HARDIN: Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, representing Legislative District 48, and I serve as chair of the committee. The committee will take up the confirmations in the order posted. This public hearing today is your opportunity to be part of the legislative process and to express your position on the proposed appointments before us. If you're planning to testify today, please fill out one of the green testifier sheets that are on the table in the back of the room. Be sure to print clearly and fill it out completely. Please move to the front row and be ready to testify. When it's your turn to come forward, give the testifier sheet to the page. If you do not wish to testify but would like to indicate your position on a bill, there's also yellow sign-in sheets at the back for each bill. These sheets will be included as an exhibit of the official hearing record. When you do come up to testify, please speak clearly into the mic. Tell us your name. Please spell your first and last name to make sure we get that right. We will begin each bill hearing today-- and in this case, we're going to go through each of these folks and they're going to talk about their whole experience in life. It's all of your experience, exhaustively I think. And so we will finish with a closing statement. You're going to be asked questions by these people today, and so we appreciate any and all that you have to share with us. This is your chance to educate us about you. So if you were sitting in these seats, what would you want to know about you? Help us out. We would appreciate that very much. If you have any handouts for people, hand them to the page. Everyone else, please silence your cell phones. That's really helpful. Verbal outbursts or applause are not permitted in this hearing room. Such behavior may cause you the opportunity to meet one of these strapping Red Coats or troopers here in the room. Finally, committee procedures for all committees state that written position comments on an appointee to be included in the record must be submitted by 8 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website at nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will be included on the committee statement. I will now have the committee members with us today introduce themselves, starting on my right.

BALLARD: Beau Ballard, District 21 in northwest Lincoln, northern Lancaster County.

QUICK: Dan Quick, District 35: Grand Island.

MEYER: Glen Meyer, District 17: northeast Nebraska, Dakota, Thurston, Wayne, and the southern part of Dixon County.

FREDRICKSON: John Fredrickson, District 20, in central west Omaha.

HANSEN: Ben Hansen, District 16.

RIEPE: Merv Riepe, District 12, which is Omaha and the city of Ralston.

HARDIN: Our research analyst, Bryson Bartels, is here. And to my far left is our committee clerk, Barb Dorn. Our pages for the committee are Sydney Cochran, and she's at UNL, majoring in business administration and U.S. history, as well as Tate Smith of Columbus, a political science major. Today's hearing is-- the agenda's posted outside the hearing room. And with that, we're going to begin with gubernatorial appointments. We have Drew Gonshorowski.

DREW GONSHOROWSKI: Yes, sir. Got it.

HARDIN: Welcome. Thanks for being with us today.

DREW GONSHOROWSKI: Yeah. Thank you for having me. All right. Good afternoon, Chairman Hardin and the members of the Hu-- Health and Human Services Committee. My name is Drew Gonshorowski, D-r-e-w G-o-n-s-h-o-r-o-w-s-k-i. And I am the Director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I am here today to begin the confirmation process. I would like to thank the people of Nebraska for welcome me-- welcoming me to the community. Although I relocated from the D.C. area, the people and the way of life here are quite familiar to me. I grew up in rural Michigan on the family farm, where many of my values are rooted. I consider myself fortunate, fortunate to have the opportunity to be here with you all today. For over a decade, my career has focused on evaluating health care and benefit programs. I earned my Bachelor of Science in Economics from Hillsdale College and my Master of Science in economics from Suffolk University. I began my career at the Heritage Foundation's Center for Data Analysis, where I developed and maintained advanced economic models to evaluate the impact of legislation on government-administered programs. I focused on legislation impacting the Medicaid program, insurance premiums and

coverage, and health care policy under the Affordable Care Act. Additionally, I developed and maintained models used to analyze other programs such as Social Security. My work provided data-driven insights to policymakers, government agencies such as the Congressional Budget Office, and the public. After my time at Heritage, I joined the Paragon Health Institute-- a think tank focused on health care policy-- as a senior research fellow. I coauthored a key report that highlighted flaws in ACA exchange enrollment processes. This piece resulted in congressional action and was widely cited. It focused on the effects of policy change on Medicaid programs across the country. My work ranged from topics such as Medicaid redeterminations, the Medicaid undercount, and extensive work analyzing the estimated effects of changes to federal Medicaid policy at the state level. My research was widely cited in leading publications, including the Wall Street Journal, Health Affairs, Politico, Axios, KFF News, and even The New York Times and the Washington Post. In addition to research and my work at the federal level, I've had the opportunity to present testimony on Medicaid policies in several states. I testified on the effects of legislation across the country, including in Pennsylvania, Michigan, Utah, and Virginia. For example, in Virginia, I testified before the state legislature on the financial implications of Medicaid expansion, providing state-specific insights into its long-term sustainability. In other states, such as Florida and Ohio, I provided technical feedback on state-contracted actuarial reports. All these experiences reinforced my belief in the importance of informed and principled state-level leadership in Medicaid programs. I have always been driven by the goal of improving the health outcomes of individuals while ensuring the fiscal sustainability of government programs. Medicaid policy requires a disciplined approach to serve vulnerable populations while maintaining accountability, efficiency, sustainability, and, most importantly, ensuring the unique needs of Nebraskans are met. If confirmed, I am excited to apply my experience and skills to address the pressing challenges facing the state's Medicaid program. As many senators have highlighted in the opening days of the legislative session, Nebraska-- like other states-- is facing budget shortfalls going into our next budget cycle. Among my top priorities are ensuring fiscal responsibility and reducing administrative inefficiencies. As one of the largest expenditures in the state budget, I look forward to working cooperatively with the Legislature to ensure we are meeting the needs of Nebraskans and the long-term sustainability of our

Medicaid program. I am also committed to collaborating with health care providers, community organizations, and other stakeholders to develop solutions informed by the diverse experiences across Nebraska. I am grateful to Governor Pillen for his confidence and support. I am excited to serve Nebraska as a part of this administration. I appreciate the opportunity to come before the committee today, and I look forward to working with each of you. Thank you for your time. I would be happy to answer any questions regarding my appointment.

HARDIN: Thank you. Questions from this committee? Senator Hansen.

HANSEN: Thank you. Thanks for being here.

DREW GONSHOROWSKI: Yeah. Thank you for having me.

HANSEN: So your background in economics I think is-- I would-- it's unique to the position maybe a little bit, maybe not. But how do you think that serves your role as Director of Medicaid and Long-Term Care? Just specifically the economic portion, especially-- you mentioned a little bit about-- maybe it's the-- a, a little bit of the shortfalls we might be kind of-- that might be impending, possibly. And so I think you-- and you mentioned also about your expertise in actuary-- actua-- actuarial reports. So I, I, I like that background when it comes to something like this. And so how do you think that benefits you being in this position?

