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The Committee on Children's Behavioral Health Oversight met at 9:00 a.m. on Friday, October 23, 2009, in Room 1113 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing. Senators present: Kathy Campbell, Chairperson; Annette Dubas, Vice Chairperson; Bill Avery; Colby Coash; Tom Hansen; Amanda McGill; Jeremy Nordquist; and Pete Pirsch. Senators absent: Gwen Howard. []

SENATOR CAMPBELL: We want to welcome you to the second meeting of the LB603 Oversight Committee. We have senators who will be coming and going. Senator Howard, for instance, is on the Education Committee, and she has some things she's trying to get ready for Ed. Senator Pirsch has a child that is ill. So, I mean, everybody will be kind of coming and going. And that's fine. The object of today's meeting is as a second orientation to bring...to make sure that all the senators, obviously, and for you that are coming have a sense of what really is in the LB603 package, the different components of it. And I'm not...I'm going to have the senators introduce themselves and then we'll get right to the agenda. So I am Kathy Campbell from District 25 in Lincoln. And we'll start to my left with Senator Coash. []

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

SENATOR HANSEN: I'm Tom Hansen, District 42, Lincoln County. []

SENATOR DUBAS: Annette Dubas, District 34. []

SENATOR AVERY: Bill Avery, District 28, right here, you're in it. []

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

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

SENATOR CAMPBELL: And our clerk and all around person who takes care of my schedule, make sure that I am fully informed is Claudia Lindley. With that, we are most welcome today. We are going to start with Dr. Boust. And I must say that I added here to the list here because she testified before the Health and Human Services Committee on what was happening with the work force. For the senators, you may want to take a look at the Appropriations information that is in front of you because a portion...each of the bills are broken down by what was appropriated or (inaudible) with an explanation. And this information was put together by Liz Hruska. So you may want to follow as we go along. Good morning, Dr. Boust. We're so pleased that you could join us. Thank you. []

SUSAN BOUST: (Exhibits 1 and 2) Good morning. And I am happy to be here. I have been going around talking about our section of LB603. Yesterday, I spoke in Omaha to a group of African-American counselors. And finished with the discussion and they said, where is the discussion about cultural diversity and health disparities? So I am ever mindful of the fact that the intention of the Behavioral Health Education Center is to be inclusive and to really deal with those issues that the state needs for work force development for behavioral health. I am going to take you through first the PowerPoint slides that I gave you, and I believe there's enough for other people, if they would like them. Our vision is to create an innovative, recovery-focused, and when I asked the group yesterday if they knew what that meant, I didn't see a lot of hands. And so we still have our work cut out for us on that. An innovative, recovery-focused education and training center for the purpose of developing a competent, interdisciplinary behavioral health work force to serve the people of Nebraska. We know that we're in the midst of a behavioral health care crisis and that there are inadequate numbers of behavioral health providers. Many of these are practicing in urban rather than rural areas. So even though I was in Omaha yesterday talking to a group and they felt...a very difficult time getting psychiatric care for their patients and even meeting the needs of their own patients, I could tell them that surely the frustration they feel is nothing compared to their

counterparts in really rural areas who have almost no access to a behavioral health work force. I gave you a picture of the state-designated mental health shortage areas for psychiatry and mental health. And you will notice that there are only two areas there, Lancaster County and Douglas and Sarpy County are not state-designated shortage areas. But even in those counties it is extremely difficult to have the access necessary to really meet the needs of people. Besides being in a shortage situation, we are getting old. I'm of a typical age for psychiatrists in this state. And I actually can see retirement at some point in my future. I don't know when that will be, but the work force is old. And so we know that this is a critical thing that needs to be addressed and was addressed in LB603 legislation. So LB603 passed in 2009 and created the Nebraska Behavioral Health Education Center. And this is the completion of part of LB1083, which was passed in 2004, which required the state to address work force needs as it changed its system of care for the state. What will we do? We're going to increase the number of psychiatrists trained in the state; develop new coursework to support our current providers; develop six behavioral health training hubs in each area of the state. So we will use the behavioral health regions and establish a hub in each of them that will outreach then to smaller communities and utilize Nebraska's existing telehealth network to provide service to rural areas through telehealth. It will be inclusive of all behavioral health professions, from psychiatry to peer support. We have responded to the state's RFP on training peer support providers. No matter how we go on that RFP, we will look to partner with whoever is doing that training and get those folks at the table as part of the work force development effort. Our resources and partners include consumers, families, Creighton University, University of Nebraska campuses, Lasting Hope Recovery Center. We are reaching out to the community colleges that do a lot of the training, especially in the more rural areas, and community-based providers. I know it might be hard for you to believe, but community-based providers have told us that we in academia don't always know exactly what people need to know when they actually get hired. So our plan is to include those people right at the start so that we can actually move towards better curricula that meet the needs when they are actually doing the hiring. Focusing then on psychiatry training, we're going to increase the number of

residents in the department by two per year. Right now we have about 32 residents, total. About six of those are child fellows, that is a separate section of the residency training program. It is a thing that residents do after they've completed their first three years of training. They can go on to a second two years of training, specializing in child psychiatry. So of those 32 residents, we're going to increase by 2 a year until four years from now we have a total of 8 additional residents. It's almost a 25 percent increase in the size of the program. We will involve all residents in interdisciplinary training. We know that we train in silos, that one of the goals of the center will be to bring psychiatry residents, people who are studying social work, people who are studying substance abuse care, that we bring them together. In the real world they have to work as a team. We want to start training as teams. We will increase the training in community-based and rural care. The legislation requires that we have these two residents spend a certain amount of time in rural care delivery. We are going to shift the entire psychiatric training program to that. And so all residents, beginning in their second year, will have tours of rural sites. And beginning in their third year will start delivering telehealth services to those rural sites. So their third and fourth year they'll be doing telehealth to rural sites and other underserved areas. And we will provide supervised telehealth care to rural communities. Our site development, another part of the legislation, requires that we have outreach education sites in each of the six regions of the state. Those aren't required to be developed until 2012. But, of course, we're starting that right now, looking for our partners out there and looking for those hubs where there is already some academic work going on that we can get further outreach going. The sites will be developed with local agreements to develop preceptor arrangements so that students can stay at home and do their training without having to come back to the urban areas so much, to make necessary modifications to curriculum to allow external rotations in sites and provide supervision for the local preceptors who will become faculty members and doing more of the training. We will have one site per region with outreach from those hub sites to more rural areas from there. So we haven't made any decisions on what those would be. But, for instance, if Norfolk is a hub site, they would be responsible for reaching out to Valentine and O'Neill and South Sioux City and other

places in that region. And then the final piece is curriculum development and it is a significant part of our budget. We will creating new curriculum in an interdisciplinary fashion. We're going to use an RFP process that requires a collaboration between academics, those community-based providers who are hiring the folks, consumers of service, and perhaps some government officials, although I see them as less interested in this. Reviewing the national evidence on best practices, developing the curriculum materials, and then disseminating them both into the current educational activity, so while people are getting their MSW, while people are getting their original substance abuse or psychiatry training, for after they've been trained and into continuing education. And we would like to develop some new certificate programs as well, so that folks who have a specialty area that we develop a curriculum that lets them take anywhere from a weekend of classes to six months of extra classes, that they have recognition as an expert in some area, and then use that to let them help their local providers gain expertise. An example of that might be primary care physicians or pediatricians who gain extra expertise in prescribing psychiatric medications to children, which is a very difficult area. And then we also are going to participate in program evaluation, including provider tracking and disseminating those results. We are collaborating with the College of Public Health and Keith Mueller and his group in looking at what are the actual numbers, where are they located, how old are they, what are they actually doing, not just the information you get from the licensing bureau, but really on the ground what is the real access out there. We will have an interdisciplinary training site that will be our model, hopefully, to be disseminated to other areas of the state. We will be developing that first at Lasting Hope Recovery Center. And we will be teaching teamwork and shared supervision, involving peer support providers in the training at that location. And we're moving along fairly well with them in getting that, probably start someplace right after the first of the year. Telehealth will cover both distance service provision and distance education. And for us that frequently doesn't mean just the distance education as you would see in elementary schools or classrooms but to a large extent distance supervision so that people can stay in their local communities and get the distance supervision that allows them to improve their

