[LR533 LR539 LR592 LR596]

The Committee on Health and Human Services met at 9:00 a.m. on Friday, October 24, 2014, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR533, LR539, LR592, and LR596. Senators present: Kathy Campbell, Chairperson; Bob Krist, Vice Chairperson; Tanya Cook; Sue Crawford; Mike Gloor; Sara Howard; and Dan Watermeier. Senators absent: None.

SENATOR CAMPBELL: Good morning, everyone, and welcome to the hearings today of the Health and Human Services Committee. I'm Kathy Campbell and I serve as the senator from District 25, east Lincoln and eastern Lancaster County. I'm going to go through a few housekeeping details and then we'll get started. If you have a cell phone with you, or anything that really makes noise, would you please turn it off or silence it because it's very distracting. If you are providing some written materials for us, we would like at least ten copies, and if you need help, the pages that are here can assist you. We're not going to use the lights today, although I would caution everyone that I'll be the one watching the clock and so we're going to try and keep everybody at least under ten minutes. So if you have a 25-minute slide show, you might want to think about narrowing it down. With that we'll start with introductions from the senators and I'll start to my far right.

SENATOR WATERMEIER: Dan Watermeier from Syracuse.

SENATOR HOWARD: Senator Sara Howard, I represent midtown Omaha.

SENATOR KRIST: Bob Krist, northwest Omaha and Bennington.

MICHELLE CHAFFEE: Michelle Chaffee, I serve as legal counsel.

SENATOR GLOOR: Mike Gloor, Grand Island.

BENNEN MILLER: Brennen Miller, committee clerk.

SENATOR CRAWFORD: And Sue Crawford, I represent District 45.

SENATOR CAMPBELL: And our pages today are J.T. and John. And so they'll be glad to help you if you need assistance. With that, we will open the hearing today on LR533, which is Senator Crawford's interim study to assess the enrollment of former foster youth in the new Medicaid category for youth formerly in foster care up to age 26 in Nebraska under the new federal Patient Protection and Affordable Care Act. Senator Crawford, welcome. [LR533]

SENATOR CRAWFORD: Thank you. [LR533]

SENATOR CAMPBELL: And go right ahead and start. [LR533]

SENATOR CRAWFORD: (Exhibit 1) All right, thank you. Good morning, Chairwoman Campbell and fellow members of the Health and Human Services Committee. My name is Sue Crawford, C-r-a-w-f-o-r-d, and I represent the 45th Legislative District of Bellevue, Offutt, and eastern Sarpy County. I'm happy to be here today to open on LR533, an interim study examining the policies of the Nebraska Department of Health and Human Services regarding Medicaid eligibility for former foster youth. Kaitlin is distributing a handout that summarizes some of our study's key findings. Before I begin, I want to thank the Division of Medicaid and Long-term Care, particularly Ruth Vineyard and her staff for their assistance with this interim study. They provided much of the data we will present here today and I appreciate the time and energy that went into generating those reports. I also want to thank the division for their continued efforts to implement the Affordable Care Act and this provision particularly, and their willingness to seek federal guidance and clarification through the process. The end result of this work is that more young adults will have access to healthcare. I commend the division

for their hard work to make this happen. I also want to thank the service providers and advocates who work with these young people, many of whom are in the room and who I know will work tirelessly to ensure former foster youth understand their benefits and enroll in this coverage. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act into law. As many of you know, the bill's provision included a variety of pathways to insurance coverage and many of these provisions were fully implemented in January 2014. One pathway to coverage under the ACA is for former foster care youth who reach 18 years old, or the age of majority, without being adopted or obtaining reunification or legal guardianship. The state served as the legal guardian for these youth. Section 2004 of the ACA allows these youth to stay on the state's insurance plan, Medicaid, until they reach the age of 26. This pathway to insurance mirrors a similar pathway for other young adults who are eligible to remain on a legal guardian or parent's health insurance plan until age 26. As you can see from the handout, this provision grants Medicaid eligibility for individuals who are in foster care under the responsibility of the state on the date of attaining 18 years of age, or such higher age as the state has elected under Section 475(8)(B)(iii), and were enrolled in the state plan under this title or under a waiver of the plan while in such foster care. This language and the interpretation of this language is important. When I introduced this interim study, the Division of Medicaid and Long-term Care based on this language and guidance they had received from the centers for Medicare and Medicaid, CMS, had determined that former foster youth who exited foster care before age 19 were ineligible for Medicaid coverage under this provision. Our first question in this interim study was to see how many of our former foster youth this narrow interpretation excluded. We learned that as of September 2014, 1,869 former foster youth were discharged from foster care at age 18, while only 1,275 youth aged out of foster care at age 19. So, many more of our former foster youth were being excluded than getting covered under the narrower interpretation. This might not matter if these youth leaving at 18 had coverage through some other provision. Unfortunately, of the 1,800 or so who left foster care at 18, only 36 qualified for Medicaid under some other category. The narrow interpretation clearly was leaving out the vast majority of our former foster youth.

Thanks to the continued hard work and persistence of the Division of Medicaid and other advocates, the department has since clarified their position granting approximately 1,800 former foster youth access to health insurance coverage. As of a meeting with the department a few weeks ago, the Medicaid director agreed to determine if they can access information to go back and locate youth who were denied prior to this policy clarification due to their age at the time they exited the system. And I hope we may hear about the progress on that front today. Insurance coverage for this population is very important for a variety of reasons, not least of which is that former foster care youth are more likely than their peers to suffer from a chronic physical or mental health condition. According to a 2012 report by the Congressional Research office, 35 to 60 percent of foster children enter the child welfare system with at least one chronic physical health condition, while anywhere from 50 to 75 percent of these youth are in need of mental health treatment. Former foster youth are also twice as likely to have a child in their household by age 21. Without consistent access to treatment, these youth are more likely to need crisis response services or utilize the emergency room for treatment which is not the appropriate level of care for the young person and is more costly to us. Part of our interim study focused on the experience of those former foster youth enrolled in coverage under this provision. Thanks to the data provided by the Medicaid, and Children and Family Services Divisions, we learned that these youth experienced an average of ten placements throughout their time in foster care with an average length of time in foster care of approximately four years and six months. As the data shows, these youth who are in the system at 18 or 19 have had significant contact with our child welfare system. We also asked the departments to provide the number of youth leaving foster care system at 18 or 19 by county since 2006, which is the last year that former foster youth could have exited the system and still be eligible for this provision. In my county, Sarpy County, 185 youth aged out of the foster care system over the past eight years. In Douglas County, 1,044 youth aged out of the foster care system; and in Lancaster, 659 youth. Your handout includes ten counties who had the most youth discharged from foster care. And if you'd like any information about any other county that's not listed, I'm happy to share that information with you. During our interim study,

we also asked the Medicaid Division to seek additional guidance from CMS on whether former foster youth who are in independent living at the time of discharge from foster care system are eligible for coverage under this provision. I also reached out to our legislative liaison at the Department of Health and Human Services in hopes of elevating attention to this issue. It is not uncommon for youth to be in independent living at the time of discharge, particularly if they're enrolled in and attending college. The data shows that 34.8 percent, or about 1,000 youth, are discharged from foster care at 18 or 19 were in independent living at the time of discharge. Unfortunately, we have clarification that we cannot cover those youth who are in independent living at the time of discharge. Those youth who were in out-of-home placement for at least some portion of their 18th year, prior to placement in independent living, should be eligible for coverage however. Because this is a fairly recent development, we don't have data from the department to determine how many of the 1,083 in independent living may still be eligible because they were in some other placement at some point in that 18th year. So hopefully some of them...many of them will still qualify because of that provision. With the current clarification of eligibility, we now have over 3,000 former foster youth potentially eligible for this coverage. DHHS has created brochures for outreach to these youth that clarify they do not need income information to qualify. DHHS has also created a streamlined renewal application for these youth that will facilitate easier renewal. I appreciate these efforts at outreach and streamlining, however, only 94 young adults are currently covered under this category. It is clear that we as a state have much more work to do to raise awareness and educate former foster youth about this option. There's also additional work to do to streamline and improve the eligibility process. Many in this room will be partners in reaching out to our former foster youth and I encourage any nonprofit or church group that serves a population that might include former foster youth to step up and help us to reach these youth. Two main issues remain: one, effective outreach to our former foster youth who are 18 to 26; and, two, continuing to streamline and improve our processes for these youth. And we will be discussing ACCESSNebraska streamlining and other improvements and so some of those improvements may fit well into that larger effort. Again, I thank the Medicaid

Division, Ruth and her policy staff for their work to clarify eligibility and to produce outreach materials and their work on a streamlined renewal form to help us to better serve our youth in Nebraska. We have others who are going to speak today to their experiences and their work with these youth. I met some of the youth themselves. But I'm happy to answer any questions you may have now or I can answer questions at the end. [LR533]

SENATOR CAMPBELL: Okay. Any particular questions from the senators today? Thank you, Senator Crawford. [LR533]

SENATOR CRAWFORD: Thank you. [LR533]

SENATOR CAMPBELL: In an interim study hearing there is no pro or con or neutral position; we just ask people to testify. So you are welcome to come forward at any time. I would ask that you complete one of the orange sheets for the clerk so that we make sure that the record spells your name correctly. You're going to be asked to state your name when you come forward and spell it so that the people who transcribe, who listen, make sure that they spell your name correctly. So it's sort of a double-check. So we'll take our first testifier. Good morning. [LR533]

SARAH HELVEY: (Exhibit 2) Good morning, Senator Campbell and members of the HHS Committee. My name is Sarah Helvey, S-a-r-a-h, last name, H-e-l-v-e-y, and I'm a staff attorney and director of the Child Welfare Program at Nebraska Appleseed. On behalf of Appleseed I want to thank you for the opportunity to testify today and share some recommendations for how we can take advantage of this new opportunity under the ACA to make sure all of our young people have the opportunity for a healthy transition into adulthood. We also want to thank Senator Crawford for introducing LR533 and for her commitment to improving access to healthcare for young people making the transition from foster care to adulthood. We also want to thank the department for sharing data as part of this interim study and for their willingness to sit down with

stakeholders and address identified issues. We know that the implementation of the ACA is still ongoing and that guidance and clarification about this provision is still forthcoming. And in light of that, we really appreciate the opportunity that this interim study has provided to bring together interested parties. Today Nebraska Appleseed released a report summarizing some of the data obtained as part of LR533 and making recommendations for how we can improve implementation of this provision in Nebraska. And we've included that report with our testimony today. Since you've already heard some of the highlights from the data, I'm going to focus my testimony today on our recommendations. But first I want to provide just a little bit of additional background on this provision and why it's important. As this committee is aware, and Senator Crawford mentioned, young people who age out of foster care face challenges in the transition from foster care to adulthood and particularly so related to healthcare access. Statistics show that they are more likely to have physical health issues that require medical care. And if these young people are not able to afford healthcare coverage, they may not receive treatment for health problems that can follow them into adulthood. But this coverage is also essential to their economic security. Starting out adulthood with medical debt can create a financial hole out of which it is very difficult for young people to climb. So for all these reasons, the ACA's coverage of youth formerly in foster care is crucial and must be properly implemented to reach these goals. To date, the federal Centers for Medicare and Medicaid Services, CMS, has issued a proposed federal rule and a FAQ document providing guidance to states regarding the implementation of this provision. Actually, I think that they did finalize a narrow rule, but the bulk of the guidance is still in a proposed federal rule and guidance. But states across the country are really...really vary in terms of the status of their implementation. And I can just speak personally, I've had the opportunity to colead a national work group of state advocates looking at the implementation of this provision in their states. And had also an opportunity to speak nationally about this provision, including on Capitol Hill to the Senate Foster Youth Caucus. And from that experience, I've learned that there are some states that are really leading the way in terms of streamlining the application process, using the flexibility that they have. A lot of it, I think, it's been clarifying with

CMS what they can and can't do. But there are other states that are still figuring it out. In Nebraska, some important progress has been made. We're very pleased, as Senator Crawford mentioned, that HHS clarified their interpretation to include young adults who reach 18 while in foster care. And HHS has also made efforts to increase communication between their Divisions of Medicaid and Long-Term Care and CFS. And as I said, the LR itself has brought together stakeholders and young people to discuss aspects of the implementation that's been very helpful. Yet, more work remains to be done. In order for this provision to meet the needs of young adults, we have several recommendations. The first is to improve outreach. With only 3 percent of young adults accessing coverage under this provision, improvements in outreach are needed to reach particularly those young people who have already left foster care. This obligation rests first and foremost on HHS under federal statute. HHS has developed a brochure for youth who will be aging out of the system, but there is more that can and should be done to directly reach out to potentially eligible young people that they know about who have already left the system. And in addition, as Senator Crawford mentioned, stakeholders can play a role in outreach too. Appleseed conducted outreach with potential eligible young people and providers that work with them. And we know other organizations and providers who are here today have made great efforts to help get young people enrolled. Second, we need to ensure that transition planning and automatic processing requirements are met. While it's more difficult to reach young people who have already left the system, HHS can and should be able to reach all young people as they age out of care. So it's one thing to try to reach a 24-year-old who has already left the system several years ago and make sure they know about this, but for young people we should be doing 100 percent for young people as they're aging out of the system to see if they may be eligible for this provision. And HHS has a legal obligation to do so as well. As I said, the department has indicated that the Division of Medicaid and Long-Term Care is working with CFS to obtain the names of current individuals aging out of foster care to ensure that their eligibility is reviewed under this category. And that's exactly what needs to happen. However, the data suggests that the processes need to be strengthened since it appears it's not happening in all cases, or

perhaps that is a more recent development that we're not seeing reflected in the data and practice. This is also a requirement as part of transition planning, that youth have a transition plan that specifically addresses healthcare access as required by Nebraska Revised Statute 43-1311.01 as part of a bill that Senator Campbell introduced a couple of years ago. An additional oversight of these requirements could be provided by juvenile courts and the Legislature. Third, Nebraska can improve implementation of this new provision by streamlining the application process. When young adults complete an application for Medicaid, those who indicate on their application that they were in foster care we think should be processed for the former foster care category. So there is a specific question on the Medicaid application that asks: Have you ever been in foster care? But instead of processing all youth who answer that question affirmatively, we understand that HHS employee...for each...each application is processed manually. So, for...as the application accepted, HHS staff determines which category it appears that that individual is applying for and then puts that...them to be processed through that category. And so that presented a limitation on the data in the report. But also, it can lead to potentially eligible young people being denied for another category of Medicaid, or perhaps not being correctly considered for the former foster care category. So for example, I think you may hear about this from other folks that testify after me, but a young person may get a denial for...that says--you're not aged, blind, or disabled, but the young person, you know, said--I know I'm not, I was applying for the former foster care category. So we need to, I think, look at that process and make sure the individuals who are applying check the box, so to speak, are processed for the former foster care category. And then in many cases, the information necessary to process eligibility for this provision, foster care status, and that you had Medicaid when you were in foster care, it's already in the possession of the department and so we think that whenever the department has information necessary to determine eligibility for this provision, they should do so. In addition, the renewal process needs to...we think needs to be simplified. It's just its existing policy is to require individuals to complete a renewal form annually and failure to complete the renewal form could result in the cancellation of coverage. And so we're concerned, particularly in light of the mobility of this population,

that we may see young people terminated from the program when this renewal process begins, I think, in December, if young people don't receive or return the renewal form with the required information. And here California is an example of a state that's really leading the way with a simplified process...processes for this provision both for application and renewal. And that was done as directed in a bill that the California Legislature passed in, I think, 2013. For example, California has a one-page...it's actually a half-page application form for this provision and the legislation directs the department to only require a redetermination form if the information that they have is no longer accurate or materially incomplete. And the text of that California legislation is included in the report that we provided. Lastly, we need to cover youth who exit foster care in other states. In federal guidance, CMS has interpreted the federal statute as allowing but not requiring states to cover youth who age out of foster care in other states. And Nebraska has chosen not to cover youth who age out in other states. We think the better policy is to cover all eligible youth irregardless of where they age out of care. This is important again because this population is highly mobile. In recognition of this, at least 12 other states provide coverage under this category to those young people and we think Nebraska should do the same and provide these individuals with the same rights as other citizens of Nebraska. In closing, we would be remiss if we did not mention the intersection of this new eligibility with the new Bridge to Independence program which launched earlier this month and we're very excited about. Many young people in the Bridge to Independence program will have access to Medicaid under this category or by virtue of their IV-E status. And they should be able to continue healthcare coverage after they age out of the Bridge to Independence program, so to speak, at age 21 to 26. So we believe both of these new opportunities in Nebraska, thanks in large part to this committee, can and will improve outcomes for young people transitioning from foster care to adulthood. And again, we just want to thank the committee and Senator Crawford for their leadership on these issues. [LR533]

SENATOR CAMPBELL: Senator Krist, do you have a question? [LR533]

SENATOR KRIST: I do, actually for the record. Your interface on the federal level, I know of several conditions, particularly in the...well, I know of several conditions where a permanent condition is registered and that permanent condition is understood; there is no need for an annual reapplication. And that law exists with...in the DEERS for CHAMPUS and TRICARE and other systems such as that. I would hope that we could find a federal law that says CMS can be...in permanent condition and if you age out of a system at 18 or 19 and you're eligible, then it's a permanent condition until you get to 26,... [LR533]

SARAH HELVEY: Exactly. [LR533]

SENATOR KRIST: ...so you shouldn't have to go through the process, just for the record. [LR533]

SARAH HELVEY: Exactly. [LR533]

SENATOR KRIST: And the second point is, I know of several situations where we have foster kids that have been placed in other states. So it's even more important when they age out. If they're in Wyoming, are they Wyoming or are they Nebraska? So your logic in terms of covering no matter what state, if they exist or if they are here in Nebraska, because I don't want them to get caught in that loop as well. So thanks for your testimony. [LR533]

SARAH HELVEY: Thank you. I agree a hundred percent. [LR533]

SENATOR CAMPBELL: And we should note that the other...one of the other issues that the committee is following, and I know...I saw Kim Hawekotte come in the back door. In the latest quarterly report, Kim continues discussion on our youth that are placed out of state. And what is interesting about those statistics is the percentage that are with kinship placement, which is, of course, what we have all talked about that is very

positive. In those situations particularly, we really ought to be paying attention and make sure that they can get...understand and know of this coverage. [LR533]

SARAH HELVEY: That's right. And we don't want to create any disincentives as well. [LR533]

SENATOR CAMPBELL: Correct. Exactly. We want them to be placed with kin if that's a workable between the foster youth and that kin. So we may want to take a look at that issue. But the Foster Care Review Office would have those statistics. Thank you. Any other questions? Thank you, Sarah. [LR533]

SARAH HELVEY: Thank you. [LR533]

SENATOR CAMPBELL: Our next testifier. Do we need to get another chair here? John or J.T. Oh, thank you, Senator Watermeier. Good morning. [LR533]

MONIKA ANDERSON: Good morning. [LR533]

SENATOR CAMPBELL: I think for the record, we'll have you both identify yourself and spell your names so the people listening can tell the difference between your voices. [LR533]

MONIKA ANDERSON: Sure, my name is Monika Anderson. That's M-o-n-i-k-a A-n-d-e-r-s-o-n. [LR533]

SARA RIFFEL: And my name is Sara Riffel, S-a-r-a, last name, R-i-f-f-e-l. [LR533]

MONIKA ANDERSON: (Exhibit 3) Thank you, Senator Campbell and members of the committee. As I said, my name is Monika Anderson. I am the legal counsel for Nebraska Families Collaborative in Omaha, or NFC. NFC is a nonprofit partnership of

five Omaha-area organizations made up of Boys Town, Child Saving Institute, Heartland Family Service, Nebraska Family Support Network, and OMNI Behavioral Health. NFC provides case management, service coordination, and delivery to all of the child welfare and non-court population in Douglas and Sarpy Counties through a contract with the Department of Health and Human Services which was extended pursuant to LB660 passed by the Legislature this past session. Attending with me today is Sara Riffel, the aftercare and independent living supervisor at NFC. NFC provides up to 12 months of aftercare services for children and families who exit the child welfare system in the Eastern Service Area. In addition, NFC provides aftercare services for certain youth who age out of foster care up to the age of 21. Sara supervises nine aftercare and independent living specialists at NFC. And we're here today at the invitation of Senator Crawford to talk about our experiences at NFC working with youth who exit foster care as they transition to adulthood and the challenges they face, particularly with regard to Medicaid eligibility and enrollment. And with that, I'll turn it over to Sara. She is the content expert on this issue. [LR533]

SARA RIFFEL: Thank you. Thank you, Senator Campbell and members of the committee. I would also like to thank Senator Crawford for inviting me to provide testimony regarding my experience working with foster youth as they reach the age of majority, specifically regarding the transition to Medicaid coverage under this new category. The expansion of Medicaid to cover former foster youth is an important triumph because it provides access to healthcare for a very vulnerable group of young adults, as several have mentioned. Children who are abused or neglected often experience a higher instance of physical/mental health needs and experience poor health outcomes into adulthood. According to the Department of Health and Human Services in an Omaha World-Herald article on October 13, 2014, 1,869 youth are eligible for former foster care Medicaid and 128 youth are currently enrolled in the program. Since the start of this new category of Medicaid in January of 2014, communication from the Department of Health and Human Services has been inconsistent and unreliable. I've faced many challenges when working with youth transitioning to former

foster care Medicaid. And some of those challenges include: a lack of communication from the Department of Health and Human Services regarding the application process; inconsistencies and confusion among Medicaid staff regarding application requirements; inconsistencies among Medicaid staff regarding eligibility requirements; a lack of outreach efforts by the Department of Health and Human Services to reach potentially eligible young adults; and incorrect Medicaid application denials, closures, and errors resulting in a lack of coverage for former foster youth. Other than a training offered in January of 2014 at Project Harmony in Omaha, I received no communication from the Department of Health and Human Services regarding this new Medicaid category. I also received no communication about automatic eligibility redetermination for youth as they age out of care. I was told that a mini training or a conference call would occur on the topic of Medicaid for former foster youth to ensure that the youth know how to complete an application, but this training did not occur, to my knowledge. The confusing and inconsistent process directly impacts former foster youth in Nebraska. According to former foster youth, Azaria, the process to apply for Medicaid was very confusing. Azaria was required to complete an application several times because she received communication from the Department of Health and Human Services stating she was ineligible for former foster care Medicaid due to insufficient income and no employment verification. Azaria called Medicaid for assistance, but was given different information each time. As a result, her Medicaid was closed on several occasions and she went many months without critical medical appointments. She even received bills from medical providers for payment during the time that she should have been covered under Medicaid. Azaria did not receive any information about Medicaid coverage to age 26 from the Department of Health and Human Services, only from NFC. Since January of 2014, NFC assisted 101 youth with the Medicaid application. Of those 101 youth, 12 are currently being denied Medicaid. As many as 19 youth were previously denied coverage due to an error on the part of the Department of Health and Human Services. NFC aftercare specialists made several calls to Medicaid regarding those denied applications, resulting in those 19 denials being reversed and those youth are now covered. During those numerous phone calls to Medicaid, it was never

mentioned that an application was not required. In fact, on three different occasions the youth was asked to complete a new application following the denial. The reason identified by the Department of Health and Human Services for those denials is due to a lack of understanding about eligibility requirements under the new category. Youth were denied coverage for the following reasons: not pregnant and no dependent children; did not meet age requirements; a renewal was not received; income verification was not received; did not meet requirements for former foster care Medicaid; and to reasons unknown. The impact of incorrectly denied or closed Medicaid cases on young adults is great. According to former foster youth, Autumn, the importance of Medicaid coverage is important because she is unable to afford medical expenses. Autumn's Medicaid was denied in an error by the Department of Health and Human Services on three separate occasions. Because of these errors, Autumn's asthma worsened and she was unable to receive treatment. Autumn remains uncovered by Medicaid today. Because over 1,800 young adults are reportedly eligible for Medicaid under this new category, it's important to conduct outreach to potentially eligible youth. Of the 101 youth that NFC assisted in applying for Medicaid, zero reported to have received any information from the Department of Health and Human Services regarding Medicaid to age 26. It is my understanding that a brochure was created by the Department of Health and Human Services regarding this new category, but to my knowledge no youth currently or previously served by NFC have received that literature. [LR533]