DREW GONSHOROWSKI: Yeah. Thank you. I, I really appreciate the opportunity to answer this question. Throughout my career, I've often been approached by dish-- decision-makers at different levels of government. They usually would come with some piece of legislation that they were wondering about the effects. My background is specifically being able to articulate to them not only what's going to happen in the short term in terms of the effects of this legislation, but also these long-running implications. Because ultimately, any decision that we make today or into the future doesn't just affect, you know, our be-- biennium, it doesn't affect us five years into the future; it has implications that are long running. Oftentimes when I've been asked to provide sort of insights either at the states or the federal level, there seems to not be a lot of communication across-- from the federal perspective into the state perspective, and vice versa. I, I think my background sort of uniquely positions me into being able to take whatever is coming from the federal

government, but also provide context at the state level that, that would be actionable for members of this committee, but also the Legis-- Legislature.

HANSEN: OK. If I can ask one more, please, Mr. Chairman? So I-- but I-- I think you make a good point. I think one of the things I feel like what we're looking for as legislators is a trustworthy source we can go to in, in a role such as yours to say, OK, we're thinking about legislation such as this or legislation is pending such as X, Y and Z. And then what is your objective, logical opinion not just in the short term, but in the long term, about what this legislation might mean? We tend to be, I think, as politicians somewhat shortsighted, either out of necessity or just because that's our makeup. But I think in a role such as yours, we, we need some of that expert advice about maybe what a bill or policy we're looking at implementing might have. And so you could see yourself kind of help fill that role as well about kind of being our expert opinion on, you know-- and giving us objective advice?

DREW GONSHOROWSKI: Yeah. And I mean-- I, I think that's, that's sort of a, a great characterization of how Medicaid departments need to operate in terms of their understanding of implica-- im-- implementation as well, right? Because ultimately, we have to make sure that we're ensuring fiscal sustainability far into the future. And, and oftentimes it's, it's, it's to no one's fault that we're, we're-- we are, you know, bogged down in the fights of the day. And ultimately, we, we want to be able to have a, a longer perspective. And, and hopefully-- that's, that's the, the main, I think, in terms of my experience that I bring to the table on, on, on-- especially on the policy side.

HANSEN: Thank you.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. One of the questions that I have-- in this role, will you have a number two person, if you will? And the reason I go there is a little bit-- most of your background, as I understand it-- and correct me where I'm wrong-- is more on a staff capacity, not a land capacity. This has a huge blind side of it with a lot of employees. And-- so I have a concern about that of-- because you're going to be in a situation

where you have to arbitrate between, you know, whether someone gets fired or they don't get fired or they get reassigned or the organization-- if you don't get the organization right, you're not going to get anything right. I have a concern-- you, you know, I think you're-- you've done a lot of research work. I think that's good. But I don't-- you, you haven't been there in the operation. Unless I'm wrong. And-- I'll let you answer that. Then I'll have another question.

DREW GONSHOROWSKI: Yeah. I, I, I really appreciate that perspective. And, and on operations, I've, I've been really heartened to to join this Medicaid team, especially at my deputy level and, and throughout the division. They are a very strong operational team. So I do have a, a very strong team, at least in terms of the personnel management, that I can rely on. They're very quick to bring issues to my attention. I've already experienced that. And then on top of that, Medicaid directors across the country can really leverage their peers. So I've already been trying to get involved and have already sat on meetings for the National Association of Medicaid Directors. I have personal contacts in the Medish-- Medicaid Leadership Institute because I understand this concern and I want to make sure that, that that does not affect or impact our mission moving forward.

RIEPE: With that said, you're still-- even your team, though, you're going to have direct supervisory responsibility and authority and you're going to have to learn something about a lot of those divisions. I'm not one that believes that one can manage something without knowing something about it.

DREW GONSHOROWSKI: Oh, of course.

RIEPE: The other question that I have plays to a little bit of a recent piece, and that is, within the Department of H-- of Health and Human Services, I believe there's a total of four auditors, and they're asking for two more. And yet it took the state auditor to find out some big missed payments. So my question, and I-- one that I will pursue is, should the auditors for DHHS be within the Department of DHHS, which is an inherent conflict of interest? Or should they be with the auditor, if you will? In the hospital business, we had auditors. They reported directly to the board of directors. They didn't report to the CEO. Just a little check and balance. And I'm, I'm just quite frankly disappointed that the four auditors in the

department didn't find this. And it took the state auditor to find this multi-- I think-- million dollar deal. So those are-- those-- you know. I think you'll be tested. And-- that's all I have. Thank you very much. Thank you.

HARDIN: Other questions? Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here. Thank you for your willingness to take this role. With the new administration coming in on the federal level, what do you see on the horizon from a Medicaid standpoint? And also, we hear often in this committee it's federal funds, but those come with a match. Kind of [INAUDIBLE]-- how should we-- as legislatures, how do-- legislators, how should we be thinking about the federal match if for some reason the federal government decides that cut a program? So--

DREW GONSHOROWSKI: Yeah. I, I appreciate the comment and the concern. I haven't had any specific conversations about what is actually coming down the line from the, from the federal, federal perspective. Currently-- especially in the federal perspective, right-- they are exploring a, a wide batch of sort of budgetary options. And we know that Medicaid has been raised as a budgetary saver-- publicly especially. I would urge this committee to not sound the alarm just yet in terms of the, the amount of money that is, that is being sort of portrayed on the, on the, on the table, right? I mean, nationally, it's between $2 and $2.5 trillion that they're looking at for savings. They're currently in the exercise where they're exploring all options, right? In the state perspective, it gets into sort of the dynamics and issues that all of you here in Nebraska are, are more familiar with when, when federal reforms actually start being proposed. There is an open dialogue across, across the state, especially in the, the national legislatures in terms of, you know, what is going to be palatable or in interest of the state. Ultimately, when we're thinking about this in the, in the state perspective, the best thing that we can do is, is, looking forward, making sure that we are injecting as much fiscal sustainability in our, in our processes and how we think about the program in the case that something happens that's out of our hands. And if we-- and if we are approaching that in sort of a disciplined way, at least that way we can react to it once, once it happens.

BALLARD: OK. Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here. And thank you for your willingness to serve. I think you, you certainly do, I think, bring a unique perspective just given your background in the federal side, and I think that's certainly going to be welcomed in our state for, for a number of reasons. You mentioned that-- I have a couple questions for you. One is you mentioned in your testimony you sort of seeing and wanting to sort of meet the unique needs that Nebraskans face as it relates to Medicaid and long-term care. Could you elaborate a little bit? Like, what, what do you see as those unique needs here?