skills, to finish their education, and not have to leave their local communities to get their final degree. We'll be leveraging the existing telehealth network, accompanied by in-person rural visits and rural healthcare education, and collaborating across the state to bring education to new locations. I'm giving you a map of the existing Statewide Secure Information Network. I'm sure you're aware that the state has plans to invest significant federal dollars in mostly electronic medical records, but that will have a very close connection with this. And we plan to work with them to see how we can dovetail with that. If you're having to collect...connect local doctor's offices to high speed internet, then let's also get the education and the supervision going right along with that. And then our outcomes are to improve rural recruitment and retention, provide more psychiatric residents, improve statewide access to high quality care, and improve the quality of behavioral health training. Those are our plans. I've given you a second document which is just text. And the first part of this document is just a review of the legislative language. The Behavioral Health Education Center was created July 1 and shall be administered by the University of Nebraska Medical Center. We had to have a holding place, someone accountable, and so the decision was made to put that in UNMC. And the rest of those, (a) through (f), give you the legislative language, the requirements for the center from the legislation, including increasing the residents; having them do rural training; increased use of telehealth; analyzing the geographic and demographic availability of the work force; and prioritizing the needs for more training; establishing the learning collaborative, which is the term we use for that curriculum development arm; and then beginning in 2011, develop two interdisciplinary sites per year until we have a total of six. Immediately below that I've given you our current personnel. We have contracted with WICHE, which stands for Western Interstate Compact for Higher Education. Compacts for higher education are nonprofit groups that band together universities to increase their purchasing power, to solve problems, to spread expertise across universities. The Western Interstate Compact for Higher Education does not include Nebraska. We are in Central. But WICHE has tremendous expertise in behavioral health work force development in rural areas--Alaska, Montana, Idaho, Arizona, New Mexico. And Dennis, for those of you who don't know him, was

actually in HHS here for some period of time. So he knows the state, he lives in Lincoln. And so we're going to use their expertise to get us up kind of running quickly on some of these things. I am the interim medical director. We will have a national search to see if there is somebody out there who can do this better. If we could get a full-time person who's being doing this someplace else, I would love to find them. Michael Rice is a Ph.D, APRN nurse at the College of Nursing at UNMC. He has success...he's been here about a year and a half now. He has successfully gotten more money from HRSA than the state gave us for the whole center. And we're collaborating with him. He has 20-some RN students who are remaining in their home communities and getting supervision through his grant to become psychiatric nurse practitioners so they can prescribe in rural areas. And we're going to partner with him, trying to get...some of those sites will be the sites that we choose for our rural site development, getting psychologists, APRNs, psychiatrists kind of focused in an area and really get some good education going in more rural areas. And then Tom Svolos, who is in Department of Psychiatry at Creighton and their vice chair for education, is assisting us as a consultant in bringing interdisciplinary education at Lasting Hope Recovery Center. And I have one part-time coordinator, new job posting yesterday. So hopefully get more help going. A list of our current projects. We will have an IT summit, Information Technology, this is kind of a very moving target, even though it is next Friday, we're bringing in an external speaker, Louis Fox. And the purpose of that summit is to pull together everybody who is doing distance, telehealth, behavioral health right now. What are they using for their equipment. We have some money to purchase equipment and I wanted to do it wisely. So we're bringing together everybody who is currently doing this, seeing how we can leverage through collaboration to take the resources we have and really have them be of greater assistance. We'll be looking at where in the rural community you can actually hook up for telehealth and bringing on-line in this conference some rural folks to help us identify the barriers to then. We will have Web site development, which is occurring right now. Suicide assessment and documentation module, that came out of discussion last year that our residents and our LMHPs maybe don't have adequate training in the...especially the documentation. I think they do a good job of the

assessment. The documentation is terrible. So we're going to have a module on that, and that's our first RFP. We have an Interdisciplinary Education Network going on at Lasting Hope Recovery Center. We have a plan for the Rural Health Education Network, every year the RHEN network takes a week right at the end of school, in the spring, and they bring students from across the state, juniors in universities and colleges across the state, and they bring them to UNMC and immerse them in a week of education. This week's education will be on behavioral health. So we're planning that curriculum right now. We will have an advisory council for the center that is being developed just to give us some folks from across the state that can take that 50,000 foot level that what we're doing, the priorities we're setting, it requires us to make a presentation like this on a kind of regular basis about how we're spending the money, the priorities we're setting. So we'll have an advisory council that will include government officials, those agency personnel, law enforcement, consumers, family members, and academic institutions. And then we're doing outcomes research on work force development. So that's where we are right now. []

SENATOR CAMPBELL: Thank you, Dr. Boust. Questions from the senators? Senator Avery. []

SENATOR AVERY: Thank you for your testimony. One of the problems we have in this state is brain-drain. Some of our best and brightest get their education here and take off to other places. Do you have any plans? I know you mentioned retention. Do you have any specific plans to make sure that those new people trained in psychiatry stay here? []

SUSAN BOUST: We do have a process right now that we are trying to improve in looking at why psychiatric residents leave. I have a resident right now who is one of our best and brightest. He does happen to have been born and raised in a foreign country, and that is a problem for psychiatry across the United States. And I heard a wonderful presentation about two weeks ago, at a national conference on psychiatric work force, by a doctor named Robert Michael's, who is the head of Cornell. and his prediction,

Robert tends to be a little bit of a naysayer. His prediction is that ten years from now we will have difficulty recruiting anybody into psychiatry. I think that's a little pessimistic. But when medical students follow doctors around, they are not only learning, they are making the decision what they are going to do when they grow up. And psychiatry of all of the medical fields is one of the three lowest paid. The way our healthcare funds medical care, the three lowest paid are the three you need the most--psychiatry, family medicine, and pediatrics. And so, you know, recruitment includes making better working environments. I know what my salary looks like on a healthcare budget when you compare me to a social worker or a psychologist or a peer support provider. And so the people who run these programs, they want me to see patients at every 15 minutes. I mean, I'm expensive. Well, at the end of a day like that, if I do three days in a row of 15-minute appointments with people, I'm gone, my brain is gone. So you have to do something about the work environment. And my plan for that is to do better teamwork. If you use the psychiatrist as the head of a team, and use the expertise of the nurse and the social worker, you don't have to just have the psychiatrist grinding out 15-minute appointments, and you don't break the bank on the budget for the agency. But it really requires teamwork. So, I guess, the answer to your question is, you know, we've looked at many things. There are federal programs, there's loan incentive programs, there are many ways to do this. I think we're just at the beginning place of looking at why do people leave and what can we do to turn that around. One of the things that I'm really, have my finger crossed, is that as we get our residents out to these rural areas early in their careers, they can start to develop those long-term relationships so that they can get recruited and stay in the state. I don't think the center in Nebraska is going to change the fact that psychiatry is the highest...the specialty that has the highest foreign medical graduates. I don't think we're going to change that overnight. But I think maybe by developing relationships, we can get some of our best and brightest foreign medical graduates to feel comfortable in our rural communities and our rural communities to feel comfortable with them. They're good doctors. And I have myself over the years tried to get them hired in Kearney and Minden. And the communities, if they'd just come in for an interview, and they don't know them, anything, other than on paper, they don't want

to hire them. So...and what I'm saying about psychiatry goes as well for social work and substance abuse counseling. I think working in teams, these are problems that require teams. These aren't problems that any individual practitioner hanging out their shingle and doing behavioral healthcare can really meet the needs of the people in the state, that the state is otherwise responsible for. []

SENATOR AVERY: Are these foreign students on scholarships or any kind of grant money to pay for their tuition, fees? []

SUSAN BOUST: No. []

SENATOR AVERY: The military uses a program whereby they train doctors and then the doctors have to pay back for the training by committing to so many years of service. That's an idea that we ought to maybe look at for this area. []

