids at the time that the program was discontinued. So this was more of a cleanup of data than it was programs actually making the decision to go out of business because of new regulations or anything like that. There were seven new programs that came up, and so our current total is 45 programs of community-based service programs. On the next slide, we have shown this by community, because I know there's a lot of interest on where those are, and so we've shown what we lost and what we added. This total adds up to more than the prior total, because in the prior total, if a facility has a program in two cities, then we would count it once on the prior slide but twice on this slide. I brought with me a case study, and I think in the interest of time I won't go through it. It is an example--I would encourage you to read it--of a child that twice came to us for approval of residential treatment, and two times, both times, got denied. And at this time we have very successful outcomes by wrapping community-based services around him. So that's what I have and that's what I brought today. []

SENATOR CAMPBELL: That's right. I'm going to hold questions for Sue for just a minute and I'm going to go ahead and let Director Reckling give us the information that he has. []

TODD RECKLING: (Exhibit 13) Good afternoon, Senator Campbell and respective senators. I'll try to limit my comments to what hasn't been covered. We tried to make sure we weren't duplicative but, through the questions that come out or have come out today, I think there's a few areas I'll just let you read rather than me go through. But I really want to talk a little bit today just about the transition planning that went on, some of the financial impact to Children and Family Services, and in particular, the service delivery system, and then just echo a little bit more about the conversations related to some community-based provision of services, right levels of care, and so forth. So thank you for this opportunity today. Real quick, we did work together with Magellan as well as Medicaid and Long-Term Care during the process to get ready for this, and in part of that, Magellan went out and reviewed all our kids that were in child welfare and juvenile services, and started to look at and help get us prepared for this transition. And through those reviews no kids were just discharged. We had up to 90 days if they weren't going to meet the new criteria, and actually the new criteria, unless there was a discharge already planned, wasn't started until August anyway. But it was nice for us to know that through working together that we had adequate planning for those kids that would in the future not meet those new requirements so we could get them where they needed to go. In preparation, I believe, Senator Howard, you had asked about the judges' preparation. One of the things we did do, we were very fortunate to have the Court Administrator's Office share a letter that I had prepared for the judges to let them know about some of these changes, and we also sent affidavits, because some of the court orders specifically talk about a level of care like residential treatment. And because that level of care and terminology didn't exist any longer after July 1, we wanted to make sure that the judges were also aware related to that court-order language. So we sent affidavits so they knew about those particular changes. And also you've heard a little bit today. I'll talk, in just a minute, more about the letters of agreement. Those were continued. So I think Senator Pirsch had asked, you know, what happens when you have a court order but not medical necessity? We follow the court order. And so I will explain a little bit further about the financial impact that has had on the system, a little bit, as you've heard today and as far as changes in funding sources and who the payer is. Some of those costs that were previously paid for by Medicaid and Long-Term Care are now with Children and Family Services. As Director Chaumont pointed out, if the child is in a PRTF and it's part of routine care for the child, that is covered. But if you have an acute situation or if they need to go to the dentist, or things like that that weren't planned on the treatment plan, then those costs come over to the guardian. So in that case, for Children and Family Services, when we have state wards that are in a PRTF, for example, need to go out and get their dental or have a broken leg, need acute care, those costs are now a part of Children and Family Services. And you also heard there are other requirements around the IMDs. If they're not a PRTF, they can't be over...you know, they have to be 16 beds or less or 51 percent of the population needs to not have a diagnosis or be on psychotropic medications. I provided a couple charts for you and I won't explain those, but basically what I'd like to point out in these charts is I tried to diagram for you the changes that I've been talking about. So what