DREW GONSHOROWSKI: I, I see-- one, one of the, the main unique needs-- and I think we might have already talked about this a little bit-- is, is ultimately trying to address in, in areas outside of the larger cities of Nebraska this puzzle on figuring out how to actually get providers to provide care to tough cases. I think ultimately this is a-- this is a, a, a specific passion of mysel-- of, of mine that is-- we, we spend a good, a good amount of money in the Medicaid program and figuring out the best way to actually direct those resources to people that we all agree really need them. And I, and I think that that's not just a unique issue in Nebraska, but it's, it's specifically very, very noticeable here in terms of farther west than the state and the-- and places outside of Lincoln and Omaha how we actually get care provided and, and serve those populations.

FREDRICKSON: Mm-hmm. Mm-hmm. That's-- I-- no, I appreciate that. And I know, I know we've had previous conversations about, you know, concerns that I, I personally have had-- you know, obviously related to urban areas, but specifically the more rural areas of our state and, and having network adequacy out there. And that kind have organically leads me to my next question, which-- you know, you mentioned fiscal responsibility being a priority. I think we can all agree with that. You know, I think when we're more fiscally responsible with our Medicaid dollars, obviously we can bundle all the dollars we do have in the most effective of ways. Can you talk a little bit about your philosophy on kind of balancing that fiscal responsibility mindset with ensuring, as we look at things like Medicaid provider reimbursement rates, network adequacy-- and again,

specifically as it relates to areas of the state where we have pretty significant provider shortages and, you know, Nebraskans who are facing at times very complex health needs that aren't able to access that care readily?

DREW GONSHOROWSKI: No. And I, I think that is a, a really important concern to raise. It's, it's ultimately-- I, I sort of view them as two sides of the same coin, for, for lack of better phrase here, in that the more that we are able to provide services in a really efficient way, make sure that we are providing services properly, it does free up more resources to do this direct need. And also it is a-- it is about open conversation across the state, being open to hearing concerns, being open to hearing specific issues even about reimbursement rates across the state. We have open lines of communication with our MCOs. And when those concerns come to Medicaid, we have the ability to raise them directly and work together to, to sort those things out.

FREDRICKSON: Mm-hmm. Mm-hmm. Great. Thank you.

HARDIN: You mentioned that you coauthored a report that highlighted flaws in the Affordable Care Act, exchange enrollment processes. Perhaps there are ways that's improved, perhaps not. I-- would you comment just a little bit-- because I think, from a million feet up, what we accomplished with Obamacare is we greatly expanded Medicaid--

DREW GONSHOROWSKI: Yeah.

HARDIN: --in that, in that whole process. Again, from way up high, would you just kind of comment on what that looked like? I recall that because March 23, 2010 is when the business that I had built changed very dramatically-- not that I'm bitter about it or anything. But in a nutshell, we all live in a very different reality for not only how Medicaid functions, but we all then get older. We all might have to deal with long-term care. I think seven out of ten of us do. And then a lot of times, it gets us right back into the Medicaid question. And I guess I'm just asking a general question of, has the ACA-- where, where does that sit right now with, with all of us and how does it affect Medicaid specifically for Nebraska? Because I do have some follow-up questions related to the supply and demand.

DREW GONSHOROWSKI: No, of course. I can-- so, so the paper I'm referencing there is, is not actually about Medicaid, but it, it has an interaction with Medicaid, and I can talk a little bit about it. It was-- and it-- and I will lead off by saying that this isn't a specific issue in, in Nebraska. It act-- Nebraska does not have this issue. Ultimately, it has something to do with-- in, in the exchanges, there is-- when, when people actually estimate their income, it's a good faith perspective estimate. So next year, I expect I'm going to make 150% of the, the federal poverty level, $20,000, or something like that. And if they don't necessarily make that or, or they go over, they go under, then there's a tax reconciliation process on the back end. Ultimately, what this did in-- and especially in states that do not have Medicaid expansion, there is at least some evidence that people were providing good faith estimates above 100% of the, the federal poverty level even if they weren't going to make that much. They-- a lot of this fraud is centered in Florida. It seems like it has-- there's open litigation about lawsuits on call centers and some-- even some, like, foreign entities. It's an ongoing process. And we ultimately don't have that issue because it, it's just not here in Nebraska, it seems. We, we sort of had highlighted-- I guess it was between five and ten states that, that had prominent issues, and Nebraska isn't one of them. Ultimately, the ACA in, in Nebraska-- we have Medicaid expansion, so we, we work under, under, under that by ballot measure. We have the exchanges. It seems as though Nebraska is unique in that their insurance markets are, are pretty healthy across, across their offerings in terms of network adequacy. Ultimately, there is this sort of question about cost and long-term cost that, that I'm still exploring, having having been here since December. But ultimately, hopefully that answers your question.

HARDIN: Different question: supply and demand. The demand for Medicaid services is far greater than our ability to supply. How do we fix that? How do we wrestle with that? I'm approaching the question again just from a philosophical discussion of the needs across the medical desert. And the further you get away from here-- which, which is where I'm from-- the bigger those deserts get, the hotter they seem. And so the demands are high, and yet we really need to watch what we spend. How do we wrestle with that?

DREW GONSHOROWSKI: Yeah. I, I think-- I really do appreciate this question. It, it does have-- I, I think you've sort of answered your question a little bit too, which is, we have to have open

conversations about what the demand actually looks like and where it is. Because ultimately, Medicaid programs, it's, it's all about-- and I, and I know I've said a similar thing already-- it's all about directing resour-- resources to the greatest need. And anything that we can do to have more information about where the greatest need is, we can more efficiently use our resources either, either now or well into the future.

HARDIN: I appreciate that. One of the things that we need, whether we're in business or government or anywhere else, is we need access to data. We really need to be able to see the numbers. And so we've had kind of an ongoing theme here in Nebraska that sometimes those numbers-- just like with CMS, they have numbers, but can we see them? Can we get to them in a timely fashion in such a way that we can begin to form bills and laws related to that data? At times, we've struggled to get that data. What are your thoughts on helping facilitate data collection and availability?

DREW GONSHOROWSKI: My, my view on data, data availability in general is that we, we should be as open as we can be, given the constraints that we have from the federal government. I, I, I don't think it's any secret that CMS is pretty-- they hel-- they hold their data closely. They have-- we are-- you know, we're, we're effectively under federal regulation, so we have to follow HIPAA. We have to be very careful and very guarded about not sharing public heal-- publi-- anything identifiable--

HARDIN: PHI.