SUSAN BOUST: And in fact, that does happen here. One of our former residents worked at Kearney for three years on exactly that kind of loan repayment form. And, I think, the experience in the Kearney-Grand Island area is the best. They get people for three years and then they go. That's better than not having anybody there. But it doesn't deal with the issue of what do we need to do in our communities so that this...so that you really get the folks who stay and are the doctor for the area. So, I think, we're interested in that kind of loan repayment process. There is also the issue of waivers. The residents who come in as foreign medical graduates are on special waivers for their ability to stay and practice in this country. And there's J1 waivers, and H1 waivers. So it becomes very complicated. I think rural communities would be very appealing to some of our residents who are in J1 waivers and have to be in designated underserved areas, if we can get those relationships going so that they feel they have a quality of life, and the community feels they can trust them. []

SENATOR AVERY: Thank you. []

SENATOR CAMPBELL: Senator Nordquist. []

SENATOR NORDQUIST: Yeah. To what extent has the telehealth network been used so far for provision of behavioral healthcare? []

SUSAN BOUST: I'll be able to answer that better after next Friday. But let me tell you what I know right now. I was at a meeting yesterday with the Veterans' Administration. And they have a tremendous amount of federal money to extend veterans' services, behavioral health services to rural Nebraska through telehealth. So we're planning on partnering with them. We have one of our special residents in the child psychiatry program. We have two pediatricians who have gone back to residency training to get the extra three years they need to be a child fellow, to be a child psychiatrist. So these are people who are already pediatricians. They're from the state of Nebraska. They're living in Omaha right now. One of them is delivering child psychiatry services to her home community over telehealth. We have geriatric psychiatrists who are doing statewide telehealth for nursing home residents who don't have access to a psychiatrist. I know that the issue...we're using the statewide network. And one of the issues is that last mile, so these folks still have to leave the nursing home, come to the hospital, it's a tremendous amount of work for the providers on the rural end. And they get no payment for that. I mean, you know, Medicaid will allow the billing for the session, but it doesn't allow any money to support the distance service system. But we are doing that. And that is very expensive. Kearney-Grand Island area has been a leader in this state in delivering telehealth services and they have tremendous outreach, mostly by master's level counselors doing therapy at distance. There's not, other than the nursing home and this child psychiatry thing, we don't have a lot of psychiatrists doing it because even in the Omaha area, you know, it's four weeks out for a new appointment. So we're going to have to carve that time out, even though there's great need in Omaha to do it. So I know there is some going on but it's not as much as we would like. []

SENATOR NORDQUIST: Is there infrastructure in every critical access hospital, rural hospital, and regional hub? All those have access. []

SUSAN BOUST: Absolutely. []

SENATOR NORDQUIST: And then outside of that it's slowly, some growing, or is it pretty limited outside of those? []

SUSAN BOUST: Well, see to get outside the critical access hospital, that's what I talked about with that last mile. If you have the T1 line, the secure line run into the critical access hospital, you can't run it from there to the doctor's office or to the nursing home. And so one of the things we're going to explore and actually the reason that we decided to have this October 30 summit we're calling it is because there's significant numbers of people who want to move away from the T1 secure line and go with high speed internet access and then secure software, such as Adobe Connect or Acrobat Connect so that they can get that last mile. []

SENATOR NORDQUIST: Sure. []

SUSAN BOUST: So those are all...I mean, it's proving to be complicated. []

SENATOR NORDQUIST: Sure, sure. Thank you. []

SENATOR HANSEN: Thank you. Thank you, Doctor, for being here this morning. Sounds like an Australian practicing on his billabong or something. (Laughter) []

SUSAN BOUST: A dentist. []

SENATOR HANSEN: A dentist, that's even worse. (Laughter) On your presentation here, box number 10, it says, provide supervisors for local preceptors. Is that a

mentoring type of process or are preceptors and mentoring interchangeable? []

SUSAN BOUST: To some extent, yes. If you look at a primary care doctor in a rural community who's doing service delivery and we want them to assist with supervising behavioral health folks who are in their area, we have to make them faculty. And believe me, academia has its own set of rules. Its accreditation bodies are very difficult. So this is the issue to do that faculty development. We're doing the same thing at Lasting Hope where those are people who are hired to do service delivery. And we need them also to be faculty. We need...and the state needs that. I mean, I know that you're aware of the issues of funding for PLMHPs and provisionally licensed psychologists and provisionally licensed substance abuse workers. You cannot build a work force if you don't have people who are in training, seeing patients under supervision. And you can't expect people to do that for 3,000 hours if they can't eat while they do it. So this is the piece for us that is talking about how are we going to make sure that those provisionally licensed folks in rural areas still have adequate faculty supervision so that their training happens. []

SENATOR HANSEN: Will the provisional license go to a family physician? Could it go to a family physician? []

SUSAN BOUST: It's not a licensing issue for the faculty member, because they are already licensed. It's more of a faculty development issue so that provisionally licensed people get the kind of supervision we need at that distance site. []

SENATOR HANSEN: When Senator Johnson was here, Joel Johnson from Kearney,... []

SUSAN BOUST: Um-hum. []

SENATOR HANSEN: ...one of his main...he talked about it every time he possibly

could, and that was to get family physicians in rural Nebraska educated in the lowest level of psychiatry as possible, but at least they could diagnose and send that person somewhere where...when and if they needed help. Is that still a background theme for UNMC? []

SUSAN BOUST: Absolutely, absolutely. []

SENATOR HANSEN: Okay. That's what I wanted to hear. Thank you. []

SUSAN BOUST: Absolutely, yes, yes. []

SENATOR CAMPBELL: We'll take one last...oh, sorry. []

SENATOR HANSEN: I have signed several of those J1 forms as state senator. And North Platte has been very good about bringing in foreign doctors. I don't know where they're trained for sure, you know, without looking at their background. []

SUSAN BOUST: Most of the ones in North Platte were not trained by us, I mean, I have looked at them. []

SENATOR HANSEN: But they do come in, they do come in and different disciplinary systems. But the J1 form, I mean, it gets doctors to rural areas. And there's a reason that those doctors come to places like North Platte, too. Because it's a good place to raise kids. []

SUSAN BOUST: It is. []

SENATOR HANSEN: Thank you. []

SENATOR CAMPBELL: We'll take Senator Dubas, and then we'll let Dr. Boust go. []

SENATOR DUBAS: Thank you very much, Senator Campbell. Thank you, Dr. Boust, for being here. And Senator Hansen's question is a nice segue into my question. I have been working and talking with providers in my area about the provisionally licensed mental health providers as well as other provisional licenses. And some changes are being made as far as provisional licenses. Medicaid won't reimburse anymore unless they're within an accredited agency. And I understand that's for oversight and making sure that care is quality. And I have no issue with that. But as I talk to my rural providers, where there's not a lot of accredited agencies in the more rural areas, they're saying this is a huge drain on their work force. And if we can't get people out into the rural areas to train, they're definitely not going to come out there and work or they're not going to stay. And so, you know, there's been a study done by, I believe, Magellan that says outside of a couple of counties in rural Nebraska, they all have access to mental health providers. Your information is saying that's not necessarily so. Do you have information about the ratio between the number of providers versus the number of clients? And would there be a way for us to maybe work through telehealth or some other ways so that we could have adequate supervision of these provisional licenses without them not having to necessarily be within an accredited agency? []

SUSAN BOUST: I believe all of that can be done. I think that's the essence of what Dr. Rice is doing with APRNs, you know the distance supervision. So when I talk distance education, I think our initial, big push will be on distance supervision of exactly this kind of thing. I think we need to continue to work with the state on exactly this kind of issue. They want a work force and they want a good work force. And we have to look for those solutions that get them what they need and what the clients need in those rural areas. []

SENATOR DUBAS: So do you have any idea about a ratio between clients and... []

SUSAN BOUST: What we...the College of Public Health has those numbers. And they're not on the top of my head. Yes, they're...we do have by county the number of

hours of psychiatric, social work, LMHP, all of that care is available by county. And I could get that for you. []

SENATOR DUBAS: Okay, I would appreciate having that information. []

SUSAN BOUST: Would you like that? []

SENATOR DUBAS: Yes, thank you very much. []