SENATOR CAMPBELL: Sara, can you kind of summarize to the end here, because we're getting pretty close to the ten minutes. [LR533]

SARA RIFFEL: Sure, yeah, absolutely. Yep. So the rest of my report really just talks about those outreach efforts and the importance of reaching those young people, not only currently served, but previously served. So the extension of Medicaid for former foster youth is an important win for the population. But it does have to be well organized and communicated effectively in order for this population to understand the application process. So I just want to thank you, Senator Crawford, Senator Campbell and

members of the committee, and I would be glad to take any questions. [LR533]

SENATOR CAMPBELL: Sara, the question I have, as I listen to your report, is do you provide your own brochure about this? [LR533]

SARA RIFFEL: Yes, we do. [LR533]

SENATOR CAMPBELL: Did I hear that? [LR533]

SARA RIFFEL: That is a little bit of the last piece of the report. [LR533]

SENATOR CAMPBELL: Okay. [LR533]

SARA RIFFEL: So NFC provides our own outreach efforts because we want to make sure that it's done. So we do provide information to the young adults as they age out of care and then also any young people that are in our aftercare program. [LR533]

SENATOR CAMPBELL: Is that available digitally? I was going to say, could you provide a copy of whatever those materials are... [LR533]

SARA RIFFEL: Yes. [LR533]

SENATOR CAMPBELL: ...for the committee so we have them for the file? [LR533]

SARA RIFFEL: Yes. [LR533]

SENATOR CAMPBELL: That would be helpful because we'll, no doubt, ask the department for the same type of information. [LR533]

SARA RIFFEL: Sure. [LR533]

SENATOR CAMPBELL: Questions from senators? Senator Gloor, did you have a question? [LR533]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you both for being here this morning. Sara, a lot of your testimony sounds sort of like the testimony I've heard with the ACCESSNebraska task force... [LR533]

SARA RIFFEL: Okay. [LR533]

SENATOR GLOOR: ...that has been formed that has to do with some of the dysfunctionality that we've got within ACCESSNebraska. And so I'm trying to pull out those things that might be unique to dealing with foster care. And one of the things for me is locating these former foster care, now adults. Are there confidentiality issues? I mean it seems to me one of the places we could go would be healthcare providers who might be of assistance in identifying former foster care because they have, literally, a financial incentive to identify them as having potential coverage. But then there's HIPAA issues that protect confidentiality. And in this day and age where we worry about privacy because of the times it's compromised on-line, tracking people down becomes, I think, more and more difficult. I mean, is this something that's...how are we going to address this issue of locating former foster youth in that kind of an environment? [LR533]

SARA RIFFEL: Sure. Well, I do think that there are some issues with confidentiality. However, if healthcare providers are just to ask the question, were you formerly in foster care or have you ever been in foster care, and the patient answers yes, then they could be providing information to them. The healthcare provider may not know if they're eligible or not, but then the young person could complete the application or find more information to find out if they're eligible. But I think one of the big barriers is they just don't even know that this provision exists or even where to go to ask if they're eligible. So, I do think that there is some potential there with healthcare providers that wouldn't

cause any issues with confidentiality. Absolutely. [LR533]

SENATOR GLOOR: Okay. Thank you. [LR533]

SENATOR CAMPBELL: Senator Krist has a question. [LR533]

SENATOR KRIST: Is there someone here from the department? [LR533]

SENATOR CAMPBELL: Yes. [LR533]

SARA RIFFEL: There is. [LR533]

SENATOR KRIST: Okay. What I'd like you to do is share this letter directly with the department and for the department to answer back this committee on the individual cases that you've outlined. Oftentimes we'll...and I'm assuming for the record that everything that you have told us is absolutely correct. But sometimes when...particularly in these hearings, when we hear the problems and we connect with the department in this setting, the oversight responsibility of the Legislature is met and the loop is closed by us asking them to answer those questions that you posed. Thank you for that. I know that it is sometimes difficult to, as an outsider...an outside agency to get the information. And again, I think it goes to our responsibility and oversight as a Legislature. So if you could please provide that to the department. And, department, if you could please answer this committee on the individual cases that have been brought forward. Thank you for coming. [LR533]

MONIKA ANDERSON: And for the record, we did obtain the consent of the young adults to share their stories with the committee this morning. [LR533]

SENATOR KRIST: That would be very helpful for the department, I'm sure. [LR533]

SENATOR CAMPBELL: Senator Howard. [LR533]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for your testimony. I did have a question about how things are going with ACCESS because you manage sort of a large docket of kids that you're working with who are aging out. Do you have a specific case manager at ACCESS that you work with? [LR533]

SARA RIFFEL: We do not, not at this time. [LR533]

SENATOR HOWARD: Okay. [LR533]

SENATOR HOWARD: Okay. Great. Thank you. [LR533]

SENATOR CAMPBELL: Any other questions? Senator Crawford. [LR533]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you for your testimony; it's very useful information. So you met...did you receive communication in September when the eligibility interpretation was changed? [LR533]

SARA RIFFEL: I did receive that information, but I received it from Nebraska Appleseed, not from the Department of Health and Human Services. [LR533]

SENATOR CRAWFORD: Okay. Thank you. [LR533]

SENATOR CAMPBELL: Any other follow-up questions? Thank you very much. [LR533]

SARA RIFFEL: Thank you. [LR533]

MONIKA ANDERSON: Thank you. [LR533]

SENATOR CAMPBELL: Oh, I'm sorry. Did you have a follow-up, Senator Howard? Oh, okay. We both thought we saw a follow-up there. Okay, our next testifier. While we are waiting, Senator Cook has joined us, welcome. We have a full house today. That's good. Good morning. [LR533]

DOUG LENZ: Good morning. My name is Doug Lenz, D-o-u-g L-e-n-z. I, first off, want to thank Senator Campbell and the Health and Human Services Committee for allowing me the opportunity to provide this testimony, in particular, a thank you to Senator Crawford for inviting me to testify today. I work...I'm a director for Central Plains Center for Services. We're a nonprofit agency offering statewide services in Nebraska, actually based out of Broken Bow, but we have offices in Omaha, Lincoln, and North Platte as well. And we were asked to testify because we have kind of a unique connection with the young people. We administer the PALS program which is designed for young people who previously were in foster care and now have aged out. And we've been administering this program for 16 years in Nebraska. We also have the education and training voucher program which is a college scholarship program for young adults who have been in foster care after the age of 16. In terms of some of the data that we've found, in particular in the area of healthcare, the time that the young people are in our program, generally speaking, a lot of the areas related to independent living, which are the things that we're focused on--education, employment, housing, transportation--they improve. We see the number of young people who have a high school diploma increase. We see the number of young people who are involved in college and being successful increase. The number of young people who have stable housing and can meet their monthly living expenses, these all increase as time and our program increases. But one of the challenging areas has always been healthcare. And this is one of those areas that we have a downward trend with time in our program because as time in our program increases, the likelihood of them being discharged increases greatly. The number is as low as 50 percent in terms of...we do regular assessments with the young people when they enter our program and then every six months after that and it's a self-report measure that they do. So we were really excited in January

when there were changes to the healthcare law, and even more excited as of late with the increase deciding to include those young people who transitioned after the age of...or who were discharged after the age of 18. And I was asked to talk about how that impacts young people. And I don't want to spend a lot of time on it because I know we have some young people in the room and I'm really looking forward to their testimony. But just a couple of examples, a year ago I worked with a young man who got himself in a situation and was assaulted by a group of young men to the extent that he was unconscious. And somebody called the fire department, thankfully, and they picked him up in an ambulance and took him to the emergency room. Now he had no healthcare, which is not a surprise. He was a former foster care youth. And he spent a day in the hospital; had some significant injuries but nothing major, some stitches and a broken bone. And his report was within a period of months he had $8,000 in charges that collections folks were after him for. And then on the reverse side of that, since the implementation of these changes, I had a young man that we were working with who was in a pretty tough situation. He was...I was contacted by...he's a former foster care youth. I was contacted by his former foster mom who had a connection with PALS and asked if we could assist. He was homeless, he had no job, and he really wanted to pursue his education but didn't have any idea how to do it. So to make kind of a long story short, we were able to help him get enrolled in college and enter the dorms. And it was a nice outcome. And during that process we applied for Medicaid coverage for him. Well, he was in school about a week and he made contact with us and indicated that he was having some difficulties and they were substantial psychiatric difficulties. He thought other people who were at the college could hear his thoughts and he thought they were making fun of him. So we were able to encourage him to seek treatment and he ended up being hospitalized at Immanuel Adult Psychiatric facility for about seven days. Now, I bring that point up because...because he had access to Medicaid, he could do that and that was a reasonable plan and it was something that he desperately needed. If he didn't have Medicaid, I don't know what the outcome would be. But I can tell you that he is getting the treatment he needs. And him, like many of the other young people we work with, he previously was receiving mental health services while he was

in foster care. But after he left, he wasn't able to access those things until he got Medicaid. So that's kind of just an example of the differences. And one final kind of story from a young person that I'll share, I was recently visiting with a young lady who was previously in our PALS and ETV program. She's now 22, and she just graduated with her RN degree. She moved to a new community and is waiting to take her boards. But before she can...until she can complete her boards, she's not able to secure employment with nursing. But one of the things that she said to me, she's working a couple of part-time jobs, and she said--but I do feel good that I...she said I have healthcare. She's 22 years old and she fits under this regulation and is able to access healthcare. So she said that's one thing I don't have to worry about. And she's kind of a great example because I anticipate within a year she'll be on employer coverage because she'll have a degree, I mean she'll have her position in nursing. So that's something that's really, really positive. And I also want to share a little bit about our experience in working with the young people and being able to access healthcare under these new provisions. And these are experiences since...really since January 1. I know as of late there's been some work by Health and Human Services to correct some shortcomings that have been identified and so we're grateful for that. But, basically, we have found that with the young people that we have helped with this process, about 60 percent of them are able to access it with...very smoothly, with no difficulty. The other 40 percent, they're...a lot of times what they're hearing back is that they're denied. And I'll use the example of the young man that I talked about who needed the psychiatric assistance. I helped him apply personally. And two days later he received a denial letter. Now the nice thing about it is the fact that I was able to make a phone call and we were able to correct the issue. I guess my major concern is that if they don't have somebody from the PALS program or some other supportive adult in their life, how are they even going to know that that's the process they have to go through? So I definitely think that that's something that needs to be addressed a little bit further. So I mention that. And then the other thing, I think, is more of a system issue that I kind of wanted to share today. And that is helping young people to identify or prioritize healthcare as an important issue in their self-sufficiency as adults. This is oftentimes...I've been doing this

work for 12 years and we always work with young people from their...what their goals are. And when I meet with young people and when my staff meet with young people, I don't think there's a single instance where, of their top three prioritized goals, healthcare was ever one of them. I mean, they're all very practical things. They want to purchase a vehicle or they want to secure independent housing or they want to pursue postsecondary education or finish high school; healthcare is not one of them. And I think that's a system issue and I think that's an issue that we as an agency have to work on as well because there's...we all know without healthcare...the example of the first young man I shared, I mean that becomes a huge barrier if they don't have access to healthcare and something comes up. So I guess those are the kind of the two key things that I wanted to make sure got pointed out, that we need to make sure that young people are able to access the Medicaid who are eligible in a straightforward fashion and that's there clear communication about that process. And then also in terms of just some system level type comments. [LR533]

SENATOR CAMPBELL: Are there any questions from the senators? Thank you for your testimony today. [LR533]

DOUG LENZ: Thank you. [LR533]

SENATOR CAMPBELL: Our next testifier. Good morning. [LR533]

MARY FRASER MEINTS: (Exhibit 4) Good morning. I'm Mary Fraser Meints, M-a-r-y F-r-a-s-e-r M-e-i-n-t-s. Thank you, Senator Campbell, Senator Crawford, members of the Health and Human Services Committee. I'm the executive director of Youth Emergency Services in Omaha, Nebraska. Our mission is to provide critically needed resources to at-risk and homeless young people to empower them to become self-sufficient. Our agency served 1,800 young people last year. Fifty percent of those young people had been in the foster care system. Some of them aged out, but some of them went home and weren't able to be successful on their own and they ended up

homeless. We provide services through Street Outreach program; Emergency Shelter; Transitional Living Program, which is housing; Maternity group Home; and mentors. I'm going to share some of the challenges this population faces and some of the ways that we can help them. Many of the youth that we serve don't have identification. They've been homeless; they don't have any ID. So the first thing we do is help them get identification and get on Medicaid. The system, as you've heard, is difficult for young people to navigate, so our staff does that with them. We are lucky that we have...and I shouldn't share all this with you all, we have a person that we use at Medicaid who comes to visit with us and helps our young people get on Medicaid. And that is incredible and she's been very helpful. So I encourage the use of those community support workers for other folks who serve populations of young people. Access to services, both physical health and mental health, are challenges for young people that we serve. Some of them leave their small community and come to Omaha because they think they can get more services. Then they get confused and don't know how to access services. It's hard for them to find a doctor, a dentist, a therapist, to navigate a hospital campus, to find a specialist, and so we need somebody that can advocate for them. In our case, managers do that, PALS do that, lots of providers help them. Young people aren't familiar with the medical home. Many of them have lived in many homes and they don't have a specific doctor. So having a medical home is very, very important and knowing the importance of one consistent medical provider is key to their future health. It's challenging for them and they need the help of other adults. Cultural confidence is also an issue. These young people come with challenges; they don't trust adults, so having providers who understand the trauma and the issues of these youth is very, very important. Transportation is also a challenge. Many of our young people just use the bus, they don't have a car. And so getting access to a doctor, a hospital is challenging for them. Mental health services are also a need for young people. There's a lack of providers and access is challenging in Nebraska, even in Omaha. We contract with two therapists to serve all the young people in our program, and that's been very helpful. None of that...some of the youth are Medicaid and some of them are not, so we have to seek other funding to provide mental health services for our young people. Young

people need safe, affordable housing. Since we provide housing, I would be remiss not to talk about that. There's a lack of affordable housing in rural and urban areas. In rural areas, the housing may not meet the Fair Housing Standards. Despite these challenges, there are services to assist these young people who are no longer in the foster care system. Bridge to Independence offers many possibilities to assist the youth in becoming self-sufficient. The independence coordinators will provide hands-on case management and this should help young people navigate the health and mental health system. Other providers in the communities will also help them. Without the support of family members, these youth will need guidance and support. We have mentors for all our young people and they commit to a year to two years to provide services for the young people. I'll be glad to answer any questions you might have. [LR533]

SENATOR CAMPBELL: Questions from the senators? Thank you, Mary, always good to see you. [LR533]

MARY FRASER MEINTS: Thank you. Good to see you. [LR533]

SENATOR CAMPBELL: Our next testifier. Okay. Good morning. [LR533]

SHANTE McKISSICK: Good morning. [LR533]

SENATOR CAMPBELL: Go right ahead and give us your name and spell it for us, please. [LR533]

SHANTE McKISSICK: Okay. All right. My name is Shante McKissick, S-h-a-n-t-e M-c-K-i-s-s-i-c-k. I'm currently a junior at the University of Nebraska-Omaha. I work part-time. In between going to school full-time and working, I really have no time to be sick, although I am today, so I'm sorry. I came into the foster system when I was 13 due to abuse and neglect I received from my parents. Ironically, one of the reasons of why I went into foster care was because my mom didn't have medical insurance and so her

lack of taking me to the hospital resulted in me taken out of my home. So this actually means a lot to me. When I was 15, I was sent to Boys Town. I had a lot of medical checks. I went to the dentist for the first time. And...I...yeah...I owe a lot of my success to them. I went from getting all Fs to graduating at the top of my class with all honors. I left there with several scholarships and continue to take in them with accountability. It wasn't until last year did I notice I didn't have health coverage. After I visited the doctor, I was left with a bill saying I didn't have Medicaid. Confused, I called my PALS worker and was immediately started working on getting it back. It wasn't until a month later did we get in contact with someone from the department that said I need to verify my employment history and wages. I had three jobs last year from Summer Kids Club to working at Omaha Steaks in the winter. It was like a wild goose chase tracking it down, but it wasn't till my last job at Suntan City did I get no participation with them. I called several times and they said that they would get back to me, I wasn't on their time. It really stunk because my medical coverage was in the hands of my past employer and they were not contacting me back. I didn't have health insurance for nine months and that's when I, ironically, got sick the most. And from strep throat to the common cold, I had to suck it up and not go. After several phone calls and being denied twice in applying on-line, my PALS worker and I finally got Medicaid about a month ago and I'm really appreciative of doing so. I recently got in contact with my therapist from when I was in Boys Town. I went to the doctor yesterday. And I guess I just want to say I appreciate being able to get medical coverage because, obviously, I didn't have it growing up and just being able to have it now is such a blessing because now I can go to school and I can work full-time and make sure that I'm getting like my medical needs. And especially going through therapy, obviously going to school full-time is really difficult and sometimes you just need to talk to somebody. And, yeah, I'm really appreciative. Thank you guys for listening. And that's my story. [LR533]

SENATOR CAMPBELL: Great job. [LR533]

SHANTE McKISSICK: Any questions? [LR533]

SENATOR CAMPBELL: Great job by the testimony. Questions from the senators? Senator Crawford. [LR533]

SENATOR CRAWFORD: Thank you, Senator Campbell. Thank you so much for being here today and sharing your story. I just want to clarify. When you worked with someone at PALS, then were you able to get access without the income verification and job verification? [LR533]

SHANTE McKISSICK: Yes, after, like, two months of calling and asking and check in and going through people. [LR533]

SENATOR CRAWFORD: So earlier you were told you needed that, but the PALS worker helped to make sure that you got through and didn't need that. [LR533]

SHANTE McKISSICK: Yeah. [LR533]

SENATOR CRAWFORD: All right, thank you. [LR533]

SHANTE McKISSICK: Um-hum. Yeah. [LR533]

SENATOR CAMPBELL: Before you go, what are you majoring in? [LR533]

SHANTE McKISSICK: Criminal justice with a minor in sociology. [LR533]

SENATOR CAMPBELL: Excellent. There will be a lot of job possibilities for you. [LR533]

SHANTE McKISSICK: I want to work for Boys Town. Giving back. [LR533]

SENATOR CAMPBELL: Excellent organization. Thank you for coming and telling your

story today. [LR533]

SHANTE McKISSICK: Thank you guys for listening. [LR533]

SENATOR CAMPBELL: Our next testifier. Okay, any other testifiers? Is there anyone else in the room who wishes to testify on LR533? Okay. Good morning. [LR533]

RUTH VINEYARD: Good morning. Good morning, Senator Campbell and members of the committee. My name is Ruth Vineyard, V-i-n-e-y-a-r-d. I'm a deputy director with Division of Medicaid and Long-term Care. I want to start by expressing my appreciation to Senator Crawford and her staff. It's been a very cooperative, collaborative relationship and we appreciate being able to provide information so the information stays current as you're conducting these studies. And having said that, I've been asked to provide an update today, and after listening to Senator Crawford's introduction, I was able to cross off almost all of it... [LR533]

SENATOR CRAWFORD: Okay. [LR533]

RUTH VINEYARD: ...because you're very current and I don't want to repeat the information that was already provided. But I will provide some clarifying points and things that we feel are very relevant. We are still operating under interim rules with the Centers for Medicaid and Medicare Service...I always do that backwards, Centers for Medicare and Medicaid Services. So we are operating under interim rules; we don't have final rules, and we're operating under interim guidance. So often that guidance comes verbally through our policy team communication with CMS. We then ask for that clarification in writing. Sometimes we can't wait for that because we have people waiting for eligibility determinations and we take our best stab at our interpretation. We work with our legal department and we interpret the regulations as best we can. So in this particular case, I found it interesting that the age of majority was an issue for us in determining the 18- or 19-year-old issue. And we believed our interpretation was

correct, that they aged out at age 19, and we went with that. CMS clarified just this July that we could cover 18-year-olds. We looked at the independent living situation and we believed that was coverable. CMS countered that and said, no, it's not. So it's sort of a...it's a tricky line to walk. So I wanted to make sure you understood that we are proactively working with CMS to clarify any interpretations that we believe are still outstanding. Our policy staff has been exceptional in documenting communications, following up where we need additional guidance, and we're still waiting for final rules, so things could still change. The other thing I wanted to clarify was the renewal process. There's been some discussion about that. I'm very pleased with the work that our team has done on that. And I'll share with you the new process that will go into effect in November. Sixty to forty-five days in advance, a desk review will be completed first to ensure the individual remains a resident of the state. A phone call will be placed to the individual if there are no electronic data sources available to verify residency. And if they cannot be reached by phone, a prepopulated renewal form will be mailed to them. If the form is not returned, then we need to close the case because we are still mandated to complete that annual renewal. But we are going to be very proactive in making sure that we take every step we can to, first of all, not require the renewal form to be completed, and second of all, to do outreach so that that gets done appropriately. We currently do have 128 youth in the program. And we did see an influx middle of the month so we're expecting that to increase. We received final guidance from CMS in writing on July 17. We immediately started the production of written material, pamphlets, fliers, those were just released in batch in boxes on October 17. So you'll see those out now. We were able to give some of those out in advance. I believe we met with the senator and advocacy groups so we could show them what was coming. We have had that information on our Web site as well, so it's been available to the public. At next printing, we will update the clarification around the 18- to 19-year-olds who are now eligible. We are also going back and we've done a data run to pull all of those that we may have missed, during the period of time we had the interpretation of the 19-year-old status, so that we can reassess those eligibility determinations. I do...I'm sorry Senator Krist left the room, I wanted to recognize and appreciate his comment. We do want to

hear about those individual cases where there were issues. And I, actually, had written down a note to reach out to the testifier to follow back on specific cases. We are...Director Chaumont was known to say--January 1, Medicaid implemented the largest change in Medicaid's history. So at a time when we were working with a single streamlined application, the federal marketplace taking in applications that came to us in a very new and different way, a completely new application form, we were implementing a new category of eligibility for former foster care youth. I'm not making excuses. I know that we made some mistakes along the way and we've been very appreciative of our communications with advocacy groups and the senator's office to help us fine-tune our program. One of the things that we've heard loud and clear is this is a new and unique situation and so we have assigned individuals specific caseworkers to this population. So if an application comes in and they have indicated they were a foster youth, that application gets routed to specialized workers who manage that. We also have trained our community support specialists. Thank you for recognizing that. We have them across the state and they can do advocacy, they can work with individuals who are having...or agencies who are having struggles with this new population. It's very new to us as well. As far as other updates, I think that pretty much covers some of the things that I've heard today and adds to what the senator provided in her opening. Are there other questions? [LR533]

SENATOR CAMPBELL: Questions from the senators? Senator Gloor. [LR533]

SENATOR GLOOR: Thank you, Senator Campbell; thank you, Ruth. Understanding that CMS can knock on your door at any time with reinterpretations, new definitions, and whatnot, but of those things that we expect to hear from CMS, are there many left? I mean, are we playing a waiting game on a lot of things or not many? [LR533]

RUTH VINEYARD: I don't believe so. So some of the things that we still reach out to CMS on is very specific case situations. So someone was in...one of the things that came up today is the denials that were coming through. So federal law requires that we

first determine someone eligible for another category. Are they eligible for any other category of Medicaid before we put them into the former foster care group? [LR533]

SENATOR GLOOR: Okay. [LR533]

RUTH VINEYARD: So that has caused some issues. People giving denials for not meeting a category and then being assessed for former foster care. [LR533]

SENATOR GLOOR: So a denial isn't by any way...in any way, shape or form a permanent denial, just a denial for that particular level of coverage. [LR533]

RUTH VINEYARD: It is, and then I will tell you we have then clarified our process, again with CMS, asking them, can we put them immediately into the former foster care group while we're waiting to determine their eligibility for another category? [LR533]

SENATOR GLOOR: Yeah, that would make sense. [LR533]

RUTH VINEYARD: And they said, yes, we can do that. [LR533]

SENATOR GLOOR: Good. [LR533]

RUTH VINEYARD: So those are the types of things that we're still working through the details on with CMS. We want to take...we want to make the decisions of how to approach this independently, but we work with our federal partners, our funding partners. We have audits. We want to make sure that we're doing it right. [LR533]

SENATOR GLOOR: What a nice term--partners. (Laughter) [LR533]

RUTH VINEYARD: They seem to like that as well. [LR533]

SENATOR CAMPBELL: Senator Cook. [LR533]

SENATOR COOK: Thank you, Madam Chair. And thank you for coming today. I'm recalling legislation that I introduced a few years ago called the Children's Health and Treatment Act. And when I heard the people get a denial letter, kind of triggered that memory. And I'm wondering what that letter or what that communication says and how it might direct the person receiving the letter to act. [LR533]

RUTH VINEYARD: Well, if the letter is an appropriate denial, we've determined someone is ineligible for Medicaid and we send a denial, it will tell them that they're ineligible and it will give them a reason. It will also tell them that they will be referred to the federal marketplace. So this is a new twist. And I'm glad you asked the question because it gives me an opportunity to also explain--when someone applies, a youth who is 23 years old, they're now required to have health insurance. So they may go to the federally facilitated marketplace and apply for insurance coverage. [LR533]

SENATOR COOK: Okay. [LR533]

RUTH VINEYARD: The application, a single streamlined application that we use for Medicaid and other insurance subsidy products, they have to...there is a question whether they were a foster care youth. If they check that, regardless, anyone who goes through the federal marketplace, that application comes to Medicaid for either a denial or an approval. So we are catching some of those youth that come through. They may not know that they're eligible for FFC. They may have never heard of it. But if they come through the marketplace, that's going to get transferred to us and we're going to be able to make a eligibility determination for that youth. Let them know that they are eligible for that program. So back to your point, the notice then...the notice that they're not eligible and why and that they will be referred to the marketplace for a determination. Now if that notice was inaccurately sent, that's another story. So that's one of the reasons we're going back and looking at those 18-year-olds who may have been denied in error.