DREW GONSHOROWSKI: --or PHI. Yeah. We, we have to be very careful and we have to advocate for the people of the state and make sure that we aren't putting them at any undue risk as well.

HARDIN: Certainly. And there is a point on the continuum where the PHI thing kind of wears thin because there's no PHI in it. We're just looking at broad strokes of the brush, right? We would really like help to get that and-- the, the next gentleman will have the same question asked to him when it's his turn. But that's something that we generally need a lot of help with. Other questions? Yes, Senator Quick.

QUICK: And I think a couple of the other questions have, have, have pointed to that. And thank you for being here, by the way. But I think sometimes the deserts may be caused by the reimbursements rate being low. We have physicians or providers who maybe will not take Medicaid patients, and that kind of leads to that, to that shortage of providers. So my question is, how-- you know, the other thing I see too-- so if they aren't-- don't have a provider, then they up in-- end up in the emergency room, which results in greater costs. So is there a way we can fix that problem?

DREW GONSHOROWSKI: Yeah, I, I think this--

QUICK: That's a tough question. Sorry.

DREW GONSHOROWSKI: Yeah. Yeah. This is one of the-- I think the, the pressing issues. And I've been thinking about how to approach this well-- as well in, in terms of-- sort of my, my ongoing projects include having a full understanding of what reimbursements rates look like across the state first as foundation, really being able to actually contextualize in, in the localities what's actually going on, and then also really encouraging open communication when these issues arise. Because ultimately, that-- I think that is where we actually get to this issue, which is Medicaid's role being able to hear issues, hear concerns, and then communicate those to our MCOs. I, I think having that happen more vigorously into the future actually does really help on these issues, or at least help us understand what's actually going on.

QUICK: Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. I, I have a follow-up question. Shall we talk a little bit of information technology? Historically, the department's been dealing with, I think, pretty antiquated technology. Is-- has that improved since? I was in here, what, five, six years ago, and it was-- quite frankly, the technology was older than the director. So have we made some roadway to improve our-- in our-- or have you been here long enough to observe that?

DREW GONSHOROWSKI: So, so in terms of specifics, I've, I've been briefed on a couple things, but at the top level-- and my

understanding is that the team has been doing system improvements and, and working to modernize our systems sort of across the board.

RIEPE: OK. OK. Thank you. Thank you, Chairman.

HARDIN: Senator Hansen.

HANSEN: So I got one more question, then I'll be done. Kind of like a job interview question. With-- for how-- from what you've seen so far being in the role that you are, if there's one part of Medicaid from a legislative perspective you think needs the most help or the most work, which would you say it is?

DREW GONSHOROWSKI: Well, that, that's a, that's a great question. I, I think from my role-- in terms of the legislative process, I don't, I don't want to necessarily comment on any current legislation, so.

HANSEN: Which makes sense. But if you're like, man, I wish we could pass this bill to make Medicaid better. You know what I mean? Like, I-- because we're always looking for feedback from you and-- which we usually always get, you know what I mean? So-- I know-- I-- just kind of curious. I know you haven't been here very long yet, and so, you know-- but if you're like one thing you think needs the most kind of improvement when it-- in Medicaid and long-term health, what would you say it is?

DREW GONSHOROWSKI: No, that's a, that's a, that's a really fun question too. I'm, I'm trying to think of what, what I would personally have, have more interest in. I think in terms of Medicaid financing, it's, it's sort of-- the, the legislation that sort of serves general goals of maintaining fiscal sustainability over time. So anything that sort of fits in terms of the priority around drawing down more funds to, to the state I think are, are, are good options from a state perspective. Obviously, in the context of the, the federal perspective, it's a, a nuanced exercise, but that is something that we are uniquely equipped to actually navigate as well.

HANSEN: OK. Thanks.

HARDIN: You gave a-- you stated a moment ago the IT is being worked on to be modernized. Can you kind of give us an example of that? What does that modernization look like?

DREW GONSHOROWSKI: I, I think, I think-- I'm, I'm trying to think of a, a couple of specifics. It's, it's ulti-- ultimately, I think, I think on systems and on IT and-- even on sort of-- I'll, I'll use behavioral health as an example, being able to understand that services are actually provided and introducing solutions that are, you know, acknowledging the context at the state level. So this is-- you know, if there is a-- someone giving home care out far west, being able to have a system that actually acknowledges that they might have issues with GPS, might have issues with, with other sorts of reporting standards, and then being able to actually integrate that into a larger system that's automated or more standardized for places that could actually get cell phone, phone service, right? I, I think they've-- this team, at least in terms of how I've been briefed so far, has been really been thinking purposefully about what sort of technology can make the lion's share of, of the work more efficient, but still being able to acknowledge that there are real issues in, in different parts of the state even on technology levels.

HARDIN: When you first came into this system-- this is an impression question-- was it your impression that our technology for handling what goes on with that was pretty old?

DREW GONSHOROWSKI: I mean, I-- being, being here since December, I, I, I don't think I really had a, had a chance to, to form that opinion. Before, I just started getting briefed about everything that, that this team's working on.

HARDIN: OK. Other questions? Seeing none. Thank you for being here. We appreciate it.

DREW GONSHOROWSKI: Yeah. Appreciate it too. Thank you for the time.

HARDIN: Thanks. This concludes this hearing for Drew Gonshor-- Gonshorowski. I worked on that with you, Drew, the other day, so I appreciate your tutelage. Clearly, I still need more lessons in getting the name pronounced correctly. I apologize.

DREW GONSHOROWSKI: Oh, you got it.

HARDIN: So thanks so much. Dr. Janousek. Welcome.

THOMAS JANOUSEK: Thank you. I'm excited to be here today. All right.

HARDIN: Take it away.