SENATOR CAMPBELL: Thank you, Dr. Boust. I'm sure the senators can appreciate why the Health and Human Services Committee got excited. The testimony that we took that day was on improving the work force for behavioral health. And this was just one component that we heard. But I'm very pleased that this part of the LB603 package has a roaring start. So thank you very much. []

SUSAN BOUST: Thank you for letting me come. []

SENATOR CAMPBELL: We will return to you a number of times. Thank you very much. Just for the senators who have an agenda in front of them, we will next go to Director Chaumont. And I know that she is here. I believe that Director Reckling and Ms. Chilese are going to trade times because of a conference or a meeting that needs to take place at the department. So we will be making that change. Again, I would refer you to the Appropriations information that Liz Hruska put together for us. She was, again, scheduled to be here, but she is ill. And I don't want to minimize the information, because she's put together a great bit of information, financially. Good morning. []

VIVIANNE CHAUMONT: Good morning, Senator. []

SENATOR CAMPBELL: How are you? []

VIVIANNE CHAUMONT: I'm great, thank you. []

SENATOR CAMPBELL: Today we are going to hear an update on how we are working with the CHIP program, the state health, with the Kids Connection and also the waiver application for community-based secure and subacute behavioral health services. So, Director, I'm just going to turn it over to you and give us an update. []

VIVIANNE CHAUMONT: I'm Vivianne Chaumont. I'm the director of the Division of Medicaid and Long-term Care at the Department of Health and Human Services. As you all know, LB603 expanded CHIP eligibility to 200 percent of the federal poverty level from 185 percent. And the expectation in the fiscal note was that this would increase coverage for about 5,400 kids in Nebraska. So it went into effect September 1. We went ahead and implemented that change. We have advertised the change. We, every year, we provide information to the schools, provide brochures and other information about CHIP enrollment to the schools when they start school. We have a Web site that details the health coverage, including the mandate to go up to 200 percent. And that site, through ACCESS Nebraska, allows application for CHIP to be completed by paper or electronically. There's also links in the Medicaid Web site regarding the new CHIP eligibility. We sent brochures, new brochures to all the local DHHS offices and to providers have been supplied with outreach materials regarding the new eligibility standards. We've sent out a bulletin as well as other notices to staff that...to make them aware, make sure that they're aware of the 200 percent change, and we've sent our press releases regarding the change. To date, I just got the September numbers not too long ago, and we had an increase in CHIP kids of about 700 kids between August and September. I don't really believe that this is probably as a result of the change. When kids go back to school we tend to see enrollment go up a big just because they get the information in their back to school. One interesting thing that I noticed in the data, an by the way we track eligibility of all types, but kids eligibility specifically by the kids that are eligible for Title XXI, the kids that are...which is CHIP, the kids that are eligible just for Medicaid, which is Title XIX, and then a total of them. Then we track to see how they go

up and down, month by month, year by year, all of that. And I thought it was interesting that...well, the numbers of kids in CHIP have been increasing in Medicaid, that the children in Medicaid have been increasing dramatically in the last nine month, most of the increases in Medicaid rather than CHIP. I think that's as a result of the economy. So that's about all of the information that I have on CHIP, unless you want something else. We don't keep track of specifically kids that were between 185 and 200. We don't...that's not how we do it. We just keep track of CHIP kids and Medicaid kids regardless of how they get to be in the program. []

SENATOR CAMPBELL: Okay. Questions from the senators? Senator Avery. []

SENATOR AVERY: Could I ask you, what kind of information do you put in these notices that go to the schools? I presume that they go in the kids backpacks. []

VIVIANNE CHAUMONT: Um-hum. []

SENATOR AVERY: You know, when my kid was in school, if we didn't dump his backpack out every week, we wouldn't know anything because he never told us anything. That seems to me to be probably not the best way to notify. And what I'm really getting at is when you do notify about this program, what kind of information do you put in there? Do you say, this salary or this amount of income for a family of four qualifies you, or do you say 200 percent of the federal poverty level? Because that makes a huge difference to the person reading it who may not have any idea what the federal poverty level is. []

VIVIANNE CHAUMONT: Um-hum. To start at the first part of your...you're lucky you got things at all. I have three kids and I pretty much never got anything. I had one responsible child out of three. (Laugh) But we are required by federal law to send that information to the schools. We actually send it not initially when they first come to school, but we send it a little bit after school starts. And my understanding, I was told

that that was at the request of the schools. And it might be for that very reason that when you first start school we all know you get tons of paper, if you're lucky to get anything at all. So that's a federal requirement that we have to comply with. You know, I don't know the answer to your question about does it talk about...it talks about benefits and how to apply. I know they send an application, those kinds of things. But I will be happy to get a brochure and send it to all of you. []

SENATOR AVERY: I would like to have that, I would because it seems to me that the kind of information that you use in your notification really does make a difference. Do you send an application too? []

VIVIANNE CHAUMONT: That's my understanding, um-hum. []

SENATOR AVERY: With instructions on how to fill it out, all of that. []

VIVIANNE CHAUMONT: Um-hum. I'll check on that as well. []

SENATOR AVERY: You know, one of the problems that you might be running into is that a lot of the people who might be eligible for SCHIP may not have computers, so they may not be able to get the application on-line. And the only thing left then is if they bump into it somewhere at a clinic or if they happen to discover it in a kid's backpack. []

VIVIANNE CHAUMONT: Um-hum. Well, they can get the application, they can go to an area, to a service area as well and apply in person there. []

SENATOR AVERY: So you are following a federal mandate. But you could, as a state agency, you could use different methods of notifying eligible families. []

VIVIANNE CHAUMONT: The only federal mandate is to send the information every year to the kids. So the other things that we do is we've just done that because we

chose to do that. The only federal mandate is to do the other. []

SENATOR AVERY: But we have the information in the Department of Revenue. We know who's eligible or we can find out. []

VIVIANNE CHAUMONT: Um-hum, um-hum. []

SENATOR AVERY: Why not get that information and then send those eligible families an application with the information on how to enroll? []

VIVIANNE CHAUMONT: We haven't done that. We have signed up to...one of the health centers, federally qualified health centers in Omaha submitted a grant that we supported. And we will be working with them. And they are going to be doing outreach to increase CHIP enrollment. And that will cover a big portion of the population. But we haven't done what you are talking about doing. []

SENATOR AVERY: But it could be done, wouldn't you admit? []

VIVIANNE CHAUMONT: It could be done. []

SENATOR AVERY: Well, maybe you'll see a bill on that. (Laugh) []

SENATOR CAMPBELL: Senator Nordquist. []

SENATOR NORDQUIST: Thank you. Thank you, Director Chaumont. Along the lines of the application, do we do...what kind of outreach do we do in Spanish language? []

VIVIANNE CHAUMONT: All of the materials are printed in both. []

SENATOR NORDQUIST: Okay. As well as the school one as well? []

VIVIANNE CHAUMONT: Um-hum, the brochures and the application, there's a Spanish application as well as an English. []

SENATOR NORDQUIST: Okay, okay. And I want to thank you on the...in One World and the South Omaha Community Health Center received, I think, it was $700,000 to do a really...outreach procedure that I think will fit the community really well. I want to thank you for partnering with them on that. We had some correspondence over the summer and I got a letter from you about the department changing the renewal time from 6 months to 12 months, in January. Is that...it says, effective January 1, DHHS changed the renewal...review renewal time of CHIP cases from 6 months to 12 months. The new policy eliminates six-month income reviews by DHHS staff. []

VIVIANNE CHAUMONT: I believe that's part of the transition that's going through with ACCESS Nebraska. []

SENATOR NORDQUIST: Okay. So now if someone becomes eligible, the only way they would be kicked out or whatever during the 12 months is if they self-reported or if there was revenue, Department of Revenue can verify. []

VIVIANNE CHAUMONT: Well, they need to self-report if there's been a change in there. But we're not looking at every application. If they self-report then, yes, you have to. []

SENATOR NORDQUIST: Okay. Does that, as far as staffing on your side, does that ease...I would assume it would ease some... []