[LR533]

SENATOR COOK: Uh-huh. So it will offer me--pardon me the interruption--so it will offer me a reason that I can understand as a consumer, as a young person, a consumer of health services. And will it offer me an appeals process beyond the referral to the marketplace? [LR533]

RUTH VINEYARD: Yes, absolutely. [LR533]

SENATOR COOK: Okay. [LR533]

RUTH VINEYARD: The appeals process is on every notice. [LR533]

SENATOR COOK: All right. [LR533]

RUTH VINEYARD: One other point, I'm sorry, I would like to make that that brought to mind, some of the confusion may also have been around...you may all know that we had a former ward program as well. That former ward program doesn't have the same requirements. There is an income requirement. So there may be some confusion, both publicly: Did they apply before January 1 for the former ward program and were they denied because they didn't provide information or did they apply for the former foster care program after January 1? And again, I will admit, not only are we getting that message out externally, we're training our own staff in the difference between these two very similar but unique programs. [LR533]

SENATOR CAMPBELL: That's a good point. Other questions? Senator Krist. [LR533]

SENATOR KRIST: I apologize if you've already covered it, but I just want to make sure you heard the discussion we had earlier about a permanent condition, which this would be. [LR533]

RUTH VINEYARD: Sure. [LR533]

SENATOR KRIST: Do we need to do something inside or does CMS or the federal government have that provision? I mean it would ease your load and certainly make it easier for the individual. [LR533]

RUTH VINEYARD: Yes. Senator, we did talk a little bit about... [LR533]

SENATOR KRIST: Okay, I'm sorry. [LR533]

RUTH VINEYARD: ...we have a very streamlined renewal process. So we're going to do some internal review prior to doing any outreach for an annual review. It is a federal requirement that we do an annual review to review for residency. But they don't have to provide any financial information, any resource information. It can be a very streamlined process. And effective November 1, that process is very streamlined in Nebraska. [LR533]

SENATOR KRIST: Okay, thank you. [LR533]

RUTH VINEYARD: Um-hum. Sure. [LR533]

SENATOR CAMPBELL: And it will be proactive. Ruth, one of the things that I'd ask NFC to provide, if you could have someone provide to the committee the materials that you have just, hot off the press October 17,... [LR533]

RUTH VINEYARD: Oh sure, sure. [LR533]

SENATOR CAMPBELL: ...to the senators' offices because we do get questions and that would be helpful. [LR533]

RUTH VINEYARD: Absolutely. [LR533]

SENATOR CAMPBELL: The other question, I mean I hadn't realized the independent living, and you know really, that is a problem because we tried in many cases across the state to have independent living programs. So it's sort of, before we had the Bridge to Independence, a way to sort of help the youth. Do you think CMS will review that? Or is the answer just no? [LR533]

RUTH VINEYARD: The answer right now is just no. Do I think they will review it? I think that we're still in interim rules. I'm meeting with my counterparts in two weeks at National Medicaid Directors Association. We'll be asking some of those questions. One of the things I want to talk about though in relation to that is independent living, if they are in foster care for any...a day, while they were 18, we can look at them for the former foster care program. The other thing I would encourage is those youth who maybe went into independent living at age 16 or 17, and are not eligible for this program, certainly will want to apply through the FFM, the marketplace, for a tax subsidy or a tax credit, depending on their situation. So there are some additional resources available, certainly not Medicaid at this point. But we can help guide them in that direction. [LR533]

SENATOR CAMPBELL: Those below 100 percent of the federal poverty level are not... [LR533]

RUTH VINEYARD: There is that issue. [LR533]

SENATOR CAMPBELL: I wasn't going to try to get that in, but...(laughter)...it was just too opportune.. [LR533]

RUTH VINEYARD: It's there, I know. I do. [LR533]

SENATOR CAMPBELL: ...not to mention it. Ruth, the other thing is, is that I really do appreciate the fact that, you know, it's sort of like you're waiting for the information, as much as we can get out to the agencies, they will make a difference for the foster care youth. [LR533]

RUTH VINEYARD: Sure. They have made a difference. And we actually have met with Appleseed early on and listened to some of the concerns that they had. [LR533]

SENATOR CAMPBELL: Good. [LR533]

RUTH VINEYARD: Actually, took some of their suggestions forward in streamlining our renewal process and getting communications prepared. [LR533]

SENATOR CAMPBELL: Right. And I'm sure that NFC, the people who testified, would be glad to give you a copy of their testimony. If not, one of the senators will, so that you can follow up on the concerns they had. [LR533]

RUTH VINEYARD: That would be great. And we hope to continue to improve the program. [LR533]

SENATOR CAMPBELL: Senator Howard. [LR533]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for your testimony. I just had a couple of questions: What's the process if you're...if I get a Medicaid application and I check the box that I'm a former foster youth, does it go into a special pile? [LR533]

RUTH VINEYARD: It goes to dedicated caseworkers who are assigned to that population. [LR533]

SENATOR HOWARD: Okay. Okay, so it doesn't matter which, sort of, ACCESSNebraska... [LR533]

RUTH VINEYARD: It doesn't matter where the application comes in. [LR533]

SENATOR HOWARD: ...office...okay. [LR533]

RUTH VINEYARD: No wrong door. It gets processed by our application management team and they know that if it's a former foster youth that it goes to a special workgroup. [LR533]

SENATOR HOWARD: And how long has that workgroup been in existence? [LR533]

RUTH VINEYARD: If I can ask the person behind me, I would know that Kat...early summer. [LR533]

SENATOR HOWARD: Okay, so they're fairly new. [LR533]

RUTH VINEYARD: The workgroup is fairly new, the caseworkers are not. [LR533]

SENATOR HOWARD: Okay. Okay. And then what is your plan for outreach now that you have a brochure? [LR533]

RUTH VINEYARD: Sure. So one of the things that we've done is worked very closely with Children and Family Services so that youth who are aging out the system have their...they have a social worker assigned. That social worker is knowledgeable and has brochures available. The fliers are being populated to community groups. Our community support specialists all have access to that material and will take that out when they meet with community partners. We also keep the Web site updated so that that information is current and available. [LR533]

SENATOR HOWARD: And then how long have you known about the out of...sort of the independent living issue? [LR533]

RUTH VINEYARD: I would say within the last two weeks. [LR533]

SENATOR HOWARD: Two weeks, okay, because I was looking at your brochure and it doesn't include that. And so are you going to reprint them and then repost it? [LR533]

RUTH VINEYARD: Right. Well...right, the brochure also doesn't include the 18- to 19-year-old clarification. [LR533]

SENATOR HOWARD: Right. [LR533]

RUTH VINEYARD: So there was a balance there. So we knew we had to get something out. We knew we didn't have final guidance on either of those two issues, but we chose to get the information out so that people had contact information, they knew about the program. We could provide information to youth who were going into the former foster care group and didn't know...didn't know they were going into that group. So it was a decision that we made to get the brochures out and, yes, we will update them on next printing. But the Web site will be updated, always be current. [LR533]

SENATOR HOWARD: Oh, I'm looking at the Web site and it's not current now? [LR533]

RUTH VINEYARD: It needs to be updated...right, yep. [LR533]

SENATOR HOWARD: Okay. Perfect. And then I'm curious about what the threshold is for a dedicated caseworker. So it sounds like the...sort of the worker from NFC has a docket of over a hundred kids, when is it appropriate to have a dedicated caseworker for a very specific population that somebody is working with? [LR533]

RUTH VINEYARD: I think it's open to discussion. You know, certainly we look at (LB)599 CHIP--a very specialized population, we want specialized caseworkers; certain waiver programs; this program, definitely new. And as it becomes more mainstream, more part of the routine, more populated, we'll move away from the dedicated caseworker model. Right now it's a very good opportunity and I'm willing to talk to anyone who deals with a large population. There's no threshold. We make a decision based on need. [LR533]

SENATOR HOWARD: Okay. And then I just...you sort of have an outreach plan looking forward with kids who are aging out in the future. [LR533]

RUTH VINEYARD: Uh-huh. [LR533]

SENATOR HOWARD: Do you have an outreach plan for kids who have already aged out? [LR533]

RUTH VINEYARD: The only outreach really...and I would hesitate to call it an outreach plan, but what I talked about, if they go through any application process to get health insurance, tax subsidy or credit, or Medicaid, the application actually asks them if they're a former foster care youth. We get all of those applications whether they come through the marketplace, the Medicaid agency, on-line, walk-in, so they're identified to us. As far as reaching out to all of those who have aged out of the program, we don't have contact information, we don't have addresses, we don't have resources. So we really are working pretty collaboratively with the community agencies, hoping that there's an avenue there as well. [LR533]

SENATOR HOWARD: Okay. And there's no information about them in N-FOCUS anymore. [LR533]

RUTH VINEYARD: I wouldn't have current information. I've...no. [LR533]

SENATOR HOWARD: Okay. Great. Thank you. [LR533]

SENATOR CAMPBELL: Senator Krist. [LR533]

SENATOR KRIST: Is anybody from the press here? Well, they're probably listening on television. This would be an excellent time, I think, to start maybe getting something into the papers, the major papers around the state to say, hey, there's been a change, because it's probably a good way to get the word out anyway. So just a suggestion. [LR533]

RUTH VINEYARD: Okay. Thank you. [LR533]

SENATOR CAMPBELL: It will also help now that the Bridge to Independence Program will be up and going because that information can be shared. Will there be...I'm assuming that there will be a special emphasis on getting this information to the caseworkers who's planning for a youth transition? [LR533]

RUTH VINEYARD: Yes, to the Children and Family Services? [LR533]

SENATOR CAMPBELL: I mean, that would be critical... [LR533]

RUTH VINEYARD: Yeah. [LR533]

SENATOR CAMPBELL: ...to have that done. Okay. [LR533]

SENATOR HOWARD: And NFC presumably. [LR533]

SENATOR CAMPBELL: Sorry, Senator Howard? [LR533]

SENATOR HOWARD: And NFC as well,... [LR533]

SENATOR CAMPBELL: Right. [LR533]

SENATOR HOWARD: ...presumably. [LR533]

SENATOR CAMPBELL: Senator Cook. [LR533]

SENATOR COOK: Thank you, Madam Chair. I just have an idea, recognizing that birthdays keep happening for me and that's a blessing. You know what, young people get their information differently from somebody like me who still likes to get ink on her fingers. So I'm wondering as we look forward if there might be ways...and I'd love to hear ideas from the young people too about the best way to reach out to them in an effective manner, whether that's peer mentoring or smartphone application or something like that. Because I know, in my other life I'm in public relations, and its easy to kind of fold into the brochure or Web site... [LR533]

RUTH VINEYARD: Sure. [LR533]

SENATOR COOK: ...or newspaper or television, and that's not how our young people communicate. So I would... [LR533]

RUTH VINEYARD: Well, fortunately, we're right on that path... [LR533]

SENATOR COOK: Oh, good. [LR533]

RUTH VINEYARD: ...with our new eligibility enrollment solution. We kicked off that implementation within the last few months. And within the next year we should have a new eligibility solution for Medicaid that's more current, more interactive. We also will

have a new Web portal, hopefully more communication means, much like you're suggesting. [LR533]

SENATOR COOK: Okay. Thank you. [LR533]

SENATOR CAMPBELL: Okay, thank you. Senator Crawford. [LR533]

SENATOR CRAWFORD: Thank you. And thank you for your work this summer and for being here today. [LR533]

RUTH VINEYARD: Thank you. [LR533]

SENATOR CRAWFORD: So I believe I heard you say that you did get clarification from CMS that you are able to assign to enroll a former foster youth while you're waiting for eligibility information for other categories. [LR533]

RUTH VINEYARD: Correct. [LR533]

SENATOR CRAWFORD: Now, but as you described it, it sounded like it was something that's still in the future. Are you still working on the guidance and training to make that happen? Or is that something that's happening now? [LR533]

RUTH VINEYARD: That's something that's happening now. [LR533]

SENATOR CRAWFORD: Okay. So the people who are on ACCESSNebraska have...who are the special... [LR533]

RUTH VINEYARD: Correct. [LR533]

SENATOR CRAWFORD: ...caseworkers know about that and are able to enroll

someone while they wait for those other eligibilities? [LR533]

RUTH VINEYARD: Correct. [LR533]

SENATOR CRAWFORD: Okay, excellent. Great. Great. And can you tell us anything about the plan you have to reassess eligibility for people who were denied earlier? [LR533]

RUTH VINEYARD: We did...yes, and we're just in the middle of it. [LR533]

SENATOR CRAWFORD: Okay. [LR533]

RUTH VINEYARD: We're doing a...did or are doing, haven't checked today, a data poll to identify those youth. And then we'll be reassessing eligibility. Same group of specialized staff who will be looking at that to make sure that we capture them. I know that you're all aware that our data systems are meeting our needs but could certainly be better. So getting the correct data, putting it... [LR533]

SENATOR CRAWFORD: Right. [LR533]

RUTH VINEYARD: ...all together from disparate sources is challenging for us and appreciated your patience through that this summer as we were pulling data for you. [LR533]

SENATOR CRAWFORD: Yeah. Right, thank you. Yeah. Yeah, thank you. I just have one final question. The issue about youth from other states has come up in our discussion here. Just wondered if that requires statute or if that would be in the division's discretion to cover youth from other states. [LR533]

RUTH VINEYARD: I would tell you it would be an optional expansion to the Medicaid

population. So I'll leave it with that. [LR533]

SENATOR CRAWFORD: Thank you. [LR533]

SENATOR KRIST: Is that a state plan or is that a waiver? [LR533]

RUTH VINEYARD: That would be a state plan. [LR533]

SENATOR KRIST: So by simply adding it to our state plan and CMS approving it, we could move into that. Just for the record, that's how that happens? [LR533]

RUTH VINEYARD: Yes. [LR533]

SENATOR KRIST: Okay, thank you. [LR533]

SENATOR CAMPBELL: Okay. Good questions. Thank you very much, Ruth. [LR533]

RUTH VINEYARD: Thank you very much. [LR533]

SENATOR CAMPBELL: I saw that as the last testifier for this hearing, so we will close the hearing on LR533. And we will take a five-minute break for those who are leaving from this hearing before we start on the next. [LR533]

BREAK

SENATOR KRIST: Okay, if you could take your seats, we will get started with our next LR, LR539, and is proposed by Senator Campbell. And I think most the people were in the room before so I won't repeat anything and we'll just get right to it. Senator, please. [LR539]

SENATOR CAMPBELL: Thank you, Senator Krist and colleagues on the committee. My name is Kathy Campbell, K-a-t-h-y C-a-m-p-b-e-l-l, and I serve the 25th Legislative District. I introduced LR539 and I want to kind of give you a little history as to how we got to this point. In 2012, I introduced LR529 and that legislative resolution was meant to review and provide an assessment in making of recommendations relating to the entry of children into the child welfare system. And Senator Coash and I had sort of corresponding LRs at that point; we did a joint hearing. It may not come back to you. It didn't to me until I started going back in the history. But one of the components that we touched on at that hearing was children in poverty because, obviously, that is too often a gateway in terms of how...how do we look at ADC, the Aid to Dependent Children. Then in 2013, I introduced LB508. This committee decided, and we had a fairly lengthy conversation, to hold the bill, as we had a number of priorities. And particularly, that was the point where we were trying to figure out how do we deal with TANF. Senator Crawford, I think, had a TANF bill, and Senator Howard had a TANF bill, if you remember that whole context for LB508. So I indicated to the committee that I was more...I was ready at that point to hold the bill because we had some other priorities, but that in the upcoming legislative session, I would be back. I am back. (Laughter) Let me remind you of the intent of LB508 because it sets the stage for what we're going to hear today. LB508 was intended to prevent the unnecessary entry of children into the child welfare system by addressing poverty, which is a key to keeping children out of the system. The bill would ensure that families are able to provide for their children's basic needs, such as rent and clothing, through the Aid to Dependent Children Program. And at that point, we assessed that people would have to have a very low income, and you're going to hear an update on that. But when I introduced the bill, a family of three could earn no more than $740 a month after a disregard. And I'm sure we're going to hear an update to that or we will get it to you. And what's also very important here is that all able-bodied individuals on ADC must engage in work requirements. Or if you remember Senator Harms's bills a couple years ago, we also added education. So this is our, if you want to call it, welfare-to-work program. I mean, we get asked that a lot. You know, are these people...do they have a job? Are they trying to find a job? Are they

getting some education? That's part of what the ADC program would do. The bill, LB508, would have aligned the ADC allotment with the cost of living. And the allotment is determined by two factors. And, you know, we're not going to get, really, into the weeds of that. James Goddard from Appleseed will talk a little bit about how that's all put together. What I want you to note however is through the standard of need increases every two years, and it does by a percentage based on the cost of living, the maximum payment that can be given to a family has not changed in 30 years. And I must say, folks, that when we begin to look at children in poverty, which has been a major emphasis out of the State Planning Committee of the Legislature, I think, Senator Gloor, we might have done a brief on it for our colleagues. [LR539]

SENATOR GLOOR: We did. [LR539]

SENATOR CAMPBELL: Senator Harms has talked about it quite consistently. To think that we have done nothing, nothing with that for over 30 years is really what calls us to some action. Today you're going to hear a little overview of ADC 101 and TANF and how that fits together. And then Liz Hruska is going to give a brief kind of update for us on where we might be on TANF. And then you're going to hear from some other people who will give you some idea of ADC and how that might affect families. I would ask that we just hold any questions because the experts are behind me. But this is a very critical issue that the Legislature, it seems to me, does need to look at, not only in context of the child welfare system but the strengthening of our families across the state. Thank you, Senator Krist. [LR539]

SENATOR KRIST: Thank you, Senator Campbell. [LR539]

SENATOR CAMPBELL: So we will start, I think, with Appleseed. [LR539]

SENATOR KRIST: Okay. Fantastic. Welcome. [LR539]