was previously paid by Medicaid and Long-Term Care and what is now being paid for by child welfare. And it's a little bit hard to read on your slides, but on that first slide if they are in PRTF or treatment group home where the professional resource family, if you look at the slide, in the middle there's some emboldened items in black and those are the new costs for Children and Family Services. So that is a change on those charts. So previously paid, Medicaid and Long-Term Care; now those costs are Children and Family. You can go to the next slide for me. This slide here is again just another diagram to visually represent when a child in this case does not meet medical necessity, who's paying for what type of services. We went back and looked at some of the historical expenditures in preparation for our budgets and how to plan the best we could for funding of this transition period. So we looked at paid Medicaid claims for 2010 state fiscal year. I won't go through those, but potentially those are, at the top, those as Director Chaumont talked about, is the providers start to come into full compliance between what their plans are that they've submitted now and July 1, 2012. As they get up and running, some will then be converted over and some will be paid for by Children and Family Services. So that upper part is some portion of that $2 million I will be paying between now and 2012. But after 2012, if we still have IMD issues, that's the full cost that I would pay. And then down below on the bottom part there's those ancillary treatment services that I know for sure I am paying at this time. Okay. This next slide gets into a little bit of a letter of agreement, and let me just basically try to...I think you probably are aware of what that means. But we have situations where application has been made to managed care, and for whatever reason, that level that was asked for was not approved. And that means that another alternative level of care has been approved but there may not be agreement around that level of care. So through a court order we have had a situation where it's believed that a child may need to go to point A facility but there's not medical necessity. So again we will absolutely comply with the court order that at that point in time, because there's no medical necessity, Children and Family Services is responsible for that cost. So if you look on this chart, I tried to go back and quantify for us what types of services are we paying on letters of agreement and what percent of type of service does that represent in total expenditures. And you can see it's a total, just last year, of $6.4 million. So those are pure state funds that we're using to pay for those nonmedical necessity treatment services. And the bigger issue for me in that slide is not the dollar amounts. The bigger question I think for all of us to ponder is we have kids in a treatment-level of care that it is believed, by the professional reviewing that, that they aren't needing that level of care. So what are we doing? We talk about the right service focus, Senator Krist, on the child. What does that mean for us when we have those kids in that level of care? Not only is it maybe not the best place for them but you're also occupying a treatment bed for a child that may actually need and be approved for that level of care. So as we go forward, one of the things in child welfare and I look forward to updating you that we should all be paying attention to is what does this cost look like and how are the numbers looking as we go forward through this transition? Another piece of the puzzle to the what-if in the future as we go through this situation is getting back to Senator McGill's point about out of state, and I want to just briefly talk about that a little bit. So if the child, if we can't find services in Nebraska, certainly we want to have community--Nebraska, our community--but we can't, and a child has to go out of home to an out-of-state facility, what we're finding is if that out-of-state facility is an IMD or if the child does not meet medical necessity, Children and Families is paying for that. Our experience so far is a lot of these kids going out of state are not meeting medical necessity or there's a court order, or the facility itself is not a PRTF and it's an IMD, and therefore we're having to pay for it. So another situation to monitor as we go forward is the number of kids in out-of-home care. I think you referenced the Ombudsman's report that talked about 159 children in out-of-home care. That is a different number. Magellan is tracking the kids that are authorized for treatment services out of state. The number of 159 is a point in time as of the first part of August for Children and Families, and it's actually an all-encompassing number. So I want to point out a couple things about that. It includes foster care, for example. So of the 159 kids in that report, 68 of them are in foster care. There's another amount... []