VIVIANNE CHAUMONT: It's for the...the staffing is actually on Director Reckling's side of the shop. And he's coming here shortly, you can ask him. []

SENATOR NORDQUIST: Okay. []

VIVIANNE CHAUMONT: But my understanding was that it was to ease the transition to ACCESS Nebraska. And then we'll be going back. []

SENATOR NORDQUIST: Okay. And then the other question I had, there's been some news cases lately, and as we approach special session we'll be looking at the budget, Medicaid reimbursement rates, the situation that's going on with Mayo Clinic. I know there's a family in Lincoln that I talked to, a family in Omaha as well, that their kids have serious conditions. And Mayo seems to be the best place of treatment. And sometimes in Nebraska there isn't even a place to treat these conditions. And I was just wondering if there was an update on that via correspondence with the Mayo Clinic and... []

VIVIANNE CHAUMONT: I believe they're coming out next week. They called us and asked if they could come to talk to us. I should just make clear that the Medicaid program never send anyone out of state for treatment, unless the treatment is not available in Nebraska. So we always check to make sure that the treatment is available in Nebraska. If it isn't, then through the doctor, the treating physician, we work with the treating physician to a referral. Mayo is a very good clinic. It is not the only clinic that offers the services that are available. And some...we're already working with folks to get them into other places. []

SENATOR NORDQUIST: Okay, thank you. []

SENATOR CAMPBELL: Other questions from the senators on this half? Oh, I'm sorry, Senator Dubas. []

SENATOR DUBAS: Thank you, Senator Campbell. Thank you, Director Chaumont. You've talked about what you have to do to get information to the kids through the schools. Do...like our local doctors, health clinics, like HHS in the regions, are they putting that kind of information out too when they're dealing with their patients or

clients? []

VIVIANNE CHAUMONT: We provide information to the providers to give to folks. And we also have that information in the local offices. And they are supposed to be talking to people about it. []

SENATOR DUBAS: So they do have that information then. []

VIVIANNE CHAUMONT: Um-hum, oh, yes. []

SENATOR DUBAS: Okay, that's what I wanted to know. Thank you. []

SENATOR CAMPBELL: Director Chaumont, on the second part of what we wanted to look at is the waiver application. And I believe this was Senator Nordquist's part of the package. Where are we on that? Have we submitted the waiver? This is on the community-based secure residential and subacute behavioral health services. []

VIVIANNE CHAUMONT: Secure residential, it's not a waiver. We submitted a state plan amendment on June 30. And how that works is you submit your state plan amendment and CMS gets to ask you questions. So on September 1 they requested additional information regarding the rate methodology for the service for that particular service, secure residential. And then they requested the rate methodology for all previously approved rehabilitation, psychiatric rehabilitation services, which is what they're doing these days. The state plan is like pages. And you submit one little bit, and they figure that they can pretty much open up the entire chapter and ask you questions about things that have been approved for 20 years. So that delays things, as you might imagine. But we haven't...so we're working on that. And who knows when, you know, they ask questions, then we answer questions, then they can ask some more. You know, they have 90 days. We have 90 days. We are trying to expedite our responses as much as possible. But it's not possible to expedite their side of things. []

SENATOR CAMPBELL: Did you have a follow-up? []

SENATOR NORDQUIST: Was there...there was a question regarding the categorization of I think it was telecare? []

VIVIANNE CHAUMONT: Yeah, they've...two issues that they've raised regarding telecare, in particular. And we've asked them for specific information. The first issue was that the Social Security Administration, which is different from CMS, which is the Medicaid agency, the Social Security Administration, they oversee the Supplemental Security Income program, SSI. And they have given an opinion that the telecare is a public facility. And that you can't have SSI coverage for a resident that lives in a public facility. So that there is that issue. We've asked CMS. We don't think that it's a public facility, it's privately owned. You know, there's no public governance of it. It's a contractor to public entities. We've asked CMS for clarification on that issue. And then we've learned that they have a new issue which is Medicaid more of a Medicaid issue. And that is that they are considering whether or not telecare is an institution for mental disease, an IMD. And there is no Medicaid funding. If someone is in an IMD if they are over 21 and under 65. So there's this...if you're under 21, Medicaid will fund an IMD. If you're over 65 Medicaid will fund an IMD, but in between Medicaid will not pay for those services. And your an IMD if you're more than 16 beds and basically have more than 50 percent of the people in your facility are there for behavioral health reasons or DD type services. So telecare is two buildings, two separate locations, 16 beds. We didn't think the IMD thing was going to be an issue because there are two facilities with 16 beds each. And they are...CMS is kind of making noises that if they have the same management and the same owner it's an IMD and they don't care how far apart they are. So we've asked for clarification on that issue. And they said they would give us clarification. Then they sent us a letter saying they would not give us clarification, they would rule on the state plan. You know, they would make a decision on the state plan amendment and it would be part of that. Now that's separate, I mean the state plan,

whether or not they approve secure, you know, residential as a service should be separate from whether or not they're going to reimburse these two providers or this provider. But for us they really are tied, because if they're not going to reimburse that provider then kind of the whole point of the bill kind of went away. []

SENATOR NORDQUIST: Yeah. If not, there would need to be a deficit appropriation to make up for that loss of federal funds or some sort. []

VIVIANNE CHAUMONT: I think that would be in Director Adams budget. But, yeah. So we are waiting to hear from them. []

SENATOR NORDQUIST: Okay, all right, thank you. []

SENATOR CAMPBELL: So we have no time line on when we would hear from them is what you're saying? It's too hard. []

VIVIANNE CHAUMONT: Right. They have 90 days. We submit things and then they give us 90 days, then they have 90 days. We have been submitting our things as soon as possible. They've been, and this is not unusual, on the last day. What they do is they say, can you withdraw the state plan amendment to preserve your implementation date to give us more time? And if you don't agree to do that and you don't give us more time we'll just deny your state plan amendment. And then you don't preserve your implementation date. So, you know, you don't really have a lot of choice. So that's the process that we're in, that 90-day, every 90 days. []

SENATOR CAMPBELL: Okay. Any other questions on this segment of the plan? Thank you, Director Chaumont. []

VIVIANNE CHAUMONT: Thank you. []

SENATOR CAMPBELL: Just as a review, this was the portion, this was LB601, and this was the portion that was to make money for us in the sense of offsetting some of the other costs. So Senator Nordquist's questions with regard to when we find this out and if there's a denial has a significant financial impact on the bill. Thanks, Director. Are we making the switch here? Did Director Reckling say you could go ahead. Would you come forward please. And I'm going to ask you to say it one more time. Ms. Chilese,... []

MAYA CHILESE: Chilese. []

SENATOR CAMPBELL: ...who is filling in today for Director Adams who could not be with us. And we are covering, under this topic today, just an update on where we might be on the Navigator, hot line, Family Partners, and Evaluation Services. So we have a large chunk of what probably will not go into effect much until after the first of the year. But it's best for us to have some idea where we are on this program. So, welcome and thanks for filling in very much. []

MAYA CHILESE: Thank you. Thank you for allowing me to pretend I'm Director Scott Adams today. []

SENATOR CAMPBELL: We might want to have you maybe...there. Can you hear in the back? []

MAYA CHILESE: Is that a little better? []

SENATOR CAMPBELL: Is that better? Okay. []