JAMES GODDARD: Thank you. Good morning. My name is James Goddard, that's J-a-m-e-s G-o-d-d-a-r-d, and I'm the director of the Economic Justice and Healthcare Access programs at Nebraska Appleseed. Appreciate having the time to sit before you today. As Senator Campbell said, what I intend to do is provide a general overview of ADC and TANF, including its funding, its rules, its payment rate, and ultimately urge an adjustment to that rate. So I intend to go through this fairly quickly, so feel free to stop me if you have a question you want to ask. So the committee is familiar with the Aid to Dependent Children, or ADC program. It's also...it's funded by TANF so some folks call it TANF, but it's cash assistance for low-income families with minor children, used to pay for very basic living expenses, and ultimately is vital to ensure many families in our state can meet their basic needs. Some of that is a monthly amount of cash assistance, but there are other supportive benefits--transportation, childcare, work-related expenses. And generally speaking, it makes someone automatically eligible for Medicaid. It's really tied to their income; not everyone, but most folks are automatically going to be eligible for Medicaid. As I mentioned a moment ago, the Temporary Assistance to Needy Families, or TANF program, is the big funding source for our ADC program. But the TANF program ended a longstanding Aid to Families with Dependent Children Program, or AFDC, that had been in place for a number of years. But it really changed the way cash-assistance programs work in our country, creating a different framework for how funds are distributed, work requirements, and fundamentally changed the way these programs work across our country. These are the goals of the TANF program. You will see that they're pretty broad: provide assistance to needy families so children can be cared for in their own homes; promote job preparation, work, and marriage; reduce the incidence of out-of-wedlock pregnancies; encourage the formation and maintenance of two-parent families. But I want to go back to the top one because I think that really underscores what we're looking at in this legislative resolution and that is providing assistance to families so children can be cared for in their own home. That is very much connected to the amount of assistance that we give folks and how we support them. So keep that in mind as the goal of TANF. TANF is a block grant from the federal government, provided annually. It's provided to the states and then the states operate

their own program. But the states still have to, to receive the funding, they have to spend some of their own dollars, which is known as maintenance of effort, or MOE, one of the more fun acronyms. As I said a moment ago, with TANF you've got these four broad goals. And what that means is you've got quite a lot of flexibility in the way that you can use those funds. Here are a few ways, and I indicate at the end here, that these are just a few. There are other ways that these dollars can be spent because it is such a flexible...broadly-written goals. But that's not to say there aren't limitations that come along with it, because there are a few. One of them is the 60-month or 5-year lifetime limit. So generally speaking, folks cannot be on the program for more than 60 months. It doesn't matter if it's consecutive; it's over the whole course of a person's life. States are allowed some amount of flexibility in that. There are some exceptions for folks that would face hardship. If you're going to be homeless or really not be able to move ahead, then there's some exemptions. And states are also allowed, if you wanted to establish a shorter time limit, you can do that. If you want to make it longer, you can do that as well. Or you can...if a parent hits a limit, you can keep a child on the program if that's what the state wants to do. So there is some flexibility there. But most states have adopted the 60-month limit, and that's what Nebraska has done. The five-year bar is not something to spend a whole lot of time on, but it's just to say for certain lawful immigrants, mostly folks with green cards, they will not be able to acquire this assistance for five years from the date of getting that status. States have the option to pay for that on their own. And we actually did that for...I want to say around ten years or so. It ended two or three years ago, but we used to do that. I talked...Senator Campbell mentioned this in her opening, through TANF there are a number of requirements around work that the states have to follow if they want to get the TANF block grant. Generally speaking, half of your TANF participants have to be engaged in an activity for 30 hours a week. So most folks are required to do work activity. It can be 20 hours. If you're a single parent with a very young child, then they're required to work a bit less. But suffice it to say, there are a lot of requirements around work and a lot of things that people can do to meet those requirements. Employment First is the name of the program here in Nebraska. It's our welfare-to-work program and helps people try and

meet their work activities and get the support that they need to do that. Here are some of those activities. I do want to just emphasize the last bullet on education. Through the work of the Legislature, we are really leading the way in the nation around letting folks on TANF access education in an easier way for things like adult basic education, GED, postsecondary ed. This is another area where there is a lot of discretion about how you want to set eligibility in a state. The states have to provide funds to serve needy families with children, but you can...states can set different eligibility limits for different things. You could have one eligibility limit for cash assistance and another one for childcare. So there's quite a lot that states can do. This is what we've done in Nebraska, our ADC eligibility. Generally speaking, you have to...these are the general requirements, they're not every single one, but you have to have a child, a dependent child, living in your home. There aren't any adults without dependents that can be eligible for this program, in other words. You have to have a low income, which we'll talk about in a moment, and limited assets. You have to be a citizen or have lawful presence. And you have to be unemployed, underemployed, or about to become unemployed. So those are the general requirements, and then some of the other factors that we already talked about--the 60-month limit and participation in the Employment First program. So this is where I'll slow down a little bit and kind of walk through the income eligibility and how folks receive their monthly allotment, how that's determined. The income eligibility threshold...this is how I describe it because I think it's the easiest way to think of this. There is something called the "standard of need" and it's basically the income threshold such that if you're over this amount of money, then you're not going to be eligible for the program. There is a 20 percent disregard right off the top, but these, generally speaking, are the ranges. So you can see $650 per month for a family of two. If you make $670 and you're a family of two, you're not going to be eligible, in other words. There is a 20 percent disregard as I said. This is a adjusted in July every two years. So this was adjusted last in July of 2013. So these are the most recent income eligibility thresholds. So we already talked about some of the supportive services that you can get through ADC. This is really the focus of what we're talking about today in this LR and that is the monthly benefit that folks get. I don't want anyone to get...this is a methodology and I

don't want anybody to get lost in it, because the point is really the second bullet. But the way it is determined, the amount someone gets each month is determined by taking their income and subtracting it from the standard of need, I just talked about, or getting the maximum payment, whichever is less. The main thing to realize here is that many participants have...don't have significant income, which means they're going to get the max payment. So we need to ensure that's adequate because most folks in the state are going to get the max payment and that's what I want to talk about here. This is what those max payments are. And as Senator Campbell said, they've been in place 30 years and are among the lowest in the United States. You can see $293 per month for a family of two. Even with some of the other supportive services that you get--childcare, SNAP--that's going to be really hard to get through a month on those amounts of money. So you can see there is an issue there with the adequacy. And just in terms of comparison, you can see that we changed the foster care rates, I think, a couple years ago and they adjust up. But you can see that the base rate is $608 to 70 (sic) per month per child. So you can see there's some imbalance there where we're...where we, as we should, support foster parents who are taking foster children, of course, but we're giving those folks quite a lot more than the folks on ADC. And the goal of TANF is to keep children in that home. So in my estimation, an adjustment is long overdue to prevent poverty, keep families together, and really meet the goals of the TANF program. With that, I'm happy to answer questions if I can. [LR539]

SENATOR KRIST: Any questions? I don't see any. As usual, thank you, "Professor," (laughter) it was very enjoyable. [LR539]

JAMES GODDARD: Thank you. [LR539]

SENATOR KRIST: Next testifier. Welcome, Liz. [LR539]

LIZ HRUSKA: (Exhibit 5) Good morning, Senator Krist, Senator Campbell and members of the Health and Human Services Committee. My name is Liz, L-i-z, Hruska,

H-r-u-s-k-a. And I...last year, I presented a report, Senator Crawford had an interim study on TANF and I presented the full report to you. In discussions with Senator Campbell, I updated the report. I also streamlined it because the purpose of this legislative resolution was not TANF, but the ADC program. So you have sort of an abbreviated report. Much of the information that James just provided is also in my report. Now I will just focus on kind of where we are as far as the funding. Our annual TANF grant is $57.5 million. HHS budgets $63.1 million. And they have been budgeting right around that $63 million for many years. But as you'll see on the second to the last page of the report, they have been underspending that amount. And there's two basic reasons for the underspending. One reason, in the last two years, childcare has not expended the maximum allowable. And federal law allows for Nebraska to transfer up to $17 million to cover childcare payments. The last two years we have not expended the full $17 million, although the department had planned on it. When I inquired about that, the agency said they are on a limited drawdown right now. They must substantiate all claims and receive federal approval. I was told that they consider the full $17 million over the last two years to be obligated but not expended. So they do intend, if they can get the documentation, to spend the full amount. And the other reason kind of relates to what this legislative resolution is about is that ADC has been underspending what they have budgeted. Since September of '13, caseloads have declined 14 percent. The year-to-date average in September of 2012 was 7,255 families; last year in September it was 6,954 families; and September of this year it's 6,227 year-to-date. Although the year-to-date is three months, it's a three-month snapshot, that's consistent over these three years. And you can see every year there is a decline. So in the last page of the document, I had asked the department to provide their projections. They assume going forward expending the full $63.1 million a year. That would leave us a balance in September of '19 of $40 million, but they would consider $8 million of that to be, again, obligated but not expended under childcare if they can work that situation out. So there is...if ADC caseloads continue to either decline or even if they level out, there would be some additional room in the TANF funding to cover an increase. I didn't calculate anything out because I didn't know what the specific proposal would be, if it would be

the same as LB508 or something different or if we would have some discretion as far as how much TANF could pick up versus the General Fund. So I think to get a calculation of how that would affect the balance, there would need to be a specific proposal and probably some discussion with the department. And also kind of a discussion on what do we feel an adequate rainy day reserve fund should be in this program. That's basically my presentation, if you have any questions. [LR539]

SENATOR KRIST: Any questions for Liz? In your discussions about the minimums for the "rainy day," what responses have you gotten from the administration? [LR539]

LIZ HRUSKA: I haven't talked to them about it. I'm saying if you want to pursue a proposal, that discussion needs to take place. So I didn't make any assessment of that and I didn't ask them to make it either. Basically, I'm just presenting kind of a picture of what it looks like today. And then as far as what the policy implications are going forward, again, that would be dependent on a specific proposal. [LR539]

SENATOR KRIST: What, in your professional opinion, what's the best way to have that conversation? [LR539]

LIZ HRUSKA: I think Senator Campbell, who has taken the lead on this, maybe should present a proposal, whether it's LB508 or a modification of LB508. Then we can do the calculations. I would work with the department to see where that would put us. Then maybe there might be modifications or we could go with that. I guess kind of what the process is, is a specific proposal, calculation, discussion, and then see if...where that would put us and whether or not the proposal might want to be modified to a different level. I was here the last time the ADC payments were increased and it was during the Orr administration. And James brought up foster care payment rates are substantially higher than ADC. Until, probably, the mid-2000s, I think, ADC payments and foster care payments were actually identical. The department, I think it was probably the old Department of Social Services at that point, brought in a proposal to separate out the

payments for foster parents so that they could continue to recruit foster parents. And it just...and it went to an age-based payment at that point, too, where ADC has always been a flat rate. So that conversion was taking place probably 20...close to 20 years ago. [LR539]

SENATOR KRIST: We're extremely lucky to have your historical data and I appreciate that. But just for the record, that's not...did it take a statute change last time it was put into effect? [LR539]

LIZ HRUSKA: I'd have to go back and look at it. I think the payment rate is in statute. I can't remember if there was some room in the statute and it was just a budget issue. I think it was statutory and I think it was former Senator Vard Johnson that probably brought the proposal. I remember working with him on this issue. But I know there is a payment rate in statute and it probably hasn't been changed since the Orr administration or it could have been even prior to that with some room. I think the language does say "up to" a certain amount. [LR539]

SENATOR KRIST: So we'll take that for action then. That's good. Thank you. Any other questions for Liz? Senator Cook. [LR539]

SENATOR COOK: Thank you, Senator Krist. And thank you, Liz, for your help in understanding this. You mentioned during your presentation the numbers of participants in Nebraska's programs. Could you point that out in the report. I can't find it, or was that something you gave verbally only? [LR539]

LIZ HRUSKA: I just gave that verbally. [LR539]

SENATOR COOK: All right. [LR539]

LIZ HRUSKA: That report--and I probably could go back and edit it--that report I just

kind of stuck to more description. I don't know why I didn't put that in. I could amend it and have it sent out to the committee. [LR539]

SENATOR COOK: Okay. [LR539]

LIZ HRUSKA: I did mention that ADC rates declined, but I didn't give the specific numbers. [LR539]

SENATOR COOK: Okay. That would be helpful and I would appreciate that kind of information as we go forward with background. I'm thinking the committee is going to be exploring this and it's just great for conversation. [LR539]

LIZ HRUSKA: Yeah, I can change that and I'll mail it to Senator Campbell's office. [LR539]

SENATOR COOK: Thank you. [LR539]

SENATOR KRIST: Thank you, Senator Cook. Thank you, Liz. Senator, I'm sorry, Senator Cook. Senator Campbell. [LR539]

SENATOR CAMPBELL: In the time period that you've watched this, has there ever been an effort to have a step-down amount instead of just, you know, when you get to seven...oh, you know, $530 you're out of the program? And the reason I ask this question is because when LB508 was discussed at some point, Senator Carlson had come to me and said, you know, isn't there some way that we can gradually help people rather than this sort of cliff effect? In your history, Liz, has there ever been an attempt to create sort of a step down. And probably have to ask the department whether we federally can even do that. But that's been a question I've gotten from senators. [LR539]

LIZ HRUSKA: As income would go up, the payment would be adjusted, as James

pointed out. [LR539]

SENATOR CAMPBELL: Right, right, but... [LR539]

LIZ HRUSKA: It's the...which ever is left of the two calculations. There is, off the top of my head, I haven't looked at this for a while, we do give a half-a-month payment, I think, for four months once a person exceeds the income requirements, so that there is sort of that transition period. Since we do adjust the income...the payments based as the income goes up,... [LR539]

SENATOR CAMPBELL: Right. [LR539]

LIZ HRUSKA: ...I think that might be the...sort of the step-down process that probably Senator Carlson was not aware of. It's different than childcare which does have a very specific cutoff, which I know in the past has been a concern to senators as far as one month you're eligible and then, you know,... [LR539]

SENATOR CAMPBELL: Then you're not. [LR539]

LIZ HRUSKA: ...you might get a small raise and you're off the program. So there is...there is a transitional benefit and there are some adjustments. But, yes, once you do exceed that and go through the transition, you are off the program. [LR539]

SENATOR CAMPBELL: We'll take a look at that, too, Liz, that period of time. Thanks. [LR539]

LIZ HRUSKA: Yeah. I wasn't really prepared to respond to those. [LR539]

SENATOR CAMPBELL: No, that's all right. I just kind of thought of that as we were going through. So we'll take a look at that issue too. Thank you, Senator Krist. [LR539]

SENATOR KRIST: Thank you, Senator Campbell. Any other questions for Liz? Thank you so much for your testimony. [LR539]

LIZ HRUSKA: You're welcome. [LR539]

SENATOR KRIST: Next testifier. Welcome. [LR539]

EBONY DORTCH: Good morning. [LR539]

SENATOR KRIST: Can you spell your name for us please before you start? [LR539]

EBONY DORTCH: My name is Ebony Dortch, E-b-o-n-y D-o-r-t-c-h. [LR539]

SENATOR KRIST: Thank you. [LR539]

EBONY DORTCH: And I am a participant with the DHHS program. And I have been struggling for many, many years. I'm a mother of five. I have...I'm single. I'm trying the best that I can do with this program. It has helped me along the way. And I just notice that I'm still struggling and I'm trying to take care of my five children. My oldest is seven, my youngest is one. And with the program I have tried to become self-sufficient. It is very, very hard. I receive $506 for my ADC and I pay all that with my rent and I braid hair on the side to make ends meet. Every day, I got about 20 to 30 clients. Most of them are my family and I love them very much for just helping me along the way. But I really don't have no one to turn to for money. I don't beg, don't panhandle. I don't believe in that. My mother was disabled. And I just wanted to be able to show my family that I can do this and become self-sufficient. My dream was to go to hair school, but with all the doctor appointments, I have been sanctioned many, many times. And once I was sanctioned for a whole year. Yeah, I was sanctioned for a whole year and I did not understand that. I missed and not turned in an income verification from a temp job. And

that completely threw me all off track. And it was hard for me to get back on track. And I have one girl and the rest all boys. I love my family. I always have my children under my custody. I'm a 25-year-old mother. And I've just been struggling to make it with the ADC program. My mother...I come from a family of four and...but when I was little, her sister died; we had to let in four other children, which was very, very hard. So it's just been a constant struggle. And I thought the program would be able to help me. But I'd rather stand on my own two feet and become self-sufficient. So any questions? [LR539]

SENATOR KRIST: Do you have any questions for Ebony? Senator Cook. [LR539]

SENATOR COOK: Thank you. And thank you, Ms. Dortch, for showing up and telling us your personal story. I have a question about this sanction. You mentioned that because of all of the doctors appointments, are you saying that you would have doctors appointments scheduled for your children and if you missed them then you would be sanctioned by this program? [LR539]

EBONY DORTCH: Yeah. Yeah. I will let them know what was probable cause, but I still would have to make up my hours. I'm required to do 20 hours a week. And I had did that, but some of my kids have asthma and it's really hard to keep on track with appointments and with the 20 hours a week. It was really hard, but I've done it. [LR539]

SENATOR COOK: Okay. Thank you. [LR539]

EBONY DORTCH: Thank you. [LR539]

SENATOR KRIST: Thank you. Welcome. Could you spell your name for us, please? [LR539]

VALERIE STEWART: I'm Valerie Stewart, V-a-l-e-r-i-e S-t-e-w-a-r-t. I'm trying my best not to cry. [LR539]

SENATOR KRIST: Take your time. [LR539]

VALERIE STEWART: Twenty thirteen, November 2013 I found out that I was pregnant. I didn't know how I was going to survive. I didn't know how I was going to take care of my daughter. So I signed up for ADC thinking it would help me. But only receiving $293: paying rent-$150, diapers, clothing--thank you--I didn't know how I was going to survive. I was living in fear. I had to worry about finding a stable place to live for my child, being able to find Pampers, a car seat, a crib. I'm still living in fear of being thrown out because I don't have enough money to pay rent, not having enough money to buy diapers, not having enough money to provide for my child. If it wasn't for the Pathways Program I don't know where I'd be right now, probably homeless on the streets, struggling. I try my best to take care of my three-month-old. She's my world. If there was an increase in ADC, it would help out a lot, it really would, because I do not want this life for me or my child. I try my best daily. I do little odd jobs on the side, take care of other people's children, clean houses just to make ends meet for the rest of the month, because $293 is gone in two weeks. I sometimes have to borrow money from people just to buy Pampers or wipes. I go to the Goodwill to buy my daughter's clothes because I can't buy her brand new clothes because $293 is not enough. [LR539]

SENATOR KRIST: Thank you for the courage of coming and talking to us. [LR539]

VALERIE STEWART: You're welcome. [LR539]

SENATOR KRIST: Thank you. Any questions? Thank you, Ms. Stewart. [LR539]

VALERIE STEWART: Thank you. [LR539]

SENATOR KRIST: Next testifier. [LR539]

MATTICE MAYO: Hello. [LR539]

SENATOR KRIST: Hi. Could you spell your name for us, please? [LR539]

MATTICE MAYO: Mattice Mayo, M-a-t-t-i-c-e M-a-y-o. I am...I used to receive food stamps and ADC. I'm a single mother of six. Growing up, it seems like it's been a generational theme, my grandmother received it, my mother received it. And instead of them encouraging me to pursue higher education, it was just help me to survive. It seems like they were adapting to government assistance. It's been a struggle, but now I am working for a nonprofit as a SNAP outreach specialist. It's hard signing up participants for that, to see what they go through as well. So it's just me trying to change it for my kids of it being a generational theme. And that's what it seems like it has been. It's not enough. When I was receiving it, I was receiving $364 and I had to resort to public living which is very scary because I had to live around certain crimes and things like that and it's something I didn't want for my kids. So I am improving my life. And I see other people in the struggle, but hopefully it gets better. Thank you. [LR539]

SENATOR KRIST: Thanks for coming. Any questions? I don't see any. Thank you very much. Next testifier. Hi, could you spell your name for us, please. [LR539]

MARY ANN KLECKNER: Mary Ann Kleckner, M-a-r-y A-n-n K-l-e-c-k-n-e-r. I'm from Omaha, Nebraska, and I would like to thank you for the opportunity to be able to tell my story to you and the struggles I am currently facing. I'm a single parent with one child, a sophomore in college; one senior in high school; followed by a junior; an 8th grader; and a 6th grader. So I have four children of my own in my home currently. All is going fairly well. I do make a meager income and am able to support my children; I work full-time. I'm not getting rich, by no means, but my bills are paid. Then in July of 2013, (emotional) sorry, my stepson, who was 24 at the time, was killed in a traffic accident. Our world fell apart. At the time of his death, he had a girlfriend who had a 14-year-old daughter and they had an infant child together. All three of them moved into my home so now I have

myself, my four children, his girlfriend and two children. Within two weeks the girlfriend abandoned the two children with me and so now I have six children in my home on my income. I, of course, had to hire day care to take care of the infant while I worked, which costs me $100 per week. I am now buying formula, diapers, baby care items, etcetera. I then after a few months hired an attorney and got full permanent guardianship of the two children. Now as you can imagine, this was a sudden and huge financial burden for me. To add to matters, I had already started notice that something was wrong and just not right with the infant. I would notice little tremors and that she had some deformities in her hands and toes. I started to take her to the doctors. And then one day she had a seizure. I rushed her to the hospital where we would stay for three days. I then started to notice that she did not follow me with her eyes. The ophthalmologist diagnosed her as legally blind. After many hospital stays that started to be a monthly...lengthy stays, she was diagnosed with in utero drug exposure brain damage, meaning she has brain damage on the right frontal lobe of her brain. Now as you may notice, at this point I am missing a lot of work, which means no income. I started going to food pantries. I drained my savings. I lost my car. I had become working poor. I was late on my bills, sometimes only being able to pay part of them and asking for extensions on them. At this point I knew I needed help, real help. I was in trouble. I turned to state aid. Surely the state would help me and I had exhausted all other resources--churches, missions, outreach programs, everything I could possibly think of. So I swallowed my pride and I signed up for welfare. I qualified, which was great. I thought to myself, well, in the phone interview with the lady from ACCESSNebraska this is wonderful. So she listened to my story and was so helpful and she told me: I'm sorry but I can only give you $293 a month for the two children. The other children did not qualify because they're receiving child support. And she said, that's all I can do to help you. I thanked her and I got off the phone and I burst into tears...$293...$293. What am I going to do? How am I going to do this? God, what am I going to do? Now, how am I going to pay the doctor bills, the day care? What about the gas to and from work and to drop and pick up from schools? As you can see, my mind was racing; I was in shock. Then a thought occurred to me. What do people do that do not have jobs? Is that why people are stealing bread from grocery stores? Is this

why there are so many homeless? Could this one tragedy cause me to become homeless? I was in sheer terror. How am I going to take care of these kids, especially the baby? She has so many problems. I am still struggling. I'm working extra hours as much as I can. I asked my boss for a raise and he did give me one, not quite big enough to get me out of the red. I frequently frequent the food pantries. I am very grateful for handouts from the church. They gave my kids Christmas gifts last year because I had to choose between electricity or Christmas for my children. I stand in line at food pantries. My kids are wearing hand-me-down clothes. It's really rough. I was asked one day about my opinion for the amount of money that the state helps with Aid to Dependent Children. My response was it's not enough, it's just not enough to help families in need. Please see this other side of the coin. I was once someone who looked down in ignorance to those who were on welfare. I never thought that I would ever be in their shoes. Now I am, because of one small tragedy. I would like to thank you for your time and encourage you to remember this story and the one little tragedy that changed my life. Thank you. [LR539]

SENATOR KRIST: Thank you for the courage. [LR539]

MARY ANN KLECKNER: Any questions? [LR539]

SENATOR KRIST: Thank you. Next testifier. Hi. [LR539]

AUBREY MANCUSO: (Exhibit 6) Good morning, Senators Krist and Campbell, members of the committee. My name is Aubrey Mancuso, A-u-b-r-e-y M-a-n-c-u-s-o, and I'm here on behalf of Voices for Children in Nebraska. I do just have to say that it's such a difficult and powerful story to follow and I think speaks to the stories of so many hardworking Nebraskans who are just living so close to the brink of where one tragedy can really change your financial experience. I'm hoping to add to this discussion today by following up on Appleseed's excellent summary of how the program is working and the experiences you've heard of families with some data about what families actually

need to make ends meet. First of all, as the committee is likely aware, the most common reason that children in Nebraska enter the child welfare system is neglect. In 2012, physical neglect accounted for 76.5 of all substantiated cases of child maltreatment in the state. And neglect cases are often related to the financial circumstances of a family. ADC grants also provide financial support to relatives and other trusted adults who have stepped forward to care for children who cannot remain with their parents before the child comes to the attention of child welfare officials. And many of these caregivers, like in the story you heard before, have not had adequate time to make financial preparations for raising a child, but choose to do so because they want to care for their kin. And access to adequate financial assistance is essential to helping keep kids in their own homes with people they trust. The most current data we have on monthly average ADC payments puts a household average payment at about $320 per month. The average payment in Nebraska has essentially remained unchanged over the past decade, and has, in fact, fallen slightly, as you'll see on the chart on the second page of my testimony. Unfortunately, for Nebraska families, the cost of basic needs has not fallen over the past decade. Earlier this year, we released the "Family Bottom Line" report that looks at what Nebraska families need to make ends meet based on household size and county of residence. Attached to my testimony is a chart that details the basic monthly expenses in different regions of Nebraska. In 2012, the majority of ADC cases did not actually include the parent as a part of the household. But of those that did, the majority were single-parent households. And according to the "Family Bottom Line" data, the monthly amount that a single-parent family with just two young kids would need to make ends meet ranges from about $2,800 per month in Hall or Johnson County, just under $4,000 per month in Douglas and Lancaster County, and actually falls just over $4,000 per month in Sarpy County. In every case, these payments are woefully short of meeting the totality of basic needs. And even if we assume that a family is receiving some additional benefits, like SNAP to cover the cost of food, the monthly ADC payment wouldn't even cover the cost of housing in any county in our state. I think another important point that Senator Campbell and others have brought up today is that because of the work participation requirements, these

families are essentially working 20 to 30 hours a week. So a person working 30 hours a week and receiving that average household payment will be making about $2.67 per hour for their time they're spending in those work-participation activities. And I also just wanted to quickly address Senator Cook's question. I have the 2012 data with me, and there were about 7,775 households, that was a monthly average, receiving ADC. And then there were just over about 15,527 children in those households. And so I think...you know, just to close, I think to Senator Campbell's point, a lot of states around the country are really looking at ways to innovate around the public safety net and really using that five-year time limit not as a punishment to cut people off but as a window of opportunity to help families transition to greater financial stability. And I really think raising the payment rates is certainly a huge piece of that and I think there's a lot of other opportunities we could look towards as well. So thank you. And I'm happy to take any questions. [LR539]