THOMAS JANOUSEK: OK. Good afternoon, Chairman Hardin and members of the Health and Human Servi-- Human Services Committee. My name is Dr. Thomas Janousek, T-h-o-m-a-s J-a-n-o-u-s-e-k. And I'm the Director at the Division of Behavioral Health in the Department of Health and Human Services. I'm here today to begin the confirmation process. I want to thank the Health and Human Services Committee for their support since beginning work at DHHS at 20-- in 2022. It is genuinely an exciting and humbling experience to be appointed to be a part of the Governor Pillen's cabinet to serve Nebraskans in the role of Director of the Division of Behavioral Health. I'm a Nebraskan, native-born and raised in Lincoln. I graduated from Nebraska Wesleyan University, and I received a Masters of Marriage and Family Therapy in 2013 and a Doctorate of Clinical Psychology in 2015 from the Forest Institute of Professional Psychology. I completed my American Psychological Association accredited internship at the Robert J. Murney Clinic in Springfield, Missouri. I am a licensed psychologist. And in my clinical work, I have balanced my practice between delivering psychotherapy services and completing psychological evaluations. I've worked with populations ranging from individuals with general mental illness, substance use, dementia, head injuries, and professionals requiring assessment for misconduct. I was the Vice President of Quality and Compliance at Burrell Behavioral Health, the second-largest certified community behavioral health clinic in Missouri. There, we spearheaded quality improvement initiatives, maintained accreditation standards, and helped develop user-friendly approaches to compliance and auditing. Du-- during my tenure, we maintained the highest level of Commission on Accreditation of Rehabilitation Facilities accreditation and achieved a historical low for financial recruitment for audits. I brought this knowledge to Nebraska to provide in-depth technical assistance with our CCBHC planning and perform-- and inform Nebraska's remediation efforts aimed at enhancing community integration for individuals with serious mental illness. Prior to my appointment, I served as the Deputy Director of Clinical Evi-- Excellence for the DHHS Division of Behavioral Health. Since October of 2022, I have been responsible for the oversight of the division's clinical operations, including the state's behavioral health prevention services, clinical services, auditing, and provider network management. Our team at the division has worked diligently to foster strong relationships, including developing a strong partnership

with our Division of Medicaid and Long-Term Care and collaborations with organizations such as the Nebraska Medical Association and the Nebraska Association of Behavioral Health Organizations. If confirmed, I'm committed to building upon the progress we have made in enhancing Nebraska's behavioral health system. I will work to ensure that services are accessible, high quality, and responsive to the needs of our communities while continuing to foster coul-- collaboration across behavioral health sectors. We want to create a system that is considerate of provider needs and looks at practical solutions to balance that access and quality of care. My technical knowledge of behavioral health systems brings a unique perspective into the inner workings of our field, and my goal will be to use this knowledge to create a system that is considerate and thoughtful in its approach to solutions. As with any endeavor, the work is not done alone. I am fortunate to stand alongside a dedi-- a dedicated crew of steadpast-- steadfast professionals in our community and at the Division of Behavioral Health, each of whom brings their own unique perspective and expertise. I am grateful for-- to Governor Pillen for his confidence and support, and I'm privileged to serve Nebraska as a part of this administration. I'm honored for the opportunity to come before the committee today, and I look forward to working with each of you. It's truly a passion of mine to improve the mental health landscape and support the well-being of all those in my home state of Nebraska. Thank you for your time. And I would be happy to answer any questions regarding my appointment.

HARDIN: Thank you. And thanks for being here.

THOMAS JANOUSEK: Certainly. Thank you.

HARDIN: Questions? Senator Meyer.

MEYER: Thank you, Senator. I have some experience working with Region 4 Behavioral Health in northeast Nebraska. Unfortunately, this fiscal year, about the time we were ready to implement budgets, we had a substantial retraction of budget. There hadn't been a drawdown-- a total drawdown of resources available to the regions in the last several years. COVID was a factor of that. The expansion of Medicaid-- the, the Medicaid expansion was a factor of that. But for delivery of services in our particular region-- and I would guess in the other regions-- we were fully committed to our providers at the time of that reduction in our budget. So we actually are reducing services. A

quarter of the way into our fiscal year, we had already exhausted our housing budget to provide adequate housing for those coming out of treatment and, and various stages of, of, of treatment. Are you committed to reestablishing those levels of, of budgets in order for us to properly deliver services? And quite frankly, we've had a expanded need of services. We had commitments to fully implement those-- that portion of the budget that we, we have been committed to initially.

THOMAS JANOUSEK: Yeah. And thank you for the question. I will-- I want to talk about the housing funds really quickly. So we've actually been working with Region 4 in addition to the other regions in regards to those housing funds. And just recently here within the last couple of months, we've been adjusting contracts to make sure that they have the money that they require for those housing services. As a little bit of background, we have a documentary stamp tax that funds the housing cash fund, and we've seen that with some-- we've seen a growth in that, so we were able to give additional funds to the regions to make sure that their housing needs were met. In regards to overall services, I know there was a $15 million reallocation back to the state General Fund for-- from the regions for this fiscal year. We've been tracking the utilization of that funding, and we have been seeing that the regions have been on track to keep spending it where in years past they may have been a little shorter. And we've been, with our finance team, kind of tweaking and optimizing that to make sure that the service needs are met. So we're continually monitoring that funding source to make sure that it's getting adjusted. But sometimes it does take a little bit of time to get the contracts adjusted.

MEYER: If I may, Senator. I know from the standpoint of trying to deliver services-- and it's true across the state-- we are critically in need of additional beds, additional spaces frequently. We travel from one state-- end of the state to the other just to find somewhere to place someone. In some cases, we go out of state. Region 4-- and I'm sure it's probably true of the other regions-- we simply do not have sufficient space for folks. The commitment is at this level and the provision of what we have is at this level, quite frankly. Any plans-- and, and certainly I want to work within the confines of our budgets. I am not for raising taxes. I certainly think we-- with proper management of our Department of Health and Human Services, we have sufficient resources to provide what initially we were told over the years we would have available to us. So are you looking at it fr--

at least from the standpoint of the behavioral health group, upping the game, I guess is the way to put it. Give us an opportunity in our, in our regions to certainly provide those services, provide sufficient funds for us to deal with the things we have to deal with at the regional level?

THOMAS JANOUSEK: Mm-hmm. Yes. One of the things that we are definitely looking at here and we're in kind of the early stages of in getting ready to kind of release more information about it, but is getting out our opioid settlement funds and making sure that we're using those to develop our infrastructure in the state. And that's namely a lot of those residential-type programs. So for instance, one of the things that's unique about this funding source is that, based upon how it's been classified in the settlement agreement, based upon how it's been kind of classified with the passage of LB1355 last year, we are allowed to use this funding source to actually build buildings and use capital expendi-- and make capital expenditures. So our Behavioral Health Services Fund currently is statutorily required to provide services. We don't have a lot of opportunity to build things. But with these opioid settlement funds, we're able to actually invest in brick-and-mortar structures or things that we need that we can't typically fund with that other pot of money. So what we are looking at trying to do is stand up more crisis stabilization centers, which are areas where individuals can, you know, receive kind of a pseudo-overnight, semi-residential level of crisis stabilization and even some withdrawal management services in there. And so we've been having a number of conversations, one of which with a provider up in Region 4, to try and utilize those funds and, and grow those types of services across the state.