MAYA CHILESE: (Exhibit 3) Okay. So there's a couple points on the handout that I provided this morning. As you know, there was two RFPs covering the Help Line and Family Navigator Services were intertwined into one RFP. And then the Evaluation Services RFP I will also be speaking about this morning. Both of those RFPs have not

reached contract award status. So there's limited information that I can provide this morning, as both of those RFPs are being facilitated by the Department of Administrative Services. I believe, that the Oversight Committee was provided a draft for those RFPs before they were released. So we're delighted to be able to have the opportunity to receive some feedback in sort of a collaborative partnership on the development of those services. So I will review just quickly where those two programs are. The Children's Behavioral Health Help Line and the Family Navigator Services, you will notice, just sort of a brief time line on the top of that page. The RFP was released on July 24. We received three intent to bids and then received three bidders submitted proposals on September 3. Those proposals were reviewed and scored by an independent review team of five individuals. Review team memberships are always private. Then there was an intent to contract that was awarded to Region V Systems as the top scorer of the submitted bidders. Subsequently, there was a withdrawal posted to withdraw the intent to contract with Region V Systems based off of an identified conflict for regions providing behavioral health services as established in LB1083 that specifically clarifies that regions are not allowed to provide additional behavioral health services outside of some specific conditions that would exist. So the withdrawal was made, I think, actually posted this week. And then subsequently an intent to contract with the second point scorer, if you will, the second bidder, second place bidder, which was Boys Town. So at this time there is then an intent to contract with the Boys Town organization. And that is a new turn of events that has occurred this week. And again, contract award has not yet occurred. So the Department of Administrative Services will then walk into the process to establish potentially a contract with that agency. As you know, the bill clearly specified that the service start date is January 1 for the "go live", if you will, of those services. The department is really excited about the initiation of these services. We think that they will add significant value to our system. We're really excited about what data outcomes we might see, not only in the effectiveness of the services, but what they might say about the rest of our system. We're very pleased to have the addition of some statewide family navigators utilizing the strength of the peer support community in our state. There are some providing the services quite well already and

showing great success. So we're really excited to see not only some funding appropriated to that work force, which we feel is of great value to our system overall. So after a contract award occurs and the department will be able to provide some additional information about what will happen, essentially, after that. What we did require in both, actually both RFPs for the service providers, which is really the phrase that we're using referring to the Help Line and Family Navigator Service providers and the post adopt service providers, so we'll use the term service providers in reference to those to differentiate between the Evaluation Provider, which is a separate third party entity. So the service providers for the Help Line and the Family Navigator Services are required to have biweekly meetings, every other week meetings with the department for the first three months of the contract. The intent behind that is so that there would be a real close partnership and ensuring that those services were up and running to meet the obligation of the January 1 start date. And so as soon as the contract award occurs, that will happen and the department will be able to provide then some...a lot more accurate information about where that's moving along in the process, etcetera. And after that three-month period, a requirement of monthly meetings, just to sort of continue how these are rolling out, what are we starting to see happen. The provider has obligatory reporting requirements, of course, quarterly reporting requirements. So the Oversight Committee would be able to receive some information from the department in that sense as well. The Evaluation Services is also amidst the RFP process facilitated by the Department of Administrative Services. That RFP was released on September 18. DAS received five intent to bids, and then also subsequently received five proposals. One of those proposals, rather bidders was deemed to be ineligible also under the LB1083, because it was a Region who was bidding on behavioral health services. So essentially, we are reviewing four proposals from four bidders for that service. And that is as we speak amidst the review period. The intent to bid should, in theory, be posted on November 2. When I say in theory, essentially, that means that that's the projected time line. The review team has the right to request for oral interviews or the time to obtain references if deemed necessary. If that was deemed necessary then the time line would be amended to reflect an extension of that. So we're set for, at least the target date,

would be an intent to contract on November 2. After which time then it would enter into...DAS would enter into the development of a contract award, which at this time is projected for November 16. The intent on the departments then was to get the evaluator contracted early enough so that they would have, and there's a required collaboration between the evaluator and the service providers. That just makes sense. The service providers are required to do their own program evaluation, collect a significant amount of data on their own accord. But the evaluator was also required to then work with the service providers to identify potential data elements, streamline some potential reporting. As you know, the evaluator will be evaluating the Help Line, the Family Navigator, and the post adopt services, so all three the evaluator will be covering, even though the Help Line, Navigator are one RFP and the post adopt is a second RFP. We felt very strongly that it was critical for an evaluator to have an understanding of the entire system and be able to provide reporting in a uniform way to speak about our entire system at large. So we're excited about what that means for us. One of the things that we built into the Evaluator Services RFP was the development of what we'll call sort of a dashboard, much like how the department currently utilizes the COMPASS ratings that you'll see on the Web site now, that are sort of a visual display of where services are at. So we had asked the Evaluation Service provider to propose their approach to that and what that would look like. And then a requirement that they would work with the service providers as well as the department to identify what would be the best reporting mechanism for that. So we're really excited about what will come out of that. We asked the Evaluation Service provider to define their approach to essentially measuring the fidelity, effectiveness and outcomes of those services. As you know, all of the documents that are currently publicly available are on the DAS Web site. So you can find the RFPs, any questions and answers that are a part of that formal process. So that's kind of a quick summary about those two things. I guess, before I move on to sort of a separate section, I would ask if there are questions about those two sections? []

SENATOR CAMPBELL: Questions from the senators? Senator McGill. []

SENATOR McGILL: I do have a question. And I'm not sure who I should be asking this of or if it would have been Scott, if he were here. But I just heard between the three different RFPs that some of scoring hasn't been consistent in terms of what's been scored for. And so maybe there's been some confusion amongst the different organizations who are applying. I'm just wondering how that scoring was structured for each of these? []

MAYA CHILESE: Yes, that's a good question. The RFP is created in such a way, and DAS has a standard scoring process that there is essentially three, actually four components of any proposal that are typically scored upon. An executive summary, the corporate experience section, a technical approach section, and then a cost proposal section. The agency who is essentially bidding out for those services can identify the scoring framework, in other words, how much each section might be worth, although DAS has frameworks in which those would normally exist. Typically, a cost proposal section might rank quite higher. However, in these circumstances there was a very specific appropriated amount, in other words, you can't bid the world, because we don't have that to give. So the points that would be awarded to the cost proposal section were significantly lower than normal. However, there is a standard template on how that occurs. The bidders, upon delivering their proposals, are provided a copy of the evaluation process, in other words, the framework of how that happens. So there is significant consistency in the total points for each of those four sections. There's a relatively well developed scoring system that was actually built into the RFP, the portion that I mentioned called the technical approach, there was a matrix, if you will. You may recall seeing that where there were pages of questions, and then the bidder would provide an answer, question, answer. So it was a very clean, sort of a transparent way in which we're saying, here's our question, you tell us your answer. And then that would be scored on a point system. And so essentially every bidder is scored exactly the same, using that point scoring system. Each reviewer scores...reviews and scores independently of one another, and then submits their total point system. And those are added, averaged, and thus in lies the final scoring. So there really isn't any opportunity

for inconsistencies in terms of how somebody might score. The only inconsistency...well, it's not an inconsistency, but would be if one individual chose to use, for example, if there was a scale of zero to five, zero being low and five, and somebody used the whole scale or somebody just used three, four, and five. However, if any scorer did that consistently throughout and is required to do so throughout their scoring process, then essentially it becomes sort of a wash, if you will, in the end. And then all scores become averaged and that's how that works. Did that answer that question? []

SENATOR McGILL: Yes. []

MAYA CHILESE: So what you'll find on the DAS Web site is the final evaluation document that demonstrates the scores of each of those sections from each bidder. []

SENATOR CAMPBELL: Okay. Other questions before we move on? Okay. []