SENATOR KRIST: Thank you. Any questions? Thank you very much. Thanks for your testimony. [LR539]

AUBREY MANCUSO: Thank you. [LR539]

SENATOR KRIST: Next testifier, please. Anybody else want to testify today? Okay. Last, but by no means least, welcome. [LR539]

GREG SCHLEPPENBACH: Yes, least. Good morning Senator Krist,... [LR539]

SENATOR KRIST: Good morning. [LR539]

GREG SCHLEPPENBACH: ...Senator Campbell, members of the committee. My name is Greg Schleppenbach, that's G-r-e-g S-c-h-l-e-p-p-e-n-b-a-c-h, and I am the now executive director of the Nebraska Catholic Conference succeeding the irreplaceable Jim Cunningham. [LR539]

SENATOR KRIST: Congratulations. [LR539]

GREG SCHLEPPENBACH: Thank you. Big shoes to fill. As I was preparing for the hearing today, I was sent a speech that was given by the Archbishop of Philadelphia, Charles Chaput, talking about a number of things of our engagement in the culture. And I read this statement and it hit me between the eyes and I want to share it with you. He's talking about our duties as Christians in the public square. He says: As I've said many times before, we have serious obligations as believers to care for the poor, the immigrant, the elderly, and persons with disabilities. Those duties belong personally to you and me, not just to the government, though government clearly has an important role. If we ignore the poor, we will go to hell. If we blind ourselves to their suffering, we will go to hell. If we do nothing to ease their burdens, then we will go to hell. Ignoring the needs of the poor among us is the surest way to dig a chasm of heartlessness between ourselves and God and ourselves and our neighbors. I share that with you not so much as a fire and brimstone admonition to you, as it is to punctuate the seriousness with which the Nebraska Catholic Conference and the Catholic Bishops of Nebraska consider public policy that impacts persons experiencing poverty. We're not only motivated by our faith, but we're motivated by the fact that we have and the church has significant skin in the game in helping persons experiencing poverty. Catholic Social Services and Catholic Charities do a tremendous amount of work in helping those in need. I handed out some comments by Curt Krueger who helps with the emergency assistance program at Catholic Social Services in the Lincoln Diocese. And last year alone, Catholic Social Services served over 42,000 individuals and provided more than $2.5 million in assistance. My own personal experience is I've, for the last 15 years, have been a volunteer with the St. Vincent DePaul Society, where we meet with and try to help materially and spiritually and otherwise really some of those who are most in need in our community. I think it's evident, as others have testified clearly, that the ADC payment level is seriously out of sync with very basic cost of living. We also think it's important to look at the effectiveness of other provisions of the ADC program,

specifically the Employment First component and the extension that helps transition out of the ADC program. I want to just share a couple of the comments that Mr. Krueger included in his comments on these two points. He asked the question, and sort of based on his experience: Does the Employment First Program actually lead to gainful employment? Is success measured through unemployment statistics or through reduction in ADC beneficiaries? It has been his observation that there are far too many ADC recipients performing their Employment First hours doing menial chores at nonprofits, as opposed to actual job skill development and job placement search. A reduction of the number of ADC recipients does not necessarily mean clients are becoming gainfully employed. And he asked...he said he would be interested to see what a study would determine of the effectiveness of this program. And then he says: It's often a complaint of both ADC recipients and human services workers who work directly with those recipients that moving off of ADC is too punitive. In the ADC rules, there is a possibility for clients to receive an extension of both medical and cash benefits after first becoming employed. How is the ability to receive this extension communicated to the client and how well are the DHHS caseworkers trained themselves to know that benefit exists? Is there something that can be done to provide greater incentive for clients to return to work? I just want to conclude by expressing that the Catholic Conference, and I know that Jim has done a tremendous amount of work in this area as my predecessor, we will continue to work with you to address these very important needs. Thank you. [LR539]

SENATOR KRIST: Thank you. I just note that in the Omaha Diocese, when I've had an issue, Father Ryan Lewis, John Pietramale, and Tom Fangman have been very responsive to making sure that the right services are available, even to the point of taking people in when time is there. So recognition that that diocese...your diocese in Omaha, the diocese in Omaha has done a wonderful job of stepping up to the plate. And thanks to Jim for all he has done in the past and congratulations to you. [LR539]

GREG SCHLEPPENBACH: Thanks. I want to shout out also to our...a lot of our

pregnancy help centers who, based on some of the testimony here, I know that they do a tremendous amount of work to provide some of those basic needs to mothers and their babies after birth. And so I want to shout out, there's over 30 of them in Nebraska that operate entirely on donations and try to provide all those basic needs to women and their children. [LR539]

SENATOR KRIST: Thank you, Greg. [LR539]

GREG SCHLEPPENBACH: You bet. [LR539]

SENATOR KRIST: Any other questions? Thank you very much. [LR539]

GREG SCHLEPPENBACH: You bet. [LR539]

SENATOR KRIST: Senator Campbell, would you like to close for us. [LR539]

SENATOR CAMPBELL: I don't really have any additional comments. We'll follow up on any of the questions that were asked. And we'll follow up with Liz. But we will certainly be introducing a bill before the committee. [LR539]

SENATOR KRIST: Thank you. That concludes our morning activities. We will reconvene at 1:30 under her control. [LR539]

SENATOR CAMPBELL: Good afternoon, everyone, and welcome to the continued hearings of the Health and Human Services Committee. I'm Kathy Campbell and I serve District 25, east Lincoln and eastern Lancaster County. We certainly appreciate you taking time from your schedules to be with us. This afternoon, we have got senators coming and going this afternoon. Some have...are opening in another hearing, some already had a meeting set up, so it will probably be an interesting come-and-go this afternoon. I'd like to go through some housekeeping details with all of you. If you have

something in your possession that makes noise, a cell phone or whatever, please put it on silent or turn it off because it's very disconcerting. We will use the lights this afternoon. The clerk will put them on after you've given your name and spelled it. You have five minutes. It will be green for a long, long time and then it will go to yellow and that will tell you, you have about a minute to wrap it up. We'll be a little bit more lenient but we're trying to get everybody in because we have two hearings this afternoon, so want to make sure that we do. When you come forward we ask that fill out one of the orange sheets with your name and print very legibly for the clerk, and then we'll ask you to state your name for the record and spell it so that the people who are listening also have the correct spelling for your name when they transcribe the hearing, and that's why the importance of both of those. What else am I forgetting? We'll do introductions as usual so we'll start...Senator, would you like to start us off?

SENATOR WATERMEIER: Dan Watermeier from Syracuse.

MICHELLE CHAFFEE: I'm Michelle Chaffee. I serve as legal counsel to the committee.

SENATOR GLOOR: Mike Gloor, District 35, Grand Island.

BRENNEN MILLER: Brennen Miller. I serve as committee clerk.

SENATOR CAMPBELL: And J.T. is our page this afternoon. So if you need some assistance with copies of material that you want to give to the committee, or really any question that you might have, J.T. is very helpful and can assist you. So with that, we will go ahead and open and invite Senator McGill to join us at the table. We'll open the hearing this afternoon on LR592, which is Senator McGill's bill or interim study to examine various methods of behavioral health work force development. Welcome, Senator McGill.

SENATOR McGILL: (Exhibit 1) Thank you, Senator Campbell and members of the

committee. I think this is my last time opening on anything here as a state senator, so I might be a little more long-winded than normal, but I just want to make sure I'm covering all my bases. This is obviously an issue that has been near and dear to my heart for many years and wanted to have the chance to really get on the record on it in a thorough way here. I'm very proud to present information to you today about Nebraska's behavioral health work force. As you know, the safe haven crisis of 2008 changed my life and my career. I was devastated to learn that as a state we were failing our children and families, and that we were ignoring some of our most vulnerable Nebraskans. It wasn't because we didn't have good behavioral healthcare services; it was because we didn't have nearly enough of it. As a result of the safe haven crisis, we formed--and I chaired--the Children in Crisis Task Force. I promised my constituents and all Nebraskans that I would do whatever I could to help. One of the many problems highlighted by the safe haven crisis was the lack of behavioral healthcare professionals. Folks weren't getting the help they needed and many times that was because they had nowhere to go. We created the Behavioral Health Education Center of Nebraska, or BHECN, to address the severe shortage of these professionals in Nebraska. BHECN was designed to recruit, retain, and train the work force, and I'm happy to report that they have made many huge strides in all of these areas. I'm comforted by the fact that they will work diligently to fulfill the intent of the changes made after safe haven. Today, you will hear about projects that were started with BHECN in 2013 and 2014. In 2013, I passed LB556 that created a BHECN pilot program where children can receive behavioral health screenings in pediatricians' offices. If those screenings reveal a concern, the patient is offered service from a psychologist that works right alongside the pediatrician in the same office. This model of integrated care, where a physician and behavioral health professional work together as a team, is proving to be effective and valuable, and you will hear more specifics about that today. In 2014, I passed LB901 that created internship opportunities for psychology students in doctors' offices. This internship program will go a long way to keep our talented students in Nebraska because before this bill was passed, these students had to leave Nebraska to complete an internship. This program will also teach students how to work effectively in an

integrated environment with a physician. As our healthcare industry evolves and we learn more and more about what works best for patients, we want to be sure we can offer experiences for students that reflect best practices. And I know BHECN is poised to support a topnotch work force that is prepared to succeed in an evolving healthcare system. I'm certain that these programs will continue to grow and increase their impact on the issues we face. We must not forget that we've got a long way to go. The majority of our state is a federally recognized healthcare shortage area. There are counties in Nebraska that have no behavioral healthcare provider at all. The few that we do have are overworked and undervalued. The majority of our citizens who need behavioral healthcare will not get it. Many will not even seek care because of the stigma attached to mental illness and addiction. We've got a long way to go. Those that will testify today understand that business as usual will not get the job done. We have to be creative and innovative if we want to get care to the masses of people that are silently suffering. I ask that you please take a look at the graph on page 4 of the pretty colored handout that we passed around. These figures tell us that in the last 50 years we have dramatically decreased the number of lives lost to heart disease, AIDS, and leukemia, but we continue to lose just as many lives to suicide. Why? Given all the fantastic advances in medicine, it's hard to believe. Business as usual will not get this job done. Those that will testify today will tell you about current practices and ideas for the future that represent innovative approaches to behavioral healthcare, approaches designed to save lives. You'll notice that the packet of information provided to you contains a lot of great information about the behavioral healthcare work force in Nebraska. I encourage you to review these materials as it provides additional information that should be useful to you throughout the legislative session. The order of the testimony today should mirror the order of the information in the packet. So I hope this simplifies the process and allows you to digest as much information as possible. We understand that you've graciously allotted one hour for testimony today and we believe we have things timed to just fit that hour. We have various behavioral health professionals and students from all over the state here to talk about the successes and challenges, and I'd like to express my sincere appreciation for their hard work on this study and for the effort it took to get

here today. As I finish my career with our Legislature, I'm left with a feeling that, of course, I could have done more if only given a little more time. But it gives me great peace, however, to know that you will all continue to shape policy in this critically important area. And I want to thank Senator Crawford in particular because she has in the last year really started to attend meetings at BHECN with me to maybe pick up where I've left off in terms of this issue. It also gives me great peace to know that there are so many members of our community, like those here today, that remain committed to the health and well-being of Nebraskans. Thank you. [LR592]

SENATOR CAMPBELL: Thank you, Senator McGill. Any questions or comments from the senators? Will you be staying for the whole hearing? [LR592]

SENATOR McGILL: I am. All right. Thank you. [LR592]

SENATOR CAMPBELL: Thank you. All right. What we're going to do this afternoon is we're going to...there is no pro or, you know, if you're against anything, or neutral; we just take testimony. But usually a senator does put together a list of people that have indicated to her that they have an interest, and so what I'm going to do is I'm pretty much going to go down the list that I've been given. And then we will...certainly any others in the room who wish to testify, we'll make sure we get that in. So, the first person on the list is Dr. Joe Evans. I saw Dr. Evans sort of get up, so I figured he knew the order here. Good afternoon. [LR592]

JOSEPH EVANS: Good afternoon. My name is Dr. Joe Evans, Joseph, J-o-s-e-p-h, middle initial H, last name Evans, E-v-a-n-s. I am currently a professor and director of psychology at the University of Nebraska Medical Center, and I'm involved in the training of psychology interns and postdoctoral fellows to become behavioral health providers in the state of Nebraska. I'd like to thank members of the Health and Human Services Committee, in particular Senator Campbell and Senator McGill, for allowing us to present today. And some of the materials, hopefully, will be of interest to you about

progress we're making in terms of implementing BHECN and some of our training programs. As you are aware, there is a significant shortage of behavioral health providers in the state, particularly in rural Nebraska. Even in areas where we have relatively adequate numbers, we have a maldistribution. So, for example, Nebraska remains below national averages in terms of numbers of behavioral health providers. By way of example, the national average for psychologists is 33.2 providers per 100,000 population. In Nebraska we're at half of that, 17.8. And when you get into rural areas it's even lower, it's 6.8. So anything outside of Omaha and Lincoln is basically considered a shortage. Seventy-four percent of our behavioral health work force works in Omaha and Lincoln. There are only 27 psychiatrists, 61 psychologists, and 20 nurse practitioners...psychiatric nurse practitioners practicing outside of the Omaha and Lincoln metropolitan areas. HRSA, the federal Health Resources and Services Administration, has designated 88 of the counties...93 counties in Nebraska as mental health profession shortage areas. And behavioral providers providing specialty care, for example, for children and adolescents, it's even harder and sometimes takes up to six months to get an appointment. In 2009, just for background information, the establishment of the Behavioral Health Education Center occurred. And under the leadership of Dr. Howard Liu and Brent Khan, BHECN has supported training for psychiatric residents, has established a pipeline Ambassador Program to attract high school and college students, has sponsored behavioral health conferences and workshops for 5,000 participants, established a BHECN Kearney Office for improving training in central and western Nebraska, created on-line modules in the use of telehealth for our colleagues in behavioral health, adapted a strategy involving integration, which I wanted to speak to more specifically, of the integration of behavioral and physical healthcare in what we are now calling the medical home or healthcare home. We've collaborated, in response to Senator Amanda McGill's in the creation of LB556, which provides a pilot program for primary care, behavioral health screening, referral, and backup psychiatric consultation, which you'll hear about in a few minutes. And last year initiated, as Senator McGill mentioned, LB901, which provides much needed stipend support for psychology internships, since most of our graduates were

leaving the state. To address many of the discrepancies, we have established a program of integrating behavioral healthcare into primary care. This was started at UNMC actually back in 1998 and this program is designed to attract, recruit, train, place, and retain providers in underserved areas, particularly in rural areas. At present, UNMC is working with 19 different sites around the state that can provide some of this training and this is in rural areas alone, and 13 in urban areas. Practices range all the way from Rushville, Nebraska, with a population of 900, down to Nebraska City, which is on the other side of the state with a population of around 7,000. Despite all these advances, we still have many areas of the state that are underserved. So, Senator McGill mentioned that we have some state...37 of our counties have no behavioral health provider at all. The number of...we have 521 incorporated cities, towns, and villages with populations ranging from 420,000 to 1. And the median size for our towns in the state of Nebraska is 318. So that means half of our towns, half of those 520, have a population of less than 318 folks. How do we get services to those folks? And that's, I think, part of our mission at BHECN and trying to out...reach out and as well as establish regional centers as well with backup from telehealth. In 2013, LB901 was approved by the Legislature to expand BHECN training, because in the past it had been more specific to psychiatric residency training, but we added in psychologists last year because, again, of the shortage and the fact that our graduates were actually leaving the state and never coming back. So an approved internship is required. It's requires 2,000 hours of supervised experience and psychologists are trained to work with individuals, children, and families. Of the eight clinical psychology residents usually graduating each year, only one stays in the state. LB901 provided BHECN with funding for five "stipended" internships in 2014, increasing eventually to ten in 2016, and this year we were able to place interns in rural sites including Nebraska City, Chadron, Gordon, Crawford, Alliance, and Valentine, Columbus, Hastings, Fremont, and Omaha. One of our interns, Anitra Warrior, who is a graduate of the UNL counseling program, will speak on this issue next. Future plans are to expand into master's level licensed mental health practitioner training from individuals in counseling, social work, and marriage and family therapy from our sister university programs at Chadron State,

Wayne State, UNK, UNL, UNO, and create positions for these individuals in integrated care practices. In those 40 states...40 cities around the state, if you look at page 6 on your handout, for example, you'll see that those are the 40 towns in the state that have populations of at least 3,500, meaning they'll have at least two or three docs there that we can partner with for integrated care. There's a...I think a good opportunity for us to target those, and we're already in 17 of those. So we think we have a good shot at meeting that goal. So BHECN is committed to targeting the primary care practices in these towns for placement and retention of behavioral health providers, and eventually making behavioral health available to all Nebraska citizens within a 60-mile radius. [LR592]

SENATOR CAMPBELL: That you, Dr. Evans. [LR592]

JOSEPH EVANS: Any questions? [LR592]

SENATOR CAMPBELL: Questions from the senators? This is a pretty thorough report. I know that you were really conscious of the time. Was there anything particular in the report that's in front of us that you might not have had time to cover or want to cover? [LR592]

JOSEPH EVANS: Well, I'm hoping that, if you think of the behavioral health work force, we're talking psychiatry, psychology, marriage and family therapy, social work, psychiatric nursing, and counseling, and drug and alcohol counseling. We've really started at the top with residency training. Now we're getting into psychology. But we know that there's a very large part of the work force that needs to be out there in our more rural programs. So the beauty of working with places like Wayne State, Chadron State that have master's degree programs, and Kearney, is that we'll be able to attract students from those areas who really have an investment and want to stay in those areas, but they don't have an access to like healthcare training. That's just not part of the usual curriculum. So the Med Center is, I think, in a position to help train those folks

using some of our distance learning technology and then provide internships and then, hopefully, placements into some of these more rural towns. [LR592]

SENATOR CAMPBELL: Dr. Evans, do you happen to know whether behavioral health is covered under the Rural Health Advisory Committee that deals with loan repayment? Doctor...or Marty Fattig is the chair of that group. [LR592]

JOSEPH EVANS: Yeah, I know that there are two...there are two programs in the state that do cover loan repayment. [LR592]

SENATOR CAMPBELL: Okay. [LR592]

JOSEPH EVANS: One of them is the National Health Service Corps, and the other one is a state program that will also do that. The state program requires a local match... [LR592]

SENATOR CAMPBELL: Correct. [LR592]

JOSEPH EVANS: ...and usually most small towns are interested in dentists and doctors, and there's been very few that have been actually able to come up with a match required for even nursing or behavioral health professionals. [LR592]

SENATOR CAMPBELL: Well, I know that Mr. Fattig talked with me the other day at the LR422 conference and indicated that that committee wanted to make some changes. [LR592]

JOSEPH EVANS: Wonderful. [LR592]

SENATOR CAMPBELL: So we'll be glad to talk to him and make sure that we ask that question of him. [LR592]

JOSEPH EVANS: Appreciate it. [LR592]

SENATOR GLOOR: I think it's just psychiatrists, MD psychiatrists. [LR592]

SENATOR CAMPBELL: Okay. Okay. Any other questions or comments? Thank you, Dr. Evans. Our next testifier is Anitra Warrior. Good afternoon. [LR592]

ANITRA WARRIOR: Good afternoon, Senator Campbell and members of the committee. My name is Anitra Warrior, it's A-n-i-t-r-a, Warrior, W-a-r-r-i-o-r. I am currently a doctoral student with the counseling psychology program at the University of Nebraska in Lincoln. And I have an internship with...through LB901, and I'm placed in...I live in Chadron, I should say, but we have several clinics, so our main clinic is in Rushville, which is through Western Nebraska Behavioral Health. So my direct supervisor is Dr. Catherine Jones-Hazledine. So through Western Nebraska Behavioral Health we have eight clinics that cover four counties, so we are in Saunders, Sheridan, Dawes, and Box Butte. This covers Valentine, Gordon, Rushville, Chadron, Crawford, Alliance, Scottsbluff, and Bridgeport. And there are still a number of towns that we serve where we have clients who drive in. And so, what I wanted to cover with my testimony today was to, first of all, express my sincere gratitude for passing the bill and allowing us to have this internship that's available for people whose hearts are in Nebraska, who plan to stay in Nebraska. So this was something that I was very, very honored to be a participant of, so very happy with the internship. So that was the first thing that I wanted to express or convey, was my gratitude for this unique opportunity. The other piece that I wanted to cover was when we're talking about rural populations, there's three areas that have been focused on in the research that can have an effect on whether or not a person seeks services, and this is accessibility, and that's how am I going to get there, how am I going to get my services paid for; availability, what is available, who is out there; and acceptability. There's something that I think is kind of funny in the research and it's "who's your daddy phenomenon." And so when you're in a rural clinic, it's, oh,

how do I know you? Do I know your dad? Do I know your mom? So, (laugh) sometimes that can inhibit people receiving services just because there's so much that's known. But the larger impact that you'll see through LB901 is that by providing these services, we're addressing each of those areas. So for me, for example, I have experience in rural communities, not necessarily in western Nebraska, more in the eastern side, but there's still that sense that she's familiar with the, basically, the rurality of our state. So there have been referrals that come across from several towns. We have several clients who drive hours to get to our site. We also have clinicians who will drive up to three hours a day to get to the clinics to provide services. So through this bill we're actually addressing each of those areas with availability, having more services that can be provided. We can go into more sites with just having the one intern that goes to multiple sites. We still open the door to several more clients being seen, several more families that are being worked with. And then with accessibility, that's something that's also very...a very important part of this bill, this funding the positions, because this allows a great deal of flexibility to be provided to the clients who have difficulty paying for services. So that was another area that I thought was important to address. And additionally through BHECN, this is a very special program that I'm very fond of. With Western Nebraska Behavioral Health, Dr. Jones-Hazledine has started a program called FARM CAMP, and this is frontier and rural mental health counseling and mentorship program. So through this program what she does is she recruits high school students who are interested in the field of psychology. So we're looking at recruitment and retention, hopefully, because they're from these areas. So every summer that she's had two summers of this so far where she recruits 10 to 12 students and they spend a week--at this point it's just in Rushville, we've had two camps in Rushville--and they partner with Chadron State College and so the high school students are able to obtain college credit for psychology...it's rural psychology is the course that they receive two credit hours for, and it's just for students who are interested in the field of psychology. So we're trying to introduce them and through that program, we have the clinicians who are on board that continue to mentor the students throughout their college career or throughout high school. And we've just recently decided to expand the program so we'll

now be providing the FARM CAMP in northeastern Nebraska as well. And we've already received a great deal of feedback with students who are interested. So that's just something else that I wanted to add about BHECN that I think is really unique with the services that are provided in the funding. [LR592]