SENATOR McGILL: So it could be a family member (inaudible). []

TODD RECKLING: Yeah, absolutely. And so that's why I think when we talk about out-of-state numbers, we really need to continue the discussion around what we're talking about. Because I would argue that some of those kids on the western part of the state, I'd much rather if they needed to and had extended family over across the border, I'd rather have them out of state and in closer proximity to their family if they can't be with their family unit, than somewhere, when you traditionally think of out-of-state, meaning, you know, Pennsylvania or Texas or somewhere long distance. So there's caveats, I guess is my point, to those numbers. But it is an issue we need to monitor. I would...we very much want to have services and supports in the state of Nebraska for our kids so we don't have to go out of state. A little bit on the funding, not to belabor it too much but it has...preparation. I just wanted you to know we were very conscience in preparing our budgets this year in conversations between the divisions of Medicaid and Long-Term Care and myself about how to best position ourselves for this. So funding that was previously paid for by Medicaid in their budget was calculated to being needed in my budget. And so you can see the net difference there of what we think we're going to potentially spend, and I created a worst-case scenario for you, because again some of those providers will come into compliance and will be fine by when we need to be.

But we have basically a net or a cushion, so to speak, of about $1.5 million or a little more. And again, the big question for me: Is that going to be enough? If we keep having letters of agreement, if we keep having to send kids out of state, how close are we going to be to where we need to be with the funds? We absolutely continue to work on the impact for children and families in congregate care. As you've heard today, I don't think anybody would argue that there's not a time and place for some use of residential treatment or congregate care for kids. What I would argue is that it's, at times, overused and that's the issue. It's the...I don't think anybody, whether it's the department or providers, would argue that we want to make sure we have the right situation at the right time, at the right level, for the right kids and so forth. The question is, how do you make sure that's adequately assessed? And we want to continue to work with everyone around as we move forward. And as Vivianne also mentioned earlier, we'll know more after September 1 or right around that time. The providers preliminarily, by July 1, said yes, this is...we intend to move forward, obviously with CMS compliance. The September 1 plans will really detail that how and when they're going to move forward, which will really help me better understand the bed capacity that we have and what that's going to mean futuristically for us. I can tell you today, as the slide indicates, we have had a net reduction of at least 14 child welfare contracted beds at this point. We've had a couple loss and then we gained a few, but the net difference is 14 less beds at the present time. Sue, from Magellan, also mentioned the Surgeon General's report and I also gave you quotations around a Bazelon Center. I'll let you read those. But again there's a time and a place for residential treatment. And the question is, are we using more than we need to? And my personal belief is that we are using more and we need to set up a culture of community-based services. And I absolutely believe that there's the ability to do that. We just need to plan and do more to develop those services. As you've heard us talk before, you have to have economy of scale. There has to be some "planful" transition, and we need to know that people are going to use those when those are brought up. So that's where we will continue to do the planning around those. But I also wanted to mention just a quick quote for you about the use of residential care, and this is not a Nebraska statistic but a national one that just came out. It's a report published by Dr. Joseph Blader, and he just released this recently. But the headline is that inpatient psychiatric admission for children between the ages of 5 and 13 years increased by 82 percent between 1996 and 2007, from 155.45 discharges per 100,000 in 1996 to 283.04 in 2007. During that same time period, the number of inpatient days per admission more than doubled, from 1,845 days per 100,000 in 1996, to 4,370 days in 2007. The proportion of inpatient days paid by private sources decreased from 36 percent to 21 percent over the decade. And again it's just a piece. You can research on both sides of the issue. But we want to continue to move in the right direction and look at community-based services for our kids and families. We've heard a lot from our families. The more I am able to hear from them and talk with others, if we can make sure that we have capacity to keep the kids safe but to wrap services around them in the home, we want to do more of that. Certainly there's kids that cannot be maintained in that environment and need a level of care outside of their home. And therefore, we need the continued array of services for our kids and families. I just wanted to mention, too, you've heard a lot of conversation today about the conduct disorder, and I'm using that collectively as a group again, as Sue did as well. But we want to be proactive in doing something more about that. We've heard that that's an issue. We're seeing it in our statistics, and we want to do something with that. So we've had conversations. At this point we'd really like to get a work group together. We haven't set the stages to actually send invitations but that's the plan at this time is to get a large group, not just department, but actually work with providers and others to talk about how can we tailor-make some type of individual package that is maybe both treatment and/or nontreatment-type services, so you don't get stuck in those funding silos--how do we work with the agencies as well as the divisions as well as the communities and the various local providers to somehow see the package that you can wrap around the child. We know that the conduct disorder grouping is an issue going forward and I think that will be a productive conversation for us to address that issue as we go forward. I also wanted to mention just real quick that the rural issue with the needs are tremendous in terms of what is it, what did it look like before, what does it look like now, and what do we need it to look like in the future for our service delivery array? The service area administrators through Children and Family Services in the Western, Central and Northern have been working on a report for me that talks about, what did we look like before reform, what do we look like now, and where do we need to go. So we know we have...we actually have identified that we do need some beds. The question is: where? How do you make an economy of scale with such diverse geographic disbursement? How many...how do you make it viable? But we also know we need community-based treatment services while that will be used. And so the planning needs to come together for not only having the service but the culture to use those community-based services. []

SENATOR CAMPBELL: I'm going to go back to Senator Avery, who has been very patient, and to his question. []

SENATOR AVERY: Not very. (Laugh) We're getting two messages here...thank you, Madam Chair. We're getting two messages here. You're saying that you believe the Surgeon General's Report in 1999 is correct that that residential treatment is not necessarily the right path even though his own statement here says that this is based on limited evidence--and that's 12 years ago. You've had 12 more years to get beyond limited evidence. []

TODD RECKLING: Yes, Senator. []

SENATOR AVERY: That's one point--let me finish. []

TODD RECKLING: Thank you. []