MAYA CHILESE: Okay. The third thing, the box that's at the bottom actually would speak to on the agenda what you have called Family Partners. I'm presuming...the department is presuming that what's really meant by that is the Professional Partner Program. So just a bit of clarification on that. With the funding that was specifically allocated to be distributed to the regions for, as the bill states, for...including but not limited to the expansion of the Professional Partners Program, which is a wraparound service that's currently being provided through each of the six Behavioral Health Regions. The regions have the opportunity to identify how they wanted to utilize their LB603 funding. The funding, as you see in this box, you can see how that essentially was distributed. But that's distributed through the current formula for which all funding is appropriated to the regions. So that's essentially just a representation of how that panned itself out. You will notice that Regions I through IV chose to utilize their funding to expand the capacity for their current traditional Professional Partners Program. You'll see the box that indicates "estimated capacity." That's essentially the region's best

guess at how many young people that would serve within a current fiscal year. So that much funding would essentially translate into this number of youth in addition. Now the time frame sometimes can vary. Young people are in there anywhere from 12 months to 18 months. So that really is sort of an estimate. But we wanted to be able to present what was sort of a best guess in this moment. As those services are implemented we'd be able to have a better sense of what that looks like. Both Region V and VI provided the department and the division with a potential program plan for a pilot for two slightly different Professional Partner Programs. What's really interesting about these two is they represent themselves to be essentially utilizing the same approach as Professional Partners, but the time frame would be shorter. And the intent is to recognize and honor the need that are oftentimes presented by county attorneys, or in Lancaster County the Youth Assessment Center, for young people or families presenting with help, we're considering relinquishment for wardship either specifically because of a behavioral health disorder or maybe an at-risk youth. You know that traditionally the division has provided funding, and in fact our federal funding usually requires the diagnosis of a mental health or substance abuse disorder. In this particular instances the regions are saying really what we saw at the heart of LB603 was a significant amount of families saying, we've got some high needs. And sometimes those are multiple needs. What we wanted to be able to do...what they're wanting to be able to do was to respond immediately to those request for services. So the intent is a sort of short-term, rapid response, if you will, wraparound programs. So if somebody calls or a county attorney calls and says, we've got a family that's seeking these services, maybe potentially thinking relinquishment, their region would then quickly come to meet that family and identify immediate needs, maybe it's simply connecting to a service or maybe it's in referring them to a service they may provide. The division has accepted those pilots as just that, a pilot, and required then the regions to be responsible for collecting additional data elements. It will be really interesting to see some, we think, some additional demographics--who are these young people, who are their families, what needs do they truly have, is this preventative approach a really beneficial way to supplement our system? So we're really excited about what that means for us. As those, essentially

those programs reach full capacity, probably after January 1, I would imagine, the division would then be able to provide some additional information from those particular regions and their pilot programs about what that might look like and the youth that they're serving. Region VI also, you will note, added...chose to add an adolescent therapist to their Mobile Crisis Response Teams, essentially in support to LB603. And hoping then that potentially as a result, if somebody were to call the Help Line and they genuinely needed immediate mobile crisis response, that that could happen via the Region VI services. So that's exciting as well. So those two particular regions that are piloting these new services are required to present the division quarterly information and data about exactly what I just described, about the program, its effectiveness, the outcomes. And then the division will be able to provide some information to the Oversight Committee about what that looks like for us as well. Any questions on that? []

SENATOR CAMPBELL: Follow up questions and that? I have a question. Is the...in Region V the use of the word "prevention" the same as rapid response? Or are they taking a little... []

MAYA CHILESE: The programs are very similar. What's sort of in quotes there are the region's name, you know, what they propose. So Region V proposed what they were calling a preventative professional partner. Region VI called their "rapid response." Great similarities between the two. Maybe some small differences in terms of the partnerships that they're using or this approach or that approach. All in all essentially it is what is a shorter term, like a 90-day version of the current professional partner services. []

SENATOR CAMPBELL: Do you think that the two pilots then will fold in together after the first of the year with the Navigator? Or will the Navigator direct or direct is not a good word, but advise or counsel families that this may be a program that they want to go into? Or will they be two separate approaches? []

MAYA CHILESE: Potentially, what both regions essentially proposed in their pilot was really a demonstration that they have received over years significant responses for partnerships from, as an example in Region VI the Douglas County Attorney calling the region saying, you know, we've got this family who's looking toward relinquishment, help, what can we do? And trying to sometimes secure the last diagnosis for a young person because our traditional funding requires a mental health diagnosis and demonstration of that. So this service is essentially saying, we're sort of going to waive the need for an immediate demonstration of that so we can help the family find out what their needs are. If there's a true behavioral health disorder we'll help connect to that service or provide it. If it's not, but the family just has some other additional needs, then we'll refer to those. So yes, in answer to your question, the Family Navigator could potentially say, because that Family Navigator service is a short time service. And the intent of that, as you know, is to connect to services. They could potentially say after their time with that individual, let's hook you up with a region, there's a program here that may be of additional benefit to you. []

SENATOR CAMPBELL: Excellent. And that in the region's, the two region's, perception as they've looked at their clients is really a gap in the services at this point. []

MAYA CHILESE: Yeah. We have...obviously, the division has significant questions. Usually when the regions are interested in amending or adding a new service they always have to provide the division with a program plan, sort of, you know, here's what we think, here's the evidence that demonstrates a need for this. We have lots of questions about, gee, this is a new turn for us. And funding potentially nonsevere emotional diagnosed young people, how do we do that? What should we be caring for? And the regions had strong demonstration of this is a real concern for us. This was clearly a concern from LB603. Let's pilot this and see what comes out of the deal. So essentially, that's exactly what we're doing is allowing the opportunity for the service to exist, looking at the outcomes, the indicators, the families. After which, probably, the end of this fiscal year then we would say, okay, where are we now? And that would be

the information that we'd want to present to the Oversight Committee as well to be able to say, does this make sense for what we thought we wanted to come out of this? []

SENATOR CAMPBELL: And my last question is, on the two pilots, will the evaluation component to LB603 also be required to take a look at the pilots? Or will the two pilots stand alone without that evaluation piece in it? []

MAYA CHILESE: Correct, the bill called for the evaluation services and funding for the Help Line, Navigator, and post adopt. So that evaluator was not required to do evaluation of those pilots. The regions, however, are required to do evaluations for any of the services that they would themselves sponsor. You'll also notice, just as a side note, the reason there's X's there in terms of potential capacity is because, obviously, it's unknown at this time. Regions V and VI have both suggested that considering the fact that it's a short-term 90-day, you may be looking at upwards of 80 to almost 100 young people served within a fiscal year period of time. So as that unfolds we'll be able to see what that turns out to be. []

SENATOR CAMPBELL: I'm sure when we all talk about LB603 we've tried to make it clear, particularly on the floor, that we saw this as really a phase I approach here to gather not only the anecdotal information certainly that Senator McGill's group did in talking to the families. And we continue to take in, all of I'm sure are still hearing from families and taking that. But the effort in LB603 was to add to that an evaluative process so that we really have some clear idea, both anecdotally and datawise, what is missing in this whole area of services for children and youth in behavioral health. So it's kind of exciting that the two regions would look at a potential gap in the system right now. I think that's exciting and glad to hear that the department is working with the two. I hope we can fold, make sure that their evaluation information gets folded in so we see the total picture. []

MAYA CHILESE: Yeah, we agree. We're really excited about these initiatives. We think

they will support the intention of LB542 as well. Very excited about the evaluations services RFP. We really left quite a bit of breadth up to the evaluator to say, you know, yes, we clearly want to know about the effectiveness of those services. But we're really interested in what next, what does that mean for us. And that was well established in RFPs. And so we'll be interested to see what comes out of that. []

SENATOR CAMPBELL: Any other questions from the senators? Senator Hansen. []

SENATOR HANSEN: Thank you, Senator Campbell. I have just a basic question. The 90-day period to get a young person without behavioral health issues is not a very long time for post adoptive or post guardian transition into the real world. Is there any concept of stretching that out to more than three months, I mean six months or...and then, I guess, my solution to the problem would be to ask different nonprofits or community foundations or something like that to enter into a mentoring program with the state and help those young people transition into the real world rather that 90 days. I don't know if 90 days is going to do it. []

MAYA CHILESE: Senator Hansen, can you clarify when you said post adopt, I was confused about which service... []

SENATOR HANSEN: Well, isn't that what we're talking about, post adoption and post guardianship? []

MAYA CHILESE: No, sir. No, sir. The pilots that are the 90 days are the funding that was specifically allocated to the Regional Behavioral Health authorities. And that population really is often the non-Medicaid, nonstate ward population. Director Reckling will be speaking about the post adopt services. []

SENATOR HANSEN: Okay. Okay, okay. Sorry. I was thinking ahead, sorry about that. []

SENATOR CAMPBELL: But it's exciting to know that we are beginning to look at that family because so much of this, of what we hear is that, you know, I have to get into the system. I have to be designated, I have to relinquish all of that in order to get the services. So to begin looking at a wraparound service right from the get-go for some of them would be excellent. []

MAYA CHILESE: Yeah. Yep, you're absolutely right. And I think what I would tack to that, however, is there very well may be a family who's post adopt and seeking and may enter in through this particular pilot at which time the region would then connect to the now available post adopt services as well. So there's sort of a requirement across the board that all of these services would be linked together. []