SENATOR CAMPBELL: Thank you so much. Questions? I don't see any questions. Good luck with your doctoral. [LR592]

ANITRA WARRIOR: Thank you. [LR592]

SENATOR CAMPBELL: When will you be finished? [LR592]

ANITRA WARRIOR: I'm hoping to graduate in August of next year, 2015. [LR592]

SENATOR CAMPBELL: And then, staying in the state of Nebraska. [LR592]

ANITRA WARRIOR: I will. I plan on it. (Laughter) My heart is here. Thank you. [LR592]

SENATOR CAMPBELL: We will expect to see you testifying for many years to come, (laughter) let's put it that way. Our next testifier on my list is Dr. Katy Menousek. I hope I didn't just murder that name, Doctor. [LR592]

KATHRYN MENOUSEK: You did a pretty good job. [LR592]

SENATOR CAMPBELL: Okay. Thank you. So go ahead and state your name and spell it for us. [LR592]

KATHRYN MENOUSEK: Okay. My name is Dr. Kathryn, or Katy, K-a-t-h-r-y-n, Menousek, M-e-n-o-u-s-e-k, and I'm an assistant professor of pediatric psychology at the University of Nebraska Medical Center. Thank you to all for...at the Health and

Human Services Committee for providing me with the opportunity to provide input about this legislative resolution, LR592. Currently I'm providing services to children and adolescents at the Columbus Children's Health Care Pediatric Clinic in Columbus, Nebraska. I'm currently training postdoctoral fellows, predoctoral interns, and master level students at this clinic. As a team, we provide behavioral health services to approximately 30 families or so a week in the clinic at Columbus and the surrounding areas, for example, Norfolk, David City, Albion, Fullerton, and Platte Center. I'm speaking today in support of the use of the behavioral health screening procedures in the primary care setting that emerged from LB556 that currently provides behavioral health screening at three pilot sites across the state. Since November 2013, the use of a behavioral health screener has been offered at all appointments for patients at the Columbus Pediatric Clinic after the passing of LB556. The clinic in Columbus currently provides services to approximately 15,000 patients. In addition, the use of the behavioral health screener has also been implemented in one clinic in midtown Omaha and at clinics in three towns in the Panhandle of Nebraska, that is Valentine, Chadron, and Alliance. The goal of LB556 is to identify and treat children and adolescents with behavioral health concerns in their medical home. Primary care physicians are the gatekeepers for behavioral health concerns. Over two-thirds of patients with behavioral health concerns present to their physician prior to seeking specialty services. LB556 seeks to utilize resources in the child's medical home to effectively screen for behavioral health concerns and provide assessment and treatment in the primary care setting. Specialty behavioral health consultation is available from UNMC, psychiatric nurse practitioners, and child psychologists for triage and initial medical management. Upon arriving at their child's appointment with their pediatrician for either a well-child checkup or for any other medical concern at the Columbus Clinic, parents are provided with the opportunity to complete a behavioral health screener. Parents are also allowed the opportunity to decline completing the screener for their child. The purpose of the screener is to access whether a child is positive for symptoms of inattention, hyperactivity, oppositional defiance, conduct problems, anxiety and depression for children or adolescents ages 16 to 18, or for symptoms of inattention, hyperactivity,

oppositional defiance, sleep concerns, and toileting problems for children ages 3 to 5. If a child screens positive for at least one of the scales mentioned previously, the family is contacted by the behavioral health professional in an attempt to coordinate services for a behavioral health referral. If the behavioral health professional is unable to contact the family via telephone, the child's primary care physician is consulted as to whether referral of a higher level of care or behavioral health referral is necessary. If necessary, referral to psychiatry, or consultation with psychiatry is conducted in order to best meet the needs of the child. As indicated on page 6, our data from three of the behavioral health pilot sites show that LB556 is working. Since the beginning of the implementation of LB556, we have provided approximately 1,700 children and adolescents with behavioral health screenings. Approximately 22 percent of patients provided with behavioral health screener were positive for at least one of the symptoms mentioned previously. In addition, approximately 17 percent of parents indicated that they would like help or assistance regarding their behavioral health concerns that they were experiencing with their child. Through the use of this behavioral health screening for the last ten months we have demonstrated initial success in identifying patients and families in need of behavioral health services. In addition, families with children or adolescents that have screened positive for at least one behavioral health concern, that indicated they would like to receive services for their concerns, have been provided the opportunity to receive behavioral health services at the Columbus Clinic. My last point, sorry, is that the utilization of this project would also...or would improve the level of integration at clinics throughout the state of Nebraska allowing more clinics to access cost-effective services demonstrated through this consultative process described today. Thank you. [LR592]

SENATOR CAMPBELL: Excellent. Thank you very much. Questions? Senator Gloor. [LR592]

SENATOR GLOOR: Thank you, Senator Campbell, and thank you, Dr. Menousek. Are you affiliated in Columbus then with a federally qualified health center, or do you just

take referrals from an adjoining clinic? [LR592]

KATHRYN MENOUSEK: I see patients out of the...it's the Columbus Children's Health Care Pediatric Clinic. [LR592]

SENATOR GLOOR: Okay. Thank you. [LR592]

KATHRYN MENOUSEK: You're welcome. [LR592]

SENATOR CAMPBELL: Next, Senator Howard. [LR592]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for your testimony. I do have a question that...traditionally, or at least my understanding of integrated healthcare is that when somebody comes for a primary care visit you can do a warm hand-off. And in LB556 process, a parent is sort of accepting an offer of screening and so there isn't really a primary care visit? [LR592]

KATHRYN MENOUSEK: There is. They're at their primary care appointment. [LR592]

SENATOR HOWARD: Okay. And so we're not conducting a brief intervention after the screening if it's indicated? [LR592]

KATHRYN MENOUSEK: Not currently immediately, but that's the direction that we're taking during this second pilot year. [LR592]

SENATOR HOWARD: Okay. Perfect. Thank you. [LR592]

KATHRYN MENOUSEK: Uh-huh. [LR592]

SENATOR CAMPBELL: Any other questions? Thank you for your testimony today.

[LR592]

KATHRYN MENOUSEK: You're welcome. [LR592]

SENATOR CAMPBELL: Our next testifier is Denise Zwhiner (phonetically)? [LR592]

DENISE ZWIENER: Pretty close. [LR592]

SENATOR CAMPBELL: I'm going to get somebody that's named Johnson or...(laughter). [LR592]

SENATOR GLOOR: "Yonson," it's "Yonson." [LR592]

SENATOR CAMPBELL: Okay, sorry, Senator Gloor. You know, there's always a way. Well, welcome, and please state your name and spell it for the record. [LR592]

DENISE ZWIENER: Thank you. I will. My name is Denise Zwiener and that's D-e-n-i-s-e, Zwiener, Z-w-i-e-n-e-r, and I'm the executive director of the Buffalo County Community Partners in Kearney, Nebraska. Well, today, each of us have the ability to empower someone to lead a healthier life in Nebraska. That person could be ourselves or it could be a loved one, but today I'm not here to preach to you about eating right and exercising because we all know the health benefits and the cost-savings for that. Instead, I want to inspire you to consider the answers to many of our healthcare problems today lie in the voices of the people that we serve. Buffalo County Community Partners is a nonprofit organization. We have over 1,000 volunteers in Kearney that are helping us with a variety of different processes to attain a healthier Buffalo County, 2020. Many of our strategies are, and our goals are, audacious. They're creating a vortex of change in Kearney and in Buffalo County. So how does a small nonprofit reduce teen binge-drinking by 65 percent, reduce teen tobacco use by 45 percent, and stall the obesity epidemic in our community? I have a secret and I'm willing to share it

with all of you of four strategies that we take to heart in our community. Those are to assess community needs and the assets that we have in our need and elevate health issues in our communities--so elevating health issues. Also empowering people to solve local issues, engaging members to take a stand on things that are important to them, and evaluating our success. So elevate, empower, engage, and evaluate. So today I want to focus on our small communities' impact on health, and three areas that I want to talk to you about are: Adverse Childhood Experiences, ACEs, if you have not heard of that before--ACEs do tell a story in our community; healthcare reform has a profound impact on our community; and our third point, engaged and empowered residents of Nebraska are change agents. So to start with ACEs research, the effect of childhood trauma on the health of adults, ACEs are changing the landscape. They're changing the how and the why. Behavioral health is not an individual responsibility of a social worker, a pediatrician, a judge, not an individual responsibility. It is shared responsibility amongst all of our communities. It is shared responsibility of our schools, of our faith communities, of our businesses, of the individuals we serve, of our government. It is a shared responsibility of our community. That's everyone's problem and we have the solutions to solve this together. So the recent ACEs study from Kaiser Permanente, 17,000 individuals were researched or were part of the study. And to illustrate, attempted suicide is extremely rare among people who have zero ACEs, so zero Adverse Childhood Experiences. As those ACE scores increase, so if a person has more than seven adverse childhood experiences, their risk of attempted suicide increases by 20 percent. So we...ACEs are telling us a story. It's showing us a direction to go. Healthcare reform, again, has a profound impact on our community. Clinics, hospitals, and physicians are working diligently on patient-centered care. Our community has introduced a new care provider--a community health worker. A community health worker in our community has saved our local healthcare hospital over a million dollars in three years on a pilot project. They are breaking down barriers and they are accessing care for individuals that they are serving. They are not licensed, they are not a professionally licensed individual, and they earn somewhere around $12 an hour. This person could assist with very complex health issues. To start with, what

we've learned is 93 percent of our clients now have a formal relationship with a primary care physician; 45 percent that applied for state or federal insurance, 26 were accepted and 83 people still are looking for healthcare insurance. So this is very key. We have a pathway that we've developed for a community health worker to be able to walk someone through the healthcare system and link them in the integrated system between healthcare and primary care. And so I will leave you with my final point that I want to spend some time on. About two weeks ago, the Institute for Health Care Improvement invited our community to come to Cambridge, Massachusetts. We were one of ten communities that were invited to come and talk with 200 amazing innovators in healthcare reform. We were there next to Harvard professors and Kaiser Permanente, it was just amazing, CDC representatives. They would like our communities to be engaged in making lives for a million people healthier. So you ask, how do we do that? Their answer after one day of brainstorming and think-tank discussions was to take it to the people. The people understand the power of what they are facing and the challenges today in our communities. Help them tell their story, help them share their learnings of how we can make the system better. So I compliment you on the work that you're doing. I encourage you to consider what the opportunity we could gain from learning from our clients in the behavioral health system and our healthcare system, and work together to really create our own vortex of change here in Kearney...or, sorry, Nebraska. I'm honored to be a partner with BHECN. I see every day how amazing the work that they are doing is making an impact in our community. So I thank them also for their commitment to the state of Nebraska. And that's all I have to share, so thank you very much. Do you have any questions? [LR592]

SENATOR CAMPBELL: Thank you for your testimony. Questions, comments? Thanks for coming today. [LR592]

DENISE ZWIENER: Yes, thank you. [LR592]

SENATOR CAMPBELL: Our next testifier is Chad Magdanz. [LR592]

CHAD MAGDANZ: Nailed it, Senator. [LR592]

SENATOR CAMPBELL: It's a lot easier during the regular session because I just say next testifier. (Laughter) I don't usually have a list of people. But you go ahead and state your name and spell it for us. [LR592]

CHAD MAGDANZ: Okay. My name is Chad Magdanz, and that's C-h-a-d M-a-g-d-a-n-z. [LR592]

SENATOR CAMPBELL: Go right ahead. [LR592]

CHAD MAGDANZ: All right. Well, thank you for listening, Senators and the committee. I'm going to do my testimony a little differently. I am with peer services in the Mental Health Association of Nebraska. I have lived experience from the past and currently and so I'm going to kind of come at it from that view a little bit, and then talk about what our organization and specifically what the program I am in charge of does. First, I'm here representing the Mental Health Association of Nebraska, specifically the REAL Referral Program, that is a referral program that is in conjunction with local law enforcement here in Lincoln. My personal history as a peer as I am, I am a Nebraskan to the core of me. I was born here. I'm also an honorably discharged veteran and when I got out of the service I had a very tough time with that. Senator McGill talked about those who suffer in silence and that was my case for about 20 years. Thoughts of depression and anxiety, and guilt that's hard to explain really began to overtake me. I used alcohol as medication and that, of course, does not add up as a solution, and life became incredibly twisted, confusing, and I became mad. I was actively homicidal and suicidal. With all that being said, the path to me getting here had to do with peers. It had to do with other peers that were haunted by their experiences, veterans. It had to do with peers who understood the drink problem and had success with that. None of my success or recovery really has to do with traditional services. It has to do with other

people with lived experience. So I hope that that's clear. Mental Health Association, where I work, is an organization of all peers. We all have past, current, lived experience. We also have lots of ideas and strategies to stay well and keep in control when we do lose control of things. What we are is a group of lots of individuals with lots of backgrounds, and with that being said, our diversity makes our usefulness, I believe, very helpful. We have three programs. We started with a supportive employment program in 1999. We became 501(c)(3) recognized in 2001. We have a supportive employment program, which I've mentioned, that's helped hundreds of people with diagnosis get into the work force, pay taxes, have normalcy in their life, purpose. We also have a place called the Keya House, which just celebrated its five-year anniversary of being open. That's how I became into MHA as I was hired to help open that. We've served over 400 nonduplicate guests there. The idea is to avert crisis; deal with things on a normal, natural way, if that's possible; listen to people that have shared experiences, shared ideas, and move forward from that. Community integration is a word that we use an awful lot and that's simply finding natural resources and going on with them. And then we'll talk about the program that I run and that's called the REAL program. Its been going now for three years. We're in our second phasing. We have had...oh, I've got a minute. We have had (laughter) 761 referrals to this date exactly. We have two-thirds of Lincoln's police force using the referral system. They are not...you know, they don't have doughnuts held in front of them to say, use this tool. This is something that they want to use. It's something that they recognize works. We have a high success rate in getting in touch with people. But the exciting part of all is, when we do get in touch with people, they're receptive to our services. They're receptive to finding a softer way than the police officers coming to the door. So we have data for that now and that is something that has been incredibly important. You can get the numbers on the top of your page of our success rates for that. We employ four people, all that have mental health...lived mental health things and we are keeping people out of tragedy and out of the way of the police department and higher levels of care, so much so that one out of five people that we talk to, the police don't see them anymore. And so we are not here by any means to replace traditional services, the doctors, the

psychologists, the psychiatrists, the whole thing. We are here as a legitimate service into the continuum of mental healthcare. I like to describe it very simply as it's someone who has success with dealing with diabetes meeting someone who may just found out they had diabetes. There's a whole lot that those two can talk about. There's a whole lot of pitfalls that can be avoided, and so we're being proactive in that way. I'm sorry, the red light went on, so. And I would really like to talk to any of you more about this, you know, so. [LR592]

SENATOR CAMPBELL: Excellent. Well, thank you for your service to our country. Where were you stationed? [LR592]

CHAD MAGDANZ: I was stationed with the 7th Infantry at Ft. Ord. [LR592]

SENATOR CAMPBELL: And so how many years did you spend? [LR592]

CHAD MAGDANZ: I was in the service for four years in the infantry. [LR592]

SENATOR CAMPBELL: Originally from Nebraska? [LR592]

CHAD MAGDANZ: Yes, ma'am. Lived in Laurel, Nebraska, so northeast Nebraska. [LR592]

SENATOR CAMPBELL: All right, thanks for coming. Absolutely. We're glad to have you back. Questions or comments from the senators? Thank you for your own story. It's very helpful. Appreciate it. [LR592]

CHAD MAGDANZ: Okay. Thanks. [LR592]

SENATOR CAMPBELL: Our next testifier is Sarah Mitchell. Good afternoon. [LR592]

SARAH MITCHELL: (Exhibit 2) Good afternoon. [LR592]

SENATOR CAMPBELL: So, go ahead and give us your name and spell it for us. [LR592]

SARAH MITCHELL: All right. My name is Sarah Mitchell, Sarah, S-a-r-a-h, Mitchell, M-i-t-c-h-e-l-l. Good afternoon, Senators, and thank you for the opportunity to speak on LR592. I speak to you today as a member of Project Everlast and a former state ward. I'm here to offer my support of LR592. I am also here to provide the perspective of a young person who was once a part of the juvenile justice system and aged out, thus, who would be directly impacted to this bill. Three years ago I aged out of the juvenile justice system. Today I am attending college at Southeast Community College, majoring in human services, while maintaining two jobs. Learning to support myself presented many challenges, including me failing my first year of college and having continued run-ins with the law enforcement. I'd like to share a few reasons why I support the program outlined in LR592. I think a peer-to-peer certificate program would invest in young professionals like me by increasing the number of state wards successfully graduating from college; a lower crime rate in former state wards; and a continuing peer-to-peer support both educationally and personally. Having a certificate program for peers, first and foremost, will have an increase in the number of state wards successfully graduating from college by giving them a step into their career, a chance to help another like them in more motivation towards the long-term goal of a college degree. The first semester of college, I lived off campus. I started to no longer attend classes and surrounded myself with many negative people. The second semester I moved on campus and got into legal trouble, which after a while caused me to be evicted from the dorms. I believe that LR592 will prevent future youth from reliving my experiences by giving them a short-term goal to focus on. Also, by having younger youth to mentor them, they will be motivated to be a positive influence. Having someone to look up to can also be a huge motivation. Also, working with other professionals gives a college student positive mentors and guidance and support to help one successfully

get through college. Next, a certificate program for peers could potentially lower the crime rate of current and former state wards. I have been in the juvenile justice system for seven years and was in the adult system after I aged out. I always needed someone to talk to, someone to guide me in the right direction, and someone who could really understand where I was coming from. It felt like I had no one. They offered counseling at my college, but giving trust to another individual was never easy after having so many professionals come and go while in the system. Peer-to-peer professionals could lower the crime rate and help create a future for many individuals by giving them someone they could trust more easily because they had come from such a similar situation. This could prevent youth from acting out and getting more deeply involved in the system. Finally, a certificate program for peers would continue the support both educationally and personally. Education is something I value because without an education, how are you ever going to learn the way of life? It would also personally affect people who have grown close during the peer-to-peer support. If I could ever ask for something to have helped me become successful, it would have been support from others. Feeling understood and encouraged is something youth in the system rarely experience. So much of their attention goes to their negative behaviors. Peer-to-peer support could help rebuild the ability to trust that has been lost. Channeling their experience to help others builds up the professional and the youth he or she helps. State wards rarely win, but this program could allow a situation where everyone wins. As we have seen, the program outlined in LR592 invests in young professionals, like myself, by increasing the number of state wards successfully graduating from college, potentially lowering crime rates in the current and former state wards, and mostly important, providing a needed support, both educationally and personally. As a youth who has "been there and done that," I ask you to remember my story and those youth, like me, when considering drafting a bill that would create such a program. Thank you again for the opportunity to share my opinion; it means a great deal. I am happy to answer any questions. [LR592]

SENATOR CAMPBELL: Good job. Questions from the senators? So when do you think that you'll finish your studies? [LR592]

SARAH MITCHELL: I still...this is...I just actually got back into school so I'll be... [LR592]

SENATOR CAMPBELL: Good. [LR592]

SARAH MITCHELL: ...I've got about almost two and a half years with full-time, so. [LR592]

SENATOR CAMPBELL: You're going to make it this time, boy. [LR592]

SARAH MITCHELL: I'm trying. It's my goal. [LR592]

SENATOR CAMPBELL: You're doing great. Thank you so much for sharing your story. [LR592]

SARAH MITCHELL: Thank you. [LR592]

SENATOR CAMPBELL: Those aren't easy to share, we know. [LR592]

SARAH MITCHELL: Thank you. [LR592]

SENATOR CAMPBELL: Take care. Our next testifier is Athena Ramos. Was I even close there? [LR592]

ATHENA RAMOS: You're close. [LR592]

SENATOR CAMPBELL: Good. [LR592]

ATHENA RAMOS: Good afternoon. I'm Athena Ramos, Athena, A-t-h-e-n-a, Ramos, R-a-m-o-s, and I work for the Center for Reducing Health Disparities at the College of

Public Health at UNMC. Today, I'm going to be providing testimony in relation to behavioral health work force development with the goal of increasing the number of providers in our state and the opportunities for communities to participate in improving behavioral health. In the spring, our center completed a report for BHECN regarding minority and non-English language providers in north and south Omaha. We found 17 individuals who can provide services in a language other than English, although many were not native speakers, and 20 providers who were from minority backgrounds. Now I want to provide you with a brief description of health disparities, cultural competency of the work force, and discuss some of the implications for the behavioral healthcare work force and our community. According to the CDC, health disparities and inequalities are gaps in health and health determinants between segments of the population. There are many reasons why health disparities exist. Unequal and poor access to quality healthcare and screening services and other important factors including education, language, legal status, poverty, and the social environment in which the people live, work, and play. Despite ongoing efforts to reduce health disparities across the country, racial and ethnic disparities in both health and healthcare continue to persist. Even when income, health insurance, and access to care are accounted for, disparities remain, especially in the area of behavioral health. Research has shown that there are cultural barriers that prevent and/or reduce access to appropriate behavioral healthcare by members of minority populations. Some of these barriers include mistrust and fear of treatment. So, for example, noncitizens are 40 percent less likely than those who are born in the U.S. to actually use mental health services; two, alternative ideas about what constitutes illness and health; three, language barriers and ineffective communication. Limited English proficiency is correlated with lower use of mental health services. And in Nebraska, almost 73 percent of our mental health facilities provide services only in English; four, the stigma of mental illness from within the society and also from within the family; five, access barriers like inadequate insurance coverage and transportation; and six, a lack of diversity in the mental health and behavioral healthcare work force. According to data from the National Survey on Drug Abuse and Health from 2013, mental health service utilization was lower than the national average for blacks,