SENATOR AVERY: We are hearing on the other side that access to care in this state is restricted by policies coming from the state. We're also hearing that the system of care in Nebraska is being dismantled. Those are two very, very different messages, and the last one is very disturbing. You're under pressure...I understand you're under pressure to limit expenditures. We understand that. But we also have an obligation to families who are struggling with children with mental illness. That should be the number one focus, taking care of the children, rather than seeing how much we can save. Ms. Mimick, when she gave her report, seemed to be--maybe I'm implying something here that's wrong--proud of the fact that the number of approvals is going down. But yet that might be because we have more restricted criteria for access to residential treatment or maybe an emphasis on something other than residential treatment. These questions need to be answered and I don't think they're being answered here today. []

TODD RECKLING: Senator, if I could just comment on your questions and comments. First of all, I don't believe you heard me say that there wasn't a niche in the service array for residential agreement. There is. []

SENATOR AVERY: No, I didn't hear that. []

TODD RECKLING: So I don't...I'm not putting all my eggs in the basket with the Surgeon General. I only say that to point out that...and I said it: You can get evidence in reports on both sides of the issue. Our only point is, and when you look at the general evidence about needs of kids and how best to serve them, some kids do need residential treatment and other don't. When you put a child in that level of restrictedness that doesn't need it, there is evidence that shows that you actually cause more harm than good to the child. My question here today to all of us is the challenge around, why do we have so many kids here in the state of Nebraska, I'm talking from my division, the kids I'm responsible for, the 6,100--we have about 67 percent of those--so 4,100-plus kids on any given day in some type of out-of-home care situation? This topic today is applicable to say, how do we best serve our kids either at home with wraparound services or closer proximity in the community with community-based services more so than we're doing today? I believe we have great flexibility to do different things in the future to serve our kids with the parents. I know you're hearing probably from your constituents that if a parent can keep a child safely at home and help them address their mental health issues, they would much rather have their child in the home than send them anywhere else. And... []

SENATOR CAMPBELL: And I'm going to interrupt here only because I want to try to get in the last if anybody's really got a burning question before we adjourn. What I think we have seen today is clearly the need that we will come back and follow up with a hearing to try to go into some of the issues that the senators have asked questions on. I'll work with Senator Dubas to figure out when that is. And I'm sorry to interrupt you but we're way over time here, so we'll try to look at some of those questions. I share the concern that we are going down in to system. I understand the regulations that have come to the state but we're also going down a path and yet we are saying, well, we don't have those services in place yet. The point being is, when does that converge and then what happens to that child if we don't have the service and we're requiring that these regulations be put into place? And I think I speak for all the senators that that's a worry and that's a gap, so. Senator Krist. []

SENATOR KRIST: This state has bit off more than it can chew in the last four or five years, and these senators and our senators, the senators that are represented in Health and Human Services, have tried over the interim period to listen to everyone. We've got problems. And one of the problems I think we have, Director, is I can't tell where the money is coming from and I can't tell where it's going to. If you're taking money out of the foster care or child care program to pay for people with disabilities, that's wrong. If you're underfunded, which this program was from the very, very beginning, let's step back two steps and fund it correctly. But I can't do that until I see the numbers. I have asked Legislative Research, I have asked our own Accountability. I have asked Liz Hruska, who, bless her heart, has come back and said, you know what? I don't know. That's wrong. I need to know where the money is coming from and where it's going to. And if we need to spend more money taking care of kids, then by God, we need to find the money to do it. And that's my conjecture. When you went out and privatized and outsourced and went out for other services--and I'm going to mix apples and oranges here but it all goes to the total picture--you took the same amount of money that you had administering the program and you gave it to the providers and said, administer that program, with no overhead to provide for that, and then you gave them additional responsibilities and you added a different layer. And I don't...I'm hearing it, I'm seeing it, I've heard it directly in the last few days. So this financial issue overweighs almost everything. And the most important thing is the kids and the family. Find me the money. Where did the money come from? When we found money to throw at a particular provider to fund that program correctly, where did it come from? Do we take it out of, you know, out-of-home services and in-home services and did we wave the magic wand? I want to know where the money came from? And when I see the money, I think we can solve a lot of the problems that we're seeing here today. []

SENATOR McGILL: And not just that infusion. Sorry for adding to that, but I've been in these hearings and had that exact conversation with you before, and I know Appropriations has had that conversation about any sort of budgetary chart in terms of what's going on in child welfare. And we've still seen nothing like that. That's been two years--about--now. []

SENATOR CAMPBELL: And I understand that. I think that's probably part of the follow-up. I want to stay pretty focused though on the four letters that we're at. So I'm going to close today's briefing and hearing but assure everyone here that we will have a follow-up hearing for more detail. So thank you. []

TODD RECKLING: Thank you. []