MEYER: Thank you. I appreciate that.

THOMAS JANOUSEK: Yeah. Thank you. That's a great question.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your willingness to serve. It's good to see you again. And I'm also thrilled that a clinician will be in this-- potentially be in this role. I think you're being a little humble. You've done some really good work in our state as it relates to crisis response and, and-- I

know we spoke about that in our private meeting. I think that's something to be really proud of.

THOMAS JANOUSEK: Thank you.

FREDRICKSON: And, and thank you for that work. I, I do have a little bit of a follow-up question to Senator Meyer's question. Do you, do you feel behavioral health services in our state are adequately funded?

THOMAS JANOUSEK: It's a difficult question because we have really been coming into a phase of trying to readjust where we had our-- and the Division of Behavioral Health coming off of Medicaid expansion and then COVID. What I would say is that we do have great rates in the state. We have-- for our Medicaid rates on a lot of the core behavioral health services, we have some of the highest in the country. But I do know that providers are often asking for, you know, additional increases to rates and things along those lines. I know working in the field how sometimes that kind of works out practically. I think that, a lot of the time, the need for some of those higher rates can come with a lot of the hoops you have to jump through to get the most out of what you can potentially build. I think that what we need to do a better job as a state is be good facilitators of looking at how to optimize the services we have, whether that's looking at service definitions or making any kind of meaningful tweaks to say, hey, if you do this, you can do these extra things, and that's-- means you could potentially be more productive. I think on the DBH side, we need to do things to support needs of clients to help make better use of that funding. So for instance, if there's anything we can do with, like, help transportation or fund projects that helps get clients in the door or help those clinicians be more productive, those are the things I want to target just simply because I don't think we've really had focused conversations on how to make those changes that help those providers, you know, render more services effectively.

FREDRICKSON: Sure. Sure. One more question, if--

HARDIN: Sure. Yep.

FREDRICKSON: So the other question I have for you-- and I, I think you bringing your experience in, I believe it was Missouri with CCBHCs I think is fantastic. And I'm wondering if you might be willing to sort

of share with the committee what role you might have now that we have enabled that model here in our state. How do you sort of view your role in helping oversee where, where that's going?

THOMAS JANOUSEK: Yeah. We-- so I'm very much involved in still-- the implementation of the program. So we, we kicked it off well over a year ago with kind of doing the initing-- initial planning of the-- how this is going to work out, defining our services, establishing what that array's going to look like, deciding what the, you know-- we can make some state requirement tweaks to the program to deviate from the federal resp-- part a little bit. I-- this thing's kind of my baby. I, I want to make sure that we see to this to the end. And I-- we-- even just today, we were-- we have regular office hours with the providers that we've selected. And I'm in those conversations, continuing to make sure we're troubleshooting stuff, bringing it back, having conversations, insisting that we have continued communication with the providers. Because as much as they're learning to transition to this system, we are too. And maintaining that communication-- I mean, I feel like this is why I was-- I came here to implement this program. So we've had a very wonderful partnership between us and the Division of Medicaid, and we just-- we're, we're dead set on making sure this thing is successful.

FREDRICKSON: Great. Thank you.

THOMAS JANOUSEK: Yeah.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. And again, thank you for your willingness to serve. How do you measure success in behavioral health?

THOMAS JANOUSEK: So-- ooh, that's a good question. You can talk about it clinically on, like, kind of a small scale, and then you could talk about it maybe larger on a, a greater scale. On a, a smaller scale, I think what needs to be done is we need to be looking with providers to talk about how we capture data on things like access times and actual quality of care. I think sometimes at the provider level, particularly when you're having to do a lot of fee-for-service work, capturing data on client outcomes is sign of a challenge. And then having to go through an additional reporting requirement to make sure that the

state is getting that can be a challenge as well. On a state level, it's ensuring that we're keeping track of individuals served and seeing growth in that. But I think kind of on a more personal level, it's just making sure that we're having individuals receive good quality of care, and we're hearing about that from providers, from clients themselves, and knowing that whenever there's a gap or a need that we're able to meet that need for them.

BALLARD: OK. I have one more question, if I may, Chair. It-- so it's, it's-- through serving on this committee, I kind of realize that a lot of providers, behavioral health providers in the department, they work in silos.

THOMAS JANOUSEK: Mm-hmm.

BALLARD: How do you-- how do you expand in making sure you're all working towards a cohesive goal? And what's your role in that?

THOMAS JANOUSEK: Sure. So you-- when you say silos in the department, do you mean just providers in the state or across--

BALLARD: Yes. Yes. Yes.

THOMAS JANOUSEK: OK. So I think it's-- it has to do with a lot of the continued conversations with our provider associations. So as I mentioned, the Nebraska Association of Behavioral Health Organizations, they're a really big group that makes up a lot of our community mental health centers. And we're always continually having conversations with them to see what their needs are, how we can collaborate. We've had some very good conversations about, you know, moving into bringing up different services, working through the CCBHC program. My-- I, I do understand the need of, of-- or, the concern of working in silos. And I think it's our goal as a division to help kind of strategically drive those groups because it's to say, OK, maybe if we come together and we say that every group is having the same problem, that's an issue we can fix that can better improve our system. If we are-- with the CCBHC initiative, we've had a lot of these providers together on these calls. And in addition to kind of optimizing this program, we have seen a lot of the things that they face in terms of the service provision piece, and that's caused us to kind of go back and look at services and say, oh, this might be something we need to tweak and fix because that's going to make

service delivery across the state better. So ultimately, I'd say it's just the continued conversations with that and coming together to form a unified goal on how we approach those issues.

BALLARD: OK. Thank you.

THOMAS JANOUSEK: Yeah. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Again, thank you for being here. I want to start on a little bit-- where is Forest Institute for Professional Psychology?

THOMAS JANOUSEK: It is located in Springfield, Missouri.

RIEPE: Springfield. OK. Thank you. The second one that I have is-- and just in terms of looking at your resume, I'm a big fan of continuity of care. That's critically important. But I look at your resume and-- when you first started out, you were at the first one for one year, second one for one year, third one for two years, the next one for two years, and-- two years. And now you've been here. So you don't have a long record, if you will, of being in one spot at one time.

THOMAS JANOUSEK: I can address the first two. Those are my clinical internship and residency that typically only last one year.

RIEPE: OK. Then I guess my third point on-- would be is, what's the largest number of employees that you've had report to you?