SENATOR CAMPBELL: Excellent. Any other questions, comments? We just want you to know you did a yeoman's job here of stepping in for the director, excellent, excellent. []

MAYA CHILESE: (Laugh) Wonderful. []

SENATOR CAMPBELL: So, hopefully, we can have some conversation in the future because this is your area of expertise. []

MAYA CHILESE: Yeah. []

SENATOR CAMPBELL: And certainly we can tell that your knowledgeable about what's going into those contracts. So thanks a lot. []

MAYA CHILESE: Thank you. Thank you for your time. []

SENATOR CAMPBELL: And we hope that we'll get you back on schedule. []

MAYA CHILESE: Thank you, thank you for that. []

SENATOR CAMPBELL: Um-hum. Director Reckling is going to visit with us today. And now we are definitely on the topic of post adoption and post guardianship serves and also you're going to touch on evaluation services also. Good morning. []

TODD RECKLING: Good morning, Senator. []

SENATOR CAMPBELL: We are glad to have you here. We also are following the information that was provided for us in this area too. []

TODD RECKLING: May I approach? []

SENATOR CAMPBELL: Absolutely. []

SENATOR HANSEN: It's not a courtroom. []

SENATOR CAMPBELL: I don't think anybody's quite thought of that before that. Well, thanks for being the cleanup hitter here, Director Reckling, and changing the schedule for us. []

TODD RECKLING: We'll see. You better wait until after my testimony. []

SENATOR CAMPBELL: Okay. Well, we'll let you go ahead and just take us through it. []

TODD RECKLING: (Exhibit 4) Thank you, Senator Campbell and other senators and members of the committee. My name is Todd Reckling. I'm the director for Children and Family Services. Vivianne and Maya did a great job of covering. And I'll be happy to answer any questions. But I just wanted to spend a few minutes on updating you where my division fits into this, as Senator Hansen started and did a segue for me with post

adoption post guardianship services. We, too, did an RFP. We are in the process right now of finalizing our contract. We did issue an intent to award letter that went to Lutheran Family Services. That will be a collaboration of Lutheran Family Services, Nebraska Children's Home Society, KVC, as well as the Nebraska Foster and Adoptive Parent Association. But our contract will actually be with Lutheran Family Services. We're in the process now of finalizing that contract. DAS is doing some additional checks and references and all the things that they need to do to help us finalize that contract. So unfortunately, I'm not able to speak directly to that contract as of yet, just in case something would happen before the ink and signed and dried. So what you have in front of you is information that was requested through the original request for proposals. I guess, I could approach this two ways. I could either walk you through some of that or let you read it at your leisure. As soon as the contract is signed I will submit to you, Senator Campbell, a letter with specific questions to address what exactly the program and services will be that the contractor will be providing, what will their training program look like, and answer those specific questions of nature that I'm not able to do yet here today. []

SENATOR CAMPBELL: That would be great. []

TODD RECKLING: Would you like me to walk through this a little bit or just let you read it later? []

SENATOR CAMPBELL: I think just a little bit, some of the high points maybe, just to refresh our memory. []

TODD RECKLING: Sure, I appreciate that opportunity. Again, the population that we're targeting are kids that would have been state wards or through Health and Human Services than then enter into a post adoption or post guardianship situation. They can live, as you can imagine, some of these kids stay in Nebraska, some of the families move to other states. So these services would be available for anybody that had a

subsidized adoption or guardianship from Nebraska. The services are, as Maya said, we want to have a connection with the Behavioral Help Line. So the service provider will have to have a number that these adopted parents or guardianship parents can call. But we'll give that number at the time of the post adoption or post guardianship services, so they're aware of these services later on and how to reach the provider. The provider then will work with the family, talk to them about what's going on, what are the needs of both the adults as well as the children in the family or the young youth to really identify what are the needs, what are the strengths, what are the areas to create some individualized services and supports to help get the family through those situations. The contractor then will offer a variety of services. Again, these are examples that were provided. But it could be like support groups or youth groups, respite care, therapy, different types of educational classes or seminars, or just general support or services to help through the crisis. Services are designed to be delivered over about a 90-day period. We'll see at that point how things are going. And certainly we can reassess if need be. And we want to make sure, obviously, that the services are tailored individually to those unique aspects of what that child and family are going through. As far as quality assurance data, certainly the provider has to have that system in place. They will have to do some pretty significant data tracking. As Maya indicated, we also left some flexibility with the evaluation piece of it for that provider to also help us look at some measures and data capturing that will be necessary to measure the effectiveness of not only the post adopt, post guardian services but the other services as well. And so some of that we've defined in the RFP. Some of it will be defined from the RFP for the evaluator and then they will connect with our post adoption, post guardianship provider to make sure all those measures are in place. As far a reporting, obviously, they will need to submit reports so we, in turn, can report out to this committee about how things are going as far as service delivery and effectiveness. As far as startup, we are on time and schedule. And we'll comply with the January 1, 2010 startup time. In the meantime, as soon as we sign this contract, we will start working with them. And we will have conversations at least every two weeks through now until January when they actually start service delivery so we know that implementation is progressing as it should be. []

SENATOR CAMPBELL: Okay. Questions from the senators? Senator Nordquist, I'm sorry. []

SENATOR NORDQUIST: When you present to us about the contract, do you have more specifics on the performance measurement pieces that are included in this as well? []

TODD RECKLING: You bet. []

SENATOR NORDQUIST: Okay. []

SENATOR CAMPBELL: Any other questions? That may be the shortest report you've had to give yet, Doctor. []

TODD RECKLING: I appreciate it, thank you. []

SENATOR CAMPBELL: Don't count on that every time we see you. Okay. Oh, excuse me, Director. Senator Avery, were there any questions that you might have had? Director Reckling distributed a copy of where they are in the post adoption, guardianship issue. []

TODD RECKLING: Senator, can I approach again? []

SENATOR CAMPBELL: Sure, absolutely. We'll make sure that...and any of the senators that could not be here, we'll make sure they get the information. Any questions that you thought you had or needed to ask? Okay. Thank you, Director, very much. []

TODD RECKLING: Thank you. []

SENATOR CAMPBELL: Before we adjourn today, I want to talk a little bit with my colleagues about November and for those of you who always faithfully join us at these meetings. In November, we had anticipated doing two things, if it's okay with the committee. We had decided at that point that we would try to address some questions that have arisen about Magellan. I know that a number of you have taken either letters or calls. Senator Coash and I have had some conversations about questions that have arisen. So we will visit with Director Chaumont of the department. But try to think about that. So if you have had questions about Magellan, if you could send them to our office, we'll start compiling some information. The second half of the November meeting, which is scheduled for Friday, November 20, is that we would provide a time for those of you who have consistently come and joined us, if there are public comments you wish to make about the progress of where we are on LB603. Most of the package will initiate in January. So there will not be a great amount of information that we will share but that we will obviously, all of us, know at this point. What we will share with our colleagues in the Legislature is the background information of the two meetings that we have had in monitoring the beginning of this package. But if you would like to make comments, they are more than welcome in November. If you would like to make them in writing without, you know, needing to testify, you certainly can do that. We also are running an electronic mailing list out of the office. So before you leave today, if you would like to be on that electronic mailing list please see Claudia. And we will make sure that any updates or information that we're putting out that you would receive a copy. That will become increasingly important once we get into session. We won't necessarily have as many committee meetings while we are in session. But we will most likely be distributing any information that comes forward. For my colleagues, is there any other topic, any other information you would like in November that we have not covered? We will probably have Liz come back just to kind of answer any questions on the money for you. But if there is anything, we would be glad to put it on the agenda. I also want to thank Senator Coash for arranging several tours for us in Lincoln, Senator McGill and I and, I believe, Senator Nordquist's staff joined us on a part of that. And it was very helpful. Any other comments that the senators wish to make before we adjourn today?

And never say we didn't get out of class early. (Laughter) Well, we all need it because I know you're all very busy. So with that, we are adjourned. And we will be around to answer any questions. []