Hispanics and Asians. Members of racial minority groups, including African-Americans and Latinos, are more likely to delay treatment. And outcomes for selected indicators were consistently poorer among American Indians and Alaska Natives, among those who were unemployed, those living below the federal poverty level, and those insured by Medicaid or CHIP or not insured at all, and those who had not completed high school or college. The data from Douglas County are also very similar. Past year mental health diagnosis was highest among those with less than a high school education, those who were retired or unable to work, and those with an annual household income of less than $20,000 per year. Expansion of health insurance coverage through the Affordable Care Act may not sufficiently address the disparities and access to behavioral healthcare services, especially for minorities in our state. Public education on mental illness is important. However, stigma remains a major concern. Furthermore, there are cultural stereotypes that need to be overcome, but without a strong understanding of the cultural frameworks, improving mental health status of minorities in our state is limited. Therefore, in order to best serve and address the needs of minority populations, it is imperative to address these barriers and challenges to service, especially in a state like Nebraska with such rapidly changing demographic composition. Already, Latinos comprise about 10 percent of the state population; the foreign-born, 6.2 percent; and African-Americans, 4.5 percent. So let me just share a little bit of information on foreign-born and Latinos, which have grown over time in both percentage and real numbers in the state and regional and national levels. Traditionally, these folks have come to gateways like California and Florida, but now there are new destination states which include states like Nebraska. And some of the fastest growth in Latinos in nonmetro areas has taken place in the Midwest. And our Latino population in the state is expected to triple by the year 2050, and much of that is going to be attributable to natural growth. So in light of the changing demographics of our state, we need to ensure the adequate provision of services to minority communities. Increasing the cultural and linguistic competency of the behavioral healthcare work force is important and necessary. Patients want to have a good relationship with their mental healthcare provider, but a patient's definition of what qualifies as a good relationship with the

provider can vary by racial or ethnic culture. So to be effective, mental health service providers must have the capacity to interact effectively with people from different cultures, races, and ethnicities. And our work force should mirror the makeup of our communities. In 2009, Nebraska was rated a D by the National Alliance on Mental Illness. So that shows that much more can be done in this area. There's research from across the country that says, what are some of the best practices? You've heard about some of those today, but there's two that I want to highlight for you. And one is increasing the diversity and the cultural competency of the behavioral healthcare work force. There are a number of states who are doing really well at that. And the other is to address the cultural competency itself, so making sure that those providers understand not only that their from that cultural background but they understand cultural competency in general. So lots of great things are happening here in the state, but there's much more that we can do, especially to support minority communities across our state. Thank you. [LR592]

SENATOR CAMPBELL: Thank you. Questions or comments? Senator Gloor and I sit on the State Planning Committee and we had a report at our last meeting about one of the fastest growing populations of entrepreneurs are Latino, the Latino population in the state. [LR592]

ATHENA RAMOS: Yes. Yes. [LR592]

SENATOR CAMPBELL: So that fits very aptly with your testimony. Senator Gloor. [LR592]

SENATOR GLOOR: Thank you, Senator Campbell. Maybe I would ask a question. Are you involved in or aware of...hopefully, I will say it correct, Promotores de Salud. [LR592]

ATHENA RAMOS: Yes, those are community health workers. Yes, we are. Our center

is involved in the statewide planning committee. I sit on the... [LR592]

SENATOR GLOOR: Okay. [LR592]

ATHENA RAMOS: ...core committee for that, and I also have a staff member who is currently the president of the Community Health Workers Association. [LR592]

SENATOR GLOOR: Well, the issue of trying to address this cultural disparity, though--and we talked about this in the Planning Committee--isn't just a language issue. Because even within our Hispanic populations, at least in my community, we're dealing with Columbians, Venezuelans, Guatemalans, Mexicans, Cubans, and the cultural differences between even those cultures make the commonality of language--which in some cases, like Guatemala, isn't even Spanish-based--problematic. So to what extent with the promoters of health have we tried to help address that cultural disparity that's out there, within their own Hispanic population groups? [LR592]

ATHENA RAMOS: I think you're right on target. There are a lot of differences between the subgroups and I think as a state and as a country we do a disservice when we group everybody into one category. From the community health worker level, I...there is nothing going on currently that I'm aware of specifically around mental health services or behavioral health. We have a lot of ideas and I'd be happy to share some of those with you at another time, but I think there's a lot that we can do. In fact, last summer I did a survey of Latino migrant farm workers in the central part of the state and talked with 200 Latino migrant farm workers. Found very high levels of stress, very high levels of depression, and then you have to look around, there's no professionals and there's no services to address those. And one of the ideas and the recommendation that my team and I put forward is to use community health workers to get these types of messages across, especially to hard-to-reach populations like that. [LR592]

SENATOR GLOOR: Okay. Thank you. [LR592]

ATHENA RAMOS: You're welcome. [LR592]

SENATOR CAMPBELL: Any other follow-ups? Thank you very much for your testimony. [LR592]

ATHENA RAMOS: Thank you. [LR592]

SENATOR CAMPBELL: Our next testifier is Dana Ramey (phonetically)? [LR592]

DANA RAML: Raml. [LR592]

SENATOR CAMPBELL: Raml. You want to hold on just a minute? J.T., do we need to get an orange sheet for you? [LR592]

DANA RAML: I believe so. [LR592]

SENATOR CAMPBELL: Okay, that's fine. We'll go ahead and take... [LR592]

DANA RAML: Okay. [LR592]

SENATOR CAMPBELL: ...your testimony and then you can fill it out. [LR592]

DANA RAML: Okay. [LR592]

SENATOR CAMPBELL: J.T. will get you one. [LR592]

DANA RAML: Thank you. [LR592]

SENATOR CAMPBELL: Go right ahead, introduce yourself and spell your name,

please. [LR592]

DANA RAML: So my name is Dana Raml, D-a-n-a R-a-m-l, and I'm a fourth-year medical student at the University of Nebraska Medical Center and I'm going into psychiatry, and I appreciate the chance to speak today as I strongly support LR592. For the past three years I have served as the mentorship chair for the psychiatry student interest group. The group is a student-run organization that's really closely associated with BHECN and it works to advance interest in behavioral health careers by creating mentorship and volunteer opportunities, coordinating lunch presentations, and promoting student mental wellness. The organization has also implemented mental health screening at UNMC's student-run, underserved clinic and provides mental healthcare for these patients under a licensed psychiatrist's supervision. As a mentorship chair, I have personally worked intimately with BHECN to organize the annual mentorship dinner. It's a growing interprofessional event with medical and nursing students, resident and faculty, psychiatrists, psychologists, psychology interns, and mental health nurse practitioners, and nurse practitioner students as well. The event helps generate communication between members of the mental health team, promotes awareness to areas of needs, and highlights resources available. Also the event fosters student interest in mental health and, most importantly, provides a catalyst for information of mentor-mentee relationships which are critical to student decisions to pursue mental health careers. These opportunities can have a profound impact on students developing career plans. At the University of Nebraska Medical College, we have 11 students this year going into psychiatry, which is more than we've ever had in the past, most of whom are hoping to stay in Nebraska, and I know this is the result of having good programming available. By further evaluating development opportunities for behavioral healthcare workers, we can continue to support programs such as BHECN and the psychiatry interest group, as these programs will continue to advance career interest and growth and eventually Nebraska's overall mental healthcare work force. I also know this to be true on a personal level as well as I've had great fortune to find my own mentor through the mentorship dinner program. My mentor, Dr. Liu, has not

only educated me on career opportunities within the field of psychiatry but helped me to establish and work towards my personal career goals. Dr. Liu has encouraged my involvement in BHECN programs, allowing me to become a mentor to other undergraduate students interested in pursuing behavioral health careers. He's also made me aware of conference opportunities and helps me to find money so I could attend those conferences. And I know, with his guidance and advice, I'm going to be a better physician for the people of Nebraska. As a state, we have to continue to support programs like BHECN, which not only encourage people to enter the behavioral health work force but provide resources and mentorship opportunities to improve the quality of that work force. LR592 is critical in demonstrating the value of such programming and will pave the way for continued and future programs, and I greatly appreciate your time and consideration. [LR592]

SENATOR CAMPBELL: Thank you. Senator Gloor has a question. [LR592]

SENATOR GLOOR: Thank you, Senator Campbell. I've been waiting all day for your testimony. [LR592]

DANA RAML: Oh, okay. [LR592]

SENATOR GLOOR: Actually, thank you for your testimony, but I've been waiting to ask some questions... [LR592]

DANA RAML: Okay. [LR592]

SENATOR GLOOR: ...because you are, I think, sort of at the ground level of helping us understand why you think we...your example of 11 of your associates... [LR592]

DANA RAML: Uh-huh. Yes. [LR592]

SENATOR GLOOR: ...want to stay in Nebraska. And we want them to stay in the state of Nebraska, but too often...and I'll use as an example, this past year the Lincoln Family Practice Program had over a half-dozen family practice residents who we understand started the program wanting to stay in Nebraska and all left Nebraska. None of them stayed in the state of Nebraska. What we need to think about in the context of behavioral health, what do we think about with students that helps them actually stay in the state of Nebraska? Is it just dollars? Is it the practice opportunity? I mean, in your mentorship role in talking to other students, do you get a sense of what it is that might have people saying, I want to stay in the state of Nebraska, but maybe they're not going to stay in the state of Nebraska? [LR592]

DANA RAML: I'm not sure why people leave, but I think one thing that will keep people here is building a good support system for them and good mentors and stuff as I alluded to earlier, because it's those foundations and finding those connections and becoming involved... [LR592]

SENATOR GLOOR: Are those professional organizations that can be helpful, or are those maintaining a relationship with faculty members and staff where you were trained? Is it with practitioners within the community, including...? [LR592]

DANA RAML: I think it's all of the above. [LR592]

SENATOR GLOOR: Well, that's not too big a task. (Laughter) [LR592]

DANA RAML: Yeah. Well, I don't think it has to be all of the above... [LR592]

SENATOR GLOOR: But I think you're right, yeah. [LR592]

DANA RAML: ...but I think it can be. Any one of those can serve as a resource and an outlet. And actually, one of the undergraduates I had been working with, I just saw her

recently interviewing for UNMC and she was still thinking about going into psychiatry. And so even just having people at the different levels, you know, a level ahead of you that can kind of direct you, you know, this is what you should be doing and helping guide you to that, and I think that makes Nebraska a really good place to be. [LR592]

SENATOR GLOOR: Is it harder to get financial assistance for a lot of students in the state of Nebraska from what you hear, or are we fairly good about that, through not just state programs but also grants and aid and other things? [LR592]

DANA RAML: As far as... [LR592]

SENATOR GLOOR: Paying for the cost of your education. [LR592]

DANA RAML: I haven't heard anything in comparison to other states, but I can look into that... [LR592]

SENATOR GLOOR: Would just be curious. [LR592]

DANA RAML: ...and get back to you. [LR592]

SENATOR GLOOR: I'm just curious. Yeah, I'm trying to peel the onion here and get down to the... [LR592]

DANA RAML: Yeah. [LR592]

SENATOR GLOOR: ...onion. And you're at a level of that onion where you're getting ready to start your practice and your career, and frankly, I don't think we do a very good job of keeping our own in this state. And our own doesn't necessarily mean native sons and daughters, but it certainly could mean people that we train, oftentimes at the taxpayers' dollar, and that's money that just goes away quite too frequently, and not just

as relates to behavioral health but primary care, specialty care. So, those are good answers. I appreciate your letting me ask those questions. [LR592]

DANA RAML: Yeah, thank you for letting me speak today. [LR592]

SENATOR CAMPBELL: Thank you very much. Our next testifier is Terry Werner. Good afternoon. [LR592]

TERRY WERNER: And you got the name right. (Laughter) [LR592]

SENATOR CAMPBELL: I knew I knew this one, yes, absolutely. [LR592]

TERRY WERNER: Good afternoon, Senators. My name is Terry Werner, spelled T-e-r-r-y W-e-r-n-e-r, and I'm the executive director for the Nebraska Chapter of the National Association of Social Workers, but today I'm also representing the Nebraska Association for Marriage and Family Therapy and the Nebraska Counseling Association, and some of those folks are here if you should have any questions of them. I want to thank Senator McGill and the committee for taking the time to consider this important topic, but I also want to thank BHECN for bringing the three professions together so that we could collaborate and come up with common solutions and build consensus on how to address the issue of this shortage of rural mental health. We are speaking today about a shortage of master's level LMHPs and LIMHPs in rural Nebraska, and how to recruit and address the need. We have identified barriers to recruiting and keeping licensed mental health practitioners in the high-need areas. One of the barriers that we have identified is the high cost of training in rural areas. To overcome this need, along with BHECN, we are exploring the possibility of providing incentives to inform stipends to students who are willing to do internships in the high-need areas. It takes money to set up and maintain integrated care in rural areas. As you know, integrated care is considered best practice and is also the focus of LR592 and it is a collaboration of the primary care physician and the LMHP or LIMHP. The

second barrier is the high cost of education and the need for loan forgiveness. There are currently some opportunities through the Nebraska rural health systems, however, all of their programs require that students be fully licensed to qualify. The two to three years that they are provisionally licensed can be a hardship. Also some of the programs require the agency match, as was mentioned earlier today, in order to receive the loan forgiveness. We feel that this is a really important area that needs further consideration. Among the three disciplines, we have a work force of nearly 3,000, the largest behavioral health work force in Nebraska, and yet most of the state is considered a shortage area. Our goal is to create incentives for students to work in the rural mental health area. The final barrier that we have identified is a Medicaid policy that does not currently allow for credentialing of provisionally licensed practitioners in Omaha and Lincoln areas. This creates a burden on provisionally licensed practitioners to be employable by removing the possibility of group practice or supervision. Of course, as you know, this is where the UNMC is and several of the other schools that train mental health providers. Students have told us that they want to stay in their home or near their home or school, but that it is too difficult to become established. The Medicaid policy limits the employability of PLMHPs in rural counties. Medicaid payments are often the largest insurance revenues. We believe that by amending this policy to include the entire state would provide for more trained clinicians in all of Nebraska. Nebraska regularly has approximately 900 provisionally licensed mental health practitioners at any one time. In addition, there are also provisionally licensed psychologists and alcohol and drug counselors that are also affected. By amending the Medicaid policy we believe that it will help at the grass-roots level of training and will ensure that graduates from training institutions stay in Nebraska rather than leaving for other states which allow Medicaid reimbursement. Whereas the underserved rural areas needs services, the urban areas need opportunities to train. To develop a behavioral health work force, we need to cover all our bases. As providers, we have identified some of the barriers and are working to offer solutions. We see these as priorities to better serve rural areas and our hope is to continue working with the Legislature to make these needed changes. Thank you very much. [LR592]

SENATOR CAMPBELL: Questions or comments? Terry, just one question. Lately, in the work of the LR422, the suggestion was made that maybe Nebraska look at enterprise zones. Have you ever heard of that? [LR592]

TERRY WERNER: Oh, I can't say that I could speak intelligently to it. [LR592]

SENATOR CAMPBELL: It's really where you create a zone...an enterprise zone in the state and it's based on underserved...underserved areas and how you could bring in medical folks, more create like a team, to do that and see it as an economic development thrust. I mean, it's an interesting concept. I'm probably really murdering the concept, but it is one thing that people have suggested that we ought to look at. [LR592]

TERRY WERNER: I think that's a great idea. When I think of enterprise zones, I don't think about it for mental health. And I had a person I talked to today setting up a practice in McCook and she's having difficulties and so I referred her to some people that are seasoned and know some of the ropes. [LR592]

SENATOR CAMPBELL: Right. [LR592]

TERRY WERNER: But that kind of thing to provide those incentives I think would really be helpful. And I know that when I travel to Chadron and to Kearney and places like that, these students they really truly do not want to leave the area. They will stay there. And I think these kinds of incentives...that kind of incentives, you know, are part of the package that we need. [LR592]

SENATOR CAMPBELL: Right. I think it's like putting a number of disciplines together in an underserved area. [LR592]

TERRY WERNER: Right. Right. [LR592]

SENATOR CAMPBELL: Yes, Senator Gloor. [LR592]

SENATOR GLOOR: Thank you. Terry, one of the learnings we've had in this state, and Marty Faddig and the Rural Health Commission has been referenced already, but one of the learnings that they've had is of the two programs that relate to help place...helping place primary care physicians in rural communities. And I speak to this as relates to the efforts to place students in rural communities or in needed areas of the state, has been that there's one that just provides a flat dollar amount that's a combination, I think, of state and federal funds to a community...or to a practitioner in a community. And then there's one that requires that community to, in fact, come up with something and have some skin in the game, in addition to the dollars that are out there. And guess which one works the best? [LR592]

TERRY WERNER: Right. [LR592]

SENATOR GLOOR: And by far and away, I guess, it works the best. And it's not just the dollars and cents. It's the fact that communities who are willing to do that are well-enough organized to be supportive in a number of ways to those practitioners who were there. And I just pass that along to you as relates to our efforts to get students interested in communities. We need to make sure those communities are also interested in the students and what they represent for the health of their communities. [LR592]

TERRY WERNER: Yes, and, you know, obviously I think those are great things. I suspect that there would be a different attitude towards master's level mental health providers than physicians. And yet, I think they're just as important and the medical home is...it's critical that you have these mental health providers. And, you know, as I said, we have 3,000 in the state of Nebraska and I think they're not utilized and we need

to provide those incentives to better utilize those folks. And we're training them and I think there are more that we can train. And somebody had mentioned the programs about going into the high schools and so on. I think that's really important. And I've gone to AHEC and I've offered, said any place in the state that you want to have someone speak on mental health, I can provide you a person to do that. And, unfortunately, they've not taken me up on that. But, you know, I think these are critical areas. But, you know, to some people being a physician is overwhelming, but getting your master's degree and being a mental health therapist is not. And we can provide those in rural Nebraska. [LR592]

SENATOR GLOOR: I'm not sure I agree with your premise though that the attitude towards a primary care physician as opposed to a master prepared therapist. It depends who you talk to. [LR592]

TERRY WERNER: Yeah, right. I'm sure that's true. [LR592]

SENATOR GLOOR: I mean, the banker and the implement dealer may be interested in a primary care physician, but the school counselor and the minister and the priest may, in fact, have a whole different attitude, given what their responsibilities have become. [LR592]

TERRY WERNER: No question. [LR592]

SENATOR GLOOR: And the level of support doesn't necessarily even have to be financial. It may be that the pastoral association is the support entity and their support is regular meetings or mentorship of that therapist in some way, shape, or form. [LR592]

TERRY WERNER: And I agree with that, and I have to tell you there has been a great response of late in the last several years to school social workers, who, as you're aware, are trained differently than the counselor or, you know, as my counselor was a

football coach. (Laughter) [LR592]

SENATOR GLOOR: It's a good example...good examples. [LR592]

TERRY WERNER: And...but there's been a big expansion in your community as well as much of western Nebraska and Omaha and Lincoln. So you're exactly right, that is an important incentive and depending on who you are talking to. And the jobs are now there, whereas they weren't before. [LR592]

SENATOR GLOOR: Yeah. [LR592]

SENATOR CAMPBELL: But it becomes important to the banker and to the implement dealer and to the grocery owner and so forth and so on when it also becomes obvious to them that they have an employee or employees that need help. [LR592]

TERRY WERNER: That's exactly right. [LR592]

SENATOR CAMPBELL: And that oftentimes for the business owner is hard because they're not quite sure where to reach out to get that, and then it really hits home that you need that practitioner in your community. [LR592]

TERRY WERNER: Absolutely. And our cities in western Nebraska have seen a big transition in the last couple decades, so. [LR592]

SENATOR CAMPBELL: Right. Exactly. Thank you, Terry. [LR592]

TERRY WERNER: You're welcome. [LR592]

SENATOR CAMPBELL: Our next testifier is Susan Feyen. Good afternoon. [LR592]

SUSAN FEYEN-REAY: Good afternoon. My name is Susan Feyen-Reay. It's F-e-y-e-n dash R-e-a-y, and I'm with the UNO School of Social Work. I'm a licensed independent clinical social worker. I've been a social worker for 20 years doing child welfare work, developmental disabilities, pretty much any job in the community dealing with families. I've done a lot of them. I also do some training for the community around mental health and I'm on the licensed Mental Health Practice Board. I'm one of the social worker representatives on that board. And I'm here to tell you guys some really good news about something that's really great has happened in terms of the work force development for master's level clinicians. The UNO Grace Abbott School of Social Work is named after Grace Abbott who is a social worker out of Grand Island. Yes, so we are very excited and having her namesake and we see the need for training and keeping people in their communities doing mental health practice work, particularly social work. UNO has created an extension program for their MSWs out of the UNK office, so UNO MSW faculty come to UNK so that students don't have to leave their home to get a MSW because UNO has the only MSW program in the state. And that program is designed to be Friday night and all day Saturday, so to help people that are working full-time in the mid-Nebraska to be able not to have to quit their job. Another component of that is that I think many people leave the state or leave their hometown in order to do an internship or practicum. And we are working diligently to build up practicum sites in the communities, rural communities in the state, so that people don't have to leave their home in order to go to school or to do a practicum. And my really big, great news I want to share with you guys--since I'm the last one it's good to have good news--is that the UNO School of Social Work put in for a $1.3 million HRSA grant for social work education and we got the grant. We just found out a couple of weeks ago. And as part of that grant, it's designed to provide to increase the number of people in...MSWs in rural areas by providing them with all kinds of training that is Web-based, so that they can stay in their community in an internship that will help them develop and then they receive additional training specific to working with people with co-occurring disorders, so developmental disabilities and mental illness or substance abuse. The training is centered around providing information and practical application for the most difficult

population that we work with. And so it's a Web-based module where you can enter in, it's an 18-year-old African-American female with aggression, and it will essentially provide information to the clinician about the literature that's current as well as steps for each session, about how to do that, what they need to do with the parent, with the child, how to facilitate that. And then we provide $10,000 to the student, a stipend, to complete this practicum as well as complete the on-line modules. And the supervisor also gets $500 for doing the supervision if they complete the modules as well, because we're trying to increase the base of training. So in providing training to the supervisors as well as to the students, we're getting at another angle, I suppose. So we're really excited to work with BHECN on this initiative for sustainability, and to continue to promote social work in particularly the rural areas to assist people, to have more clinicians to be able to see people with these kind of issues in the community. [LR592]

SENATOR CAMPBELL: Okay. Any other questions? Thank you very much for your testimony. [LR592]

SUSAN FEYEN-REAY: Yes. [LR592]

SENATOR CAMPBELL: The last testifier that I have had added to the list is Blaine Shaffer, who is from the Behavioral Health Division of the Department of Health and Human Services. Is there anyone else in hearing room who wishes to testify today? Okay. One person. All right. Go right ahead, sir. [LR592]

BLAINE SHAFFER: (Exhibit 3) Thank you, Senator Campbell and members of the Health and Human Services Committee, for the opportunity to provide information, and to Senator McGill for introducing this resolution. My name is Blaine Shaffer, B-l-a-i-n-e S-h-a-f-f-e-r. I'm a board certified psychiatrist and serve as the chief clinical officer for the Division of Behavioral Health in the Department of Health and Human Services. In addition, I'm on the Medical Directors' Council of the National Association of State Mental Health Program Directors, a member of the Opioid Treatment Network for the