THOMAS JANOUSEK: I think I'm going to have to say it's currently-- because we-- the Division of Behavioral Health--

RIEPE: Excluding this one.

THOMAS JANOUSEK: Oh, OK.

RIEPE: Because you're just brand-new here.

THOMAS JANOUSEK: I would-- at the-- largest number of employees I've had is about 40 underneath me.

RIEPE: 40?

THOMAS JANOUSEK: Yep. In my role over at the Division-- or, I'm sorry, at Burrell Behavioral Health, overseeing their quality and compliance unit, we oversaw our electronic medical record teams, our health information management teams, our risk management and compliance teams. So we had a pretty broad swath of individuals reporting up to us. And it's been kind of nice because it-- the office building with the Div-- core Division of Behavioral Health, it's about the same size of a team.

RIEPE: What, what kind of an organizational structure, though? You certainly couldn't have had all 40 of those reporting directly to you.

THOMAS JANOUSEK: Oh, sure. There was, I believe, four directors that reported up to me, and then their direct--

RIEPE: The board of directors reported to you?

THOMAS JANOUSEK: No, no, no. Director-level positions. I was a vice president. They had four directors that reported to me, and then they each had a collection of staff [INAUDIBLE].

RIEPE: And then you reported to a chief executive of some kind?

THOMAS JANOUSEK: That's correct. Yeah.

RIEPE: OK. Have you ever fired an employee?

THOMAS JANOUSEK: Unfortunately, I have.

RIEPE: Oh, that, that's, that's a growth moment. What would you describe as your organizational management structure? How do, how do you-- how do you work with staff to gain motivation, to get communication, to get all that kind of-- what's your philosophy on that, if you would, please?

THOMAS JANOUSEK: It's truly been about keeping open communication. And I'll say one of the guilty things about being a psychologist in an administrator role: you want to get to know a little bit about everything on everyone. One of the things that I've really valued about work in, in DBH with the staff that we have here, kind of organizationally, just in terms of what's in the office building, we're really one of the smallest divisions. And I am really excited about the fact that, in a lot of cases, I'm getting to know every

individual member on my team. I could go through the division and pretty much list everybody. We get to have meet and greets with one another, and I have an open-door policy. And, you know, no matter who someone reports to, they're usually coming in to chat for a minute. And that's been one of the most valuable things because I think as we maintain that connection in our role and people know that they can have open communication, whether it's to a deputy, to the director themselves, they can-- they know that there's a connection there.

RIEPE: I'm impressed. You have a Wesleyan background [INAUDIBLE], so.

THOMAS JANOUSEK: Thank you.

RIEPE: Thank you, Mr. Chairman.

HARDIN: Senator Hansen.

HANSEN: Thank you, Mr. Chairman. I think Senator Ballard took my job interview question. How do you measure success in behavioral health? And you mentioned, like, make sure their needs are being met. I, I think that's a good governmental answer. But I think maybe from a provider perspective, is that-- there are less needs having to be-- been met I think is how we measure success. But that might be a societal question, though, as well.

THOMAS JANOUSEK: Sure.

HANSEN: I'm glad you mentioned crisis stabilization centers because that was one question-- I know it's something we discussed earlier. I know one of the concerns that I have-- maybe it's in my district, but I'm sure other senators have as well, about law enforcement and their ability to take care or handle situations where they may have to go deal with domestic dispute, other kinds of things where the behavioral health need may need to be met and they don't know what to do with them.

THOMAS JANOUSEK: Correct.

HANSEN: I think that's-- I think that seems to be a, a growing concern I hear more and more every year from law enforcement. And so I know that's one thing you mentioned, that that's one of things we're trying

to work towards, is more-- that's kind of more of an infrastructure, I think, concern.

THOMAS JANOUSEK: Well, I can talk a little bit about where we're going. So with the crisis stabilization centers, those are typically a lot of those areas where they all are, are alternatives for law enforcement, where they can bring someone in and they can receive something if they're a crisis, if they're in a wor-- withdrawal state and then get referred on to additional services. So that's kind of the-- you have your brick-and-mortar type buildings that work for that. But with our CCBHC initiative, we are incorporating crisis response teams into each of these clinics. Most of them have their own, but it allows for more expansion of that. So what the benefit of that is too is it allows for a little bit more flexibility to get mobile crisis response providers out into the community, to partnership with law enforcement. Speaking from experience, when we have these types of-- when we [INAUDIBLE] CCBHC in Missouri, we hooked up a lot of law enforcement with tablets so that they could, you know, Skype right into one of our clinicians that was working round the clock. You know, hey, driving around, find a person, hey, you can talk to someone right away. And so with this model, it allows a lot more for those flexibilities and to fund initiatives like that, where even if you maybe can't get someone directly out there, you have the opportunity to give law enforcement the resources they need wherever they are.

HANSEN: OK. And-- if I may, Mr. Chairman. A couple-- just a couple more quick questions here. I know-- something this committee has wrestled with a little bit, especially last year, and what we hear from providers is the idea of maybe-- if there's a way we can have some kind of provider rate formula that gives a little bit more stabilization to the pro-- provider rate conundrum that we deal with every year when they all come to us asking for more money. What's your thoughts on that? If we're e-- if there's some way we can figure out a formula where providers have some kind of stabilization that-- from year to year knowing what their rates are going to increase.

THOMAS JANOUSEK: Mm-hmm. Yeah. I know that there's been conversations about that, and I'm certainly not opposed to the idea. I just know it's something we have to have a continued conversation within-- with

Medicaid because we really try to move our rates together similarly and match one another for both the populations we provide.

HANSEN: OK. And one other thing that also is a-- seems to be a growing concern in my district and especially in rural Nebraska. Why do you think, from a professional-- from your professional opinion, why is there such an increase, it seems like, in the need for mental health services or problems in rural Nebraska, especially with farmers?

THOMAS JANOUSEK: Mm-hmm. I think it is-- there's a-- it's a multi-factored situation. I think there's a lot to do with stigma sometimes. I think it is-- in smaller communities-- because I've done some practice in smaller communities, when people know that you're going to the mental health center, you know, there's that concern that people are going to talk about it. I think general access is we-- it-- trying to get providers out to rural communities when everybody in the state needs behavioral health access and you can kind of hang your shingle and get-- generate business wherever you need to be, it kind of less incentivizes people to move out to rural communities. I know what-- we try to focus on, though, is bring-- making incentives to get folks out there, get providers out there. We have the Rural Health Advisory Board that we work with on public health that provides tuition reimbursement for-- or, I'm sorry, not tuition reimbursement-- tuition forgiveness or tuition grants to providers that set up in rural areas. And I've been a huge proponent of standing up more sites that are funded through the National Health Service Corps, which is a federal program that provides tuition grants to or for individuals that set up in shortage areas, so.

HANSEN: I hear that. They say it's a stigma issue. I, I, I have a hard time wrestling with that because it-- I-- it's made them more comfortable receiving behavioral services now as opposed to previously? And maybe that's the stigma part you're addressing.

THOMAS JANOUSEK: Well, I--

HANSEN: [INAUDIBLE] I just want to follow up with that. Do you think there's anything, like, environmental or, like, because we have-- maybe there's a depopulation in rural Nebraska, when they're kind of go-- going east, there's less people there, maybe less people to

confide in. I, I don't know there's some other kind of environmental factor you might think there is.

THOMAS JANOUSEK: Yeah. It could be-- contributing factors could be, you know, lower income in certain rural areas. Sometimes-- and, you know, I know we all know sometimes there's lack of access to government services out in rural areas that provides the support that people need to kind of improve their economic situation. And I think those are all areas that we need to work to improve on because, I mean, honestly, as a provider, I can tell you, you know, any amount of psychotherapy isn't going to offset you being in hard economic circumstances. And sometimes that's something we need to look at in terms of providing support for folks.

HANSEN: OK. Thank you.

THOMAS JANOUSEK: Yep.

HARDIN: Again, the supply and demand question-- and we've talked about that quite a bit. Let me approach it from a little different angle. How does a Six Sigma aficionado look at the supply and demand challenge of what's going on with mental health care needs in our state? How do you look at that from that perspective?

THOMAS JANOUSEK: Yeah. So I'm really a person-- and I appreciated that Senator Riepe earlier was talking to Director Gonshorowski about operations, because when I go into a system, I am-- I'm going to say pathologically structured. My team is probably laughing at me right now about how I'm, like, always asking about work instructions and manuals for things. I think as we go into looking at a behavioral health system-- and we've done some mapping with this-- but, how do you look at an individual's continuity of care from start to finish? Like, how do they come into a system? How do they come out of a system? And then what's on the bookends of that that either prevent them from relapsing or continuing on in their recovery in some way? And what-- I, I see that in such a way-- almost like building a process-- which is, you know, kind of akin to the Six Sigma processes. And as we map that out, how do we find the barriers in the way and then how do we meaningfully address them to improve the quality of service?

HARDIN: Very well. Thank you.

THOMAS JANOUSEK: Thank you.

HARDIN: Any other questions? Senator Meyer.

MEYER: If I may. Thank you, Senator Hardin. One of the questions I had-- when I was on the board at Region 4 Behavioral Health is, we get statistics-- you know, emergency protective custody, involuntaries, and, and then recidivism, for lack of a better word, you know, the repeat treatments and things of that nature. And I always had the question, OK, if we have someone that has a history of, of coming to a center five times, six times, eight times in the course of a calendar year, fiscal year, irregardless, what's our next step? And frankly, I don't know that there is a next step to, to, to help these individuals. Could you just give me some idea of, of-- and, and I think-- once again, I think we're, we're going to be required based on Department of Justice and the state of Nebraska in negotiations trying to improve the delivery of services for our mental health folks. What's our next step?

THOMAS JANOUSEK: I love that you asked that question because I want-- I was wanting to talk about this. So one of the things that we're bringing on in the division is a-- we're working on building a 1915(i) waiver to support individuals with serious mental illness, which are typically those folks that are coming out of facilities and have the highest need. What this is going to look like in our division is we're kind of trying to build more in-home supports for those individuals so that they are continually getting a level of care that prevents them from relapsing or recidivizing into a facility. And we are looking at building kind of a case management structure within the division to make sure that folks that have SMI are getting adequate supervision and not falling through the cracks, so that they're getting regular follow-up and having someone that's designated to them. It's super exciting for us because it is truly moving into a service management area for the Division of Behavioral Health, where we typically just manage contracts and process payments, but this time we'll actually be able to start working with clients, having a little bit more hands-on experience, and preventing folks from falling through the gra-- cracks and keeping an eye on them, so.

MEYER: I appreciate that very much. Thank you.

THOMAS JANOUSEK: Yeah. I appreciate the question.

HARDIN: Any other questions? Given the discussion we've had, what would you like to add?

THOMAS JANOUSEK: I don't really have much to add. I think you guys have really asked a lot of good questions. I do like to mention the things that we have going on that's, that's great with some of the programs we offer through DBH. We recently released a same-day access website at dhhs.ne.gov/sameday to get the word out about same-day access providers we have across the state. So we do have a number of them that are, you know, available that could do a same-day scheduling so people can get an intake and start their journey. We have a wonderful 988 system that is our mobile crisis response. We've-- in this last year, we served over 20,000 people with 988. And only 2% of them have resulted in a mobile crisis response. So to say that just talking to a counselor on the phone has been able to divert-- like, someone going out and doing a crisis response-- is huge. And then we also have our no-cost naloxone program, which offers free Narcan and opioid reversal agents across the straight-- or, across the state. And we've seen a huge uptake in that. So I say all those things because I am just proud to know that the community is uptaking on behavioral health services, that we as DBH are being stewards for those services and doing what ultimately my goal is, which is to translate sometimes this complicated system to the average person. So if I had to have a shameless plug at the end there, that would be it.

HARDIN: Very good. I know that Senator Hansen has one more question.

THOMAS JANOUSEK: OK.

HANSEN: I forgot to ask this. Sorry. Mainly because I wanted your opinion on this as well. I think one of the concerns we're going to have as legislators is the growing concern of social media use and-- especially teenage use and behavioral health issues, depression. And there's been some kind of need for us to do something from a government approach, perhaps. What's your thoughts on that?

THOMAS JANOUSEK: I, I've-- you know, I'm generally in support of prov-- improving the mental health of younger individuals. I do think that there is a growing body of evidence that shows that social media is, is being detrimental to the minds of others. There's a lot of

depression that results of comparison. And I do think that there is an opportunity there to make sure that we are looking out for our kids and making sure that they're kind of being protected in the way that they need to.

HANSEN: OK. Thank you.

THOMAS JANOUSEK: Thank you.

HARDIN: Thank you very much.

THOMAS JANOUSEK: All right. Thank you guys.

HARDIN: Proponents for either Mr. Gonshorowski or Dr. Janousek? Any proponents? Any opponents for either of the appointees? Anyone testifying in the neutral for either of the appointees? Seeing none. This concludes our day. Thank you so much. We're going to exec, folks.