National Association of State Alcohol and Drug Abuse Directors, and on the editorial board of the Journal of Psychiatric Administration and Management. Prior to my work with DHHS, I spent 26 years in academic psychiatry, including serving as director of two psychiatric residency programs, and so I am very passionate about work force development in this field. The Division of Behavioral Health is the chief behavioral health authority for the state of Nebraska and directs the administration and coordination of the public behavioral health system. State Statute 71-806, also referred to as LB1083, requires the division to promote activities in research and education and to improve the quality of behavioral health services, recruit and promote retention of behavioral health professionals, and provide access to behavioral health programs and services. While the division has never been funded for behavioral health education or work force development, LB603, in 2009, created the Behavioral Health Education Center of Nebraska for that purpose and funded it within the University of Nebraska Medical Center. The intent was to realize the commitment made in LB1083 to improve community-based behavioral health services by increasing the number of behavioral health professionals and increasing training in evidence-based practices, telehealth, and other programs. The division has worked closely with BHECN, and I currently serve on its two advisory councils. We have a good relationship with BHECN, yet we do not have an official role in their work force development to serve the needs of people in the public behavioral health system. As the state continues to move to community-based services, the work force shortage for the people we serve is increasingly an issue across the state. Currently, the focus for work force development by BHECN is in the area of mental health integration with primary care. This is important, yet there are needs beyond integration with primary care necessary to best serve people who rely on the public behavioral health system. This is, in part, because the majority of people served through the public system often do not have primary care physicians. I would encourage broadening the scope of focus to include providers trained to work with consumers with severe and persistent mental illnesses, substance use disorders, and sex offenders. While all behavioral health providers are in short supply, we also need more certified peer specialists and certified behavioral health prevention specialists. I'll

speak to each of these populations. Consumers with severe and persistent mental illness have unique needs and priorities. They die 25 years earlier than the general population. They smoke 47 percent of all cigarettes sold in Nebraska. They have high rates of diabetes and obesity. They generally receive little dental care. The overall quality of health and well-being is less than the general population. Persons with severe and persistent mental illness are often not well-served in primary care settings due to stigma and lack of provider training, and are often better served in behavioral health settings with embedded primary care providers. This has been done by Community Alliance in Omaha and is working very well. Consumers with co-occurring mental illnesses and substance use disorders also have unique needs and challenges, and there is a significant shortage of providers trained in evidence-based practices to effectively work with them. Nationally, only about one of ten people with substance-use disorders receive any treatment at all, and of those, most do not have a physician included in their care. Physicians in general are currently not well trained to assess or treat substance-use disorders. In fact, most consumers with addictions who receive care from primary care providers do so for the consequences of their addictions, but not for their addictions which often go unrecognized. We need to develop a diverse behavioral health work force trained in recovery-oriented and trauma-informed care models able to work with consumers in both medical homes and behavioral health homes. Inadequate treatment leads to increased costly and preventable hospitalization, incarceration, loss of economic productivity, homelessness, public safety issues, as well as the pain and suffering of the consumers and their families. A particular need in Nebraska is physicians trained to use medication assisted treatment, or MAT. There are several FDA-approved medications for the treatment of alcohol and opioid dependence that are very effective when used with other psychosocial interventions. Nebraska ranks very low nationally in the number of physicians who use MAT. In fact, we have only three opioid treatment programs in Omaha and Lincoln able to use methadone, serving roughly 500 individuals, and only a couple dozen physicians certified to use buprenorphine across the state. I am designated as Nebraska's federally recognized State Opioid Treatment Authority, and am concerned about our ability to address the

small but growing problem of the abuse of opioid pain medications and of the increased use of heroin in the state. Opioid overdoses are on the rise and, nationally, deaths now exceed those from motor vehicle crashes annually. Another shortfall are providers willing and able to work with sex offenders as part of their community management, including providers for behavioral health consumers who are also convicted sex offenders as well as providers specifically trained to do sex offender treatment. Another key component in the continuum of care for behavioral health is prevention. The prevention work force in Nebraska is moving beyond just the historical prevention of substance use disorders and into mental health promotion and mental illness prevention. These latter initiatives are new and not as well-established. A trained, competent, certified work force in prevention is needed. Forty-four states have a prevention credential for their prevention work force and I believe Nebraska should develop this as well. To make the discussion even more complicated, we have identified about one dozen separate and distinct behavioral health systems in Nebraska. These include the VA, federally qualified health centers, private insurance, Medicaid, etcetera. All serve specific populations, have specific funding sources, and usually don't regularly interact with each other. The systems compete with each other for the small number of trained providers. The Division of Behavioral Health, as the state behavioral health authority, is the only agency interacting with all of the other systems in the state. We can assist in providing leadership in work force development and will continue our work with the Health and Human Services Committee, BHECN, and others across the state to develop, recruit, and retain a competent, caring, and effective behavioral health work force across the continuum, in a coordinated way, so that all Nebraskans can live the good life, because there is no health without behavioral health. Thank you. [LR592]

SENATOR CAMPBELL: Thank you, Dr. Shaffer. Any questions? Thank you for your testimony today. [LR592]

BLAINE SHAFFER: Thank you. [LR592]

SENATOR CAMPBELL: And we'll take the last testifier. [LR592]

LINDA JENSEN: (Exhibit 4) Thank you for taking me. I wasn't really planning to testify. Linda Jensen, L-i-n-d-a J-e-n-s-en, and I'm here representing NAMI, the National Alliance on Mental Illness. I've given you just a couple of handouts and so it will take me about three minutes, maybe, max to talk about, not even that long. One is about First Episode Psychosis programs. These are to target youth and young adults experiencing early psychosis. And I'll skip down to see the coordinated array of recovery-oriented services and supports that include outreach, family support and education, peer support, supported education and employment, case management, behavioral therapy, and low doses of antipsychotic medication. These are being followed...following the lead of Australia and several other countries. There actually is now a nationwide--what do I want to say--initiative research that's being done. And I think there is one site in Lincoln where this is being carried out. I guess, I would suggest that perhaps one reason that mental health behavioral health professionals leave the state is because they get really discouraged. Right now in Omaha people stay in emergency rooms for three or four days; they're in the hospital two to three days; they go out; they're not ready to go out; they're back in. I mean, it's just a continual fact...you know, recycling. And it's really discouraging to work in that kind of situation. There are other states that have better models and that have the peer specialists. I commend those so much. Unfortunately, in Nebraska they aren't licensed. They aren't...they haven't gone ahead and done the Medicaid waiver situation so that they could receive...so that Medicaid reimbursement could be received for their services. So...and they have done that in many other states. I slipped in there the Family-to-Family flier because it does say family support and education. In my own case, I have a son with schizophrenia. Family support is just tremendous. I teach family-to-family all the time practically. We have several classes going in Omaha and the families just say that it saves their family's lives. It just makes a tremendous difference. They learn to accept their family member. They learn to understand them, to communicate, to solve problems better with them, and that's an important piece too. So that's all I have to say. [LR592]

SENATOR CAMPBELL: Thank you, Linda. Any questions? Senator McGill, would you like to make any other comments? [LR592]

SENATOR McGILL: No, I don't think so. [LR592]

SENATOR CAMPBELL: All right. With that, we will close the public hearing and we will take barely five minutes for those people who wish to leave from this hearing while Senator Watermeier sets up for his hearing. [LR592]

BREAK

SENATOR CAMPBELL: (Recorder malfunction)...and proceed to our next hearing which is LR596, Senator Watermeier's interim study to evaluate the potential uses of Physicians Orders for Life-Sustaining Treatment and out-of-hospital do not resuscitate protocols. And I think most people in the room sort of know the drill. Make sure that you've turned off your cell phones, that type of thing. And if you are testifying today, and Senator Watermeier's office has provided a list to me, please fill out one of the orange sheets. So, with that, Senator Watermeier, would you like to open on the interim study for us? [LR596]

SENATOR WATERMEIER: (Exhibits 5, 6, and 7) I sure would. Thank you, Chairman Campbell and members of the Health and Human Services Committee. I am Dan Watermeier, spelled...Senator Watermeier, W-a-t-e-r-m-e-i-e-r, and I'm here today to introduce LR596. The purpose of LR596 is to study and evaluate the potential use of Physician Orders for Life-Sustaining Treatment, or POLST, and out-of-hospital do not resuscitate, DNR, protocols. A POLST is a medical order completed and signed by a physician resulting from the detailed conversation between the patient and a physician or other healthcare professionals. A POLST is geared towards cancer patients and other severely ill patients who life expectancies have been identified and reduced. The

purpose of a POLST is to improve end of life care by converting patient's treatments preferences into medical orders that are transferable amongst home and healthcare settings, including emergency medical technicians, emergency physicians and nurses, and nursing facility staff. It can be reviewed and revisited at any time. A POLST is a detailed document stating the types of medical interventions which might be anticipated and further directs whether those interventions, such as resuscitation, intubation, antibiotics, hospitalization, should be provided. I have distributed a sample POLST form, which is on a green stock, for your review. It is limited to one page, usually printed on bright colors for easy recognition, and paramedics are trained to look for them. POLST have been approved in 19 other states. Additionally, states are in the process of developing programs. In Oregon, where POLST originated in the early 1990s, documents are recorded in an electronic registry so first responders are able to access them on-line. POLST is a written document by a provider based on a patient's wishes. It is a valid medical order for current treatment. This differs from an advance medical directive which is usually written by an attorney containing instructions for future treatment in the event the person becomes unable to make or to communicate such decisions themselves. An advance medical directive is more vague, dealing with hypothetical situations, than a POLST where the patient can opt in or opt out of specific treatments. The two most common advance medical directives are a living will and a medical power of attorney. This is an example of situations when the need for potential POLST changes. Let's just say a husband meets a paramedic arriving on a call at his home. He tells them that his wife has terminal cancer. She has a weak pulse and shallow breathing. She was under the hospice care and had a signed DNR order. She had made her wishes very clear, she did not want to be taken to the hospital if a life-threatening emergency arose. But the woman was not in cardiac arrest--the situation specified in the DNR order. Therefore, protocol requires paramedics to save...to try to save her life by inserting a tube to restore breathing and transporting her to a hospital where she would be put on a ventilator, just what she did not want to happen. Keep in mind that a POLST is a form, it's completely voluntary. It is to be used only if a patient desires to complete one. It is meant for end of life situations when the

patient is wanting to provide more specific information to caregivers than a DNR order contains. POLST expands out-of-hospital DNR orders which only apply when the patient is in the cardiopulmonary arrest. At least one community in Nebraska has been using POLST for several years. Since these forms are already in use, I think it is important that we discuss the development of a standardized form. A standardized form would lessen confusion and decrease the chance of unwanted care as all healthcare professionals would be familiar with this form. I'm providing you with a copy of the POLST legislative guide and beginning on page 8, it discusses whether legislation is needed to establish a POLST program. Some states have successfully not used legislation but established their POLST system through clinical consensus, where healthcare professionals view it like other medical orders. Other states develop it through their medical board's rules and legislation is needed only if impediments exist in state law that pose legal barriers to the implementation of a POLST program. Regardless of whether these develop through statute, rule, or consensus, it is important that the program have the flexibility to evolve over time. Furthermore, I understand there are already multiple versions of DNR forms within the state which are used by more people than those in which a POLST form is applicable. I believe a standardized out-of-hospital DNR form should be also discussed. I'm submitting a letter from the Nebraska Board of EMS Services that I would like to be part of the record. I would like to thank you for holding the public hearing on the issue. I think it will provide a good forum to get the discussion started. And if you have any questions, I would be happy to try to answer them. I really have learned an awful lot about this discussion in the last several months as we've had several meetings. And it's not something that I'm anxious to come forward and have legislation on other than to have this discussion, and it's really been a real learning experience for me. [LR596]

SENATOR CAMPBELL: Senator Gloor. [LR596]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Senator Watermeier. This is an important subject, no doubt about it. In your research on this, have we had

other legislation that has been directed specifically towards POLST? Have you found past legislation introduced? [LR596]

SENATOR WATERMEIER: I haven't, and I think there will be people behind me that can maybe talk to it a little bit more about it, but I'll try to look into that a little further, but I don't believe we have, some to the DNR but not to the POLST. [LR596]

SENATOR GLOOR: Yeah, I was just going to say, it probably was more related to do not resuscitate, but...okay. Thank you. [LR596]

SENATOR WATERMEIER: And you know, a little of my history on this as I was thinking about it in the last couple of months is that I really don't know. I'm not the person that's an expert on this, obviously. I've had some experiences through the rescue squad and service that I have. My father passed away a few months ago, so I have discussions about palliative care and all these things. And I guess it just came to me and I was willing to bring it up and I think it's worth a discussion. I'm certainly not a big person as far as mandating from the state what you're going to do, but if we can get a standardized form in place before a lot of hard feelings are made, a medic has...my institution does it this way and I don't want to change. You know, and it's probably helpful and healthy for the state. [LR596]

SENATOR GLOOR: And what's the basis for the green form again? Where did you get this? [LR596]

SENATOR WATERMEIER: That's the DNR and the other example is the POLST, I believe. [LR596]

SENATOR GLOOR: But where did you get this? What's...who was the generator of this, do you know? [LR596]

SENATOR WATERMEIER: I'm going to turn behind me. I think this young lady behind me here is going to talk a little bit more about that. [LR596]

SENATOR GLOOR: Okay. Good. Thank you. [LR596]

SENATOR CAMPBELL: Senator Watermeier, I have one question, and maybe I missed it while you were talking. So where would the repository of this form be? [LR596]

SENATOR WATERMEIER: That's part of the whole discussion, whether it's going to be an electronic form. But let me bring the following up. [LR596]

SENATOR CAMPBELL: Sure. No, that...and I will hold my question. That's fine. [LR596]

SENATOR WATERMEIER: Okay. [LR596]

SENATOR CAMPBELL: Great introduction. At least I have a little better understanding, so, and we'll give you a chance to close too. [LR596]

SENATOR WATERMEIER: And I learn about it every time we discuss it. It's going to be well-needed, much needed. Okay. [LR596]

SENATOR CAMPBELL: Absolutely. Well, I appreciate that. I also have a list from Senator Watermeier's office, so I'm going to go through that list and if your name isn't on the list but you plan to testify, well, you certainly can. Just make sure we have a orange sheet as you come forward. The first testifier is Jerry Stilmock from the volunteer firefighters and chiefs. Good afternoon. [LR596]

JERRY STILMOCK: Senator Campbell, thank you. Members of the committee, my name is Jerry Stilmock, J-e-r-r-y, Stilmock, S-t-i-l-m-o-c-k, testifying on behalf of the Nebraska State Volunteer Firefighters' Association, the Nebraska Fire Chiefs'

Association. Senator Watermeier's introduction was super because he's identified that the POLST--and I'll just continue to use the acronym--the POLST is separate and apart from what we have in Nebraska law now with either a living will or a healthcare power of attorney. As you know, if you had medical care yourself, you've been in the hospital, you've been an outpatient, perhaps a family member, one of the things they ask you upon admission was, do you have a directive or it's kind of the generic term, do you have a living will. That's not what a POLST is, obviously. A POLST is intended...and you know, because if you've signed one of those documents--a healthcare power of attorney, living will--that's either you at the admission table at the hospital where they ask you to step aside and review and sign, or you've done it as a part of your estate and medical planning with your attorney. It is...it, the healthcare power of attorney, is intended to be a part of long-range future planning. As with the POLST comparatively, it's intended to be used, as the literature speaks, if there's an imminent illness or disease that your physician would expect you to terminate it in a year's time. So it's for...truly for end of your...end of one's life planning. For emergency medical services it's very helpful because it gives a directive, an order from the physician. And most states, in the research I've done, also require the patient to sign along with that physician. A sidebar: physician I'm using just for purposes of discussion, but there's another element then that other states have wrestled with is, is a physician alone the only authorized medical provider, or is a physician assistant able to sign, or is a nurse practitioner able to sign and have this be a valid document along with the patient. For emergency medical service providers, my men and lady that I represent on behalf of those two clients I mentioned, they dearly need a uniform directive when they're called upon. And in the light that the Senator Watermeier shared with you an example, the examples have happened. They're real-life stories where the family may be with Grandma or Grandfather. They may know Grandma or Grandfather's wishes, or their mother or father's wishes, that they do not want to be resuscitated. They want to pass peacefully because of their condition. But yet in angst, or in a moment of crisis, Grandma, Grandfather, Mom, or Dad fail and they call 911. Then the emergency medical responders, many of whom throughout the state are volunteers, are tasked with, now

what do we do? Upon entering the home, they're made aware of, we, the family members there, we haven't started resuscitation efforts on our own. We know that Dad didn't want that because he told us, but yet we're putting medical providers in a dilemma of, we're called, we need to respond, but yet the people there that have placed the call have said, no, don't. So it would be helpful, we believe, if the state looked at, number one, uniformity. Number two...and there's a whole list of issues, but the second one, what about other states? I have documented about 20 states that have POLST in place and recognized. What about a POLST from another state coming into Nebraska? Senator Campbell, your question, what about the registry, some states have spelled out statutorily that there shall be a central registry, that they shall be filed, they should be filed electronically, and that, upon proper protocol, the emergency responders in the field shall be able to access that information ahead of time so they know. They know what kind of situation they're going into. Another issue is a surrogate. Should a surrogate be able to change or modify the POLST. The other...the final point in relation to the emergency medical volunteers is, these items are out there now. What level of immunity, protection from civil or criminal liability is out there to assist and direct? What...you know, what should happen? It is truly an intriguing dialogue and I'm happy to say that the lady, who hopefully is going to follow me, brings a wealth of information and knowledge. And with that, I'll end my comments, Senators. Thank you. [LR596]

SENATOR CAMPBELL: Questions for Jerry? Thank you much for your testimony. [LR596]

JERRY STILMOCK: Thank you. [LR596]

SENATOR CAMPBELL: Our next testifier is Lisa Weber. Lisa is with the Columbus Hospital as a social worker. Is that correct? [LR596]

LISA WEBER: (Exhibit 8) Thank you. And my name is Lisa Weber, L-i-s-a W-e-b-e-r, and I am a clinical social worker and counselor in Columbus, Nebraska. And my area of

practice focuses primarily working with individuals with chronic and terminal illnesses. And I also work with individuals and families in the emergency room facing traumatic situations and unexpected losses. Well, I'm here today because I'm the one that developed the POLST program in Nebraska. It started in Columbus and since then there has been several other communities that has adapted what we have done in Columbus in their areas. Now, because it doesn't...it's really a communication tool that we use in our community. But I just kind of want to go, and it's kind of a repeat of the two individuals that kind of went before me, but I just want to reiterate a few things, you know. POLST is an acronym for Physician Orders for Life-Sustaining Treatment. There's a lot of emphasis on what should not be done for individuals, according to the POLST, but I do want to say, it is Physician Orders for Life-Sustaining Treatment. So there's individuals that do fill it out saying that they do want these things, but because it's such a simple, easy to interpret form, we use it for both ways. And also you'll find that POLST across America now seems to be the generic term of what they want, and a very specific advance directive that is a way of documenting an individual's desired choices for healthcare in this easy formation. You know, currently Nebraska doesn't have a consistent tool that communicates these options, especially in emergency situations. And you'll discover that today that facilities and hospitals and communities, we have kind of...they all have different ways of doing it, and a lot of them don't have anything to address emergency situations, especially out of a medical setting. We in Columbus, our program is pretty specific in that in order to complete a form, or even address and approach somebody about completing a form if they don't ask, is a physician's order to even start the process. But I want to talk a little bit about advance directives in general. You know, in Nebraska we have two as a result of the Self-Determination Act of 1990 that states nationally that individuals have the right to decide about what types of treatments and the extent of medical care that they want if they can't speak for themselves. We currently have in Nebraska the living will declaration, the durable power of attorney, and I put a book that actually HHS has developed that many hospitals use that kind of explain those things. The Nebraska living will document tells medical providers what they do or do not want as far as

life-sustaining or death-prolonging treatment, if they are in a persistent vegetative state and the end of their terminal condition, and they cannot speak for themselves. And the durable power of attorney is a legal document which allows individuals to appoint someone to make those medical decisions if the person becomes temporarily or permanently unable to make these decisions. But there are limits to these documents. They're not in effect in emergency situations, especially when the individual is outside a medical facility, and they're not orders. In fact, many of them are drawn up by attorneys in the estate planning process. Currently, if the first responders are contacted, like by calling 911, the paramedics or emergency medical technicians are obligated to initiate all efforts of lifesaving procedures and treatments, regardless of the burdens or benefits to the individual unless they have a signed order from a physician saying not to do that. Because of the lack of the consistent documentation, many times the first responders, which are normally volunteers, are really put in the position...or a difficult position. A document such as the POLST form or another chosen out-of-hospital do not resuscitate document will assist in the communication and care of the first responders. Do not resuscitate or allow a natural death for individuals that because of advanced illnesses or advanced age that do not want specifically cardiopulmonary resuscitation if their heart would stop or they would stop breathing where the person's opinion is that the burdens would outweigh the benefits. I'm honest. I'm partial to the POLST program or similar documentation that would allow autonomy for individuals because it addresses both emergency and nonemergency life-sustaining and death-prolonging treatment. In Columbus and other communities, it's determined that the POLST document is for individuals with advanced age or advanced illness. The power of attorney can make decisions for the individual in a nonemergency situation when facing the end of life situation, but there needs to be a visible doctor's order in place in emergency situations, such a resuscitation and intubation. And then we also run into being that, you know, sometimes the power of attorney is not available. I spent countless hours in emergency rooms in both urban and rural settings counseling families in the time of crisis on life-sustaining and death-prolonging medical care. And we all know that the time to make education...education, rational decisions is not in the time of crisis. I'm concerned

about the ability to honor wishes and desires of Nebraska citizens regarding their healthcare because of the lack of consistent, reliable communication tools and procedures assuring an individual's autonomy, while supporting community medical providers. Questions? [LR596]

SENATOR CAMPBELL: Senator Gloor. [LR596]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Lisa. Did you come over to Grand Island and do a POLST presentation? [LR596]

LISA WEBER: Many times, yes, I did the train the trainer program for Grand Island. [LR596]

SENATOR GLOOR: Yeah, that's...yeah, yeah, that's why all this sounded familiar. It wasn't past legislation. It was Lisa coming over to Grand Island. (Laughter) So what would you like to see if you were in charge of...if you were the queen of POLST for the state of Nebraska, what would you like to see in POLST for the state of Nebraska? [LR596]

LISA WEBER: Well, I have...we in Columbus actually are in the process of reviewing what that form is. And actually... [LR596]

SENATOR GLOOR: And this is your form? [LR596]

LISA WEBER: Yeah, that's the form that I developed with a team of individuals. Ours just happens to be blue instead of green and I think blue...because we want all the documentation as far as that advance directive in that. And we also developed a handout that I gave you that goes through kind of the definitions. I'd like to see at minimum the do not resuscitate, some kind of something in the home of individuals that do not want this type of procedure, that in their mind, the burdens outweigh the benefits,

you know, so that the emergency medical providers would be able to honor their wishes. I am looking at a form right now or adapting that one that has two different sides. One addresses just emergency situations like intubation and CPR, signed by the physician, and an optional side in the back that addresses nonemergency, such as feeding tubes, long-sustaining IV therapies, those kind of things, so that if the individual wishes not to even complete the back, and allow their power of attorney to make those decisions if needed, then that would be, you know, just an optional part. So that would be, if I was the queen of POLST, is what I would want, is just a... [LR596]

SENATOR GLOOR: Is your preference for that form based upon some of your readings or what you've heard has worked best in some other states? [LR596]

LISA WEBER: And research and maybe just because, you know, the end of life situation is very emotional. And there's some people that don't...that feel, and they have the right to feel that as part of the Self-Determination Act is that they do want certain things. And this would be just...if they don't want to do the nonemergency things, if they want to try feeding tubes or that kind of stuff, they have that option. But there's people that are very, very passionate about the fact that in the home or outside the home if their heart would stop, because of their advanced illness, they do not want resuscitation. There's other people that are very, very passionate about the fact that they never want feeding tubes and dialysis and those kind of things, and I think...a form like that would be less controversial in Nebraska. [LR596]

SENATOR GLOOR: Okay. Thank you. [LR596]

SENATOR CAMPBELL: You know, Lisa, I've been listening to this and I'm trying to figure out, we have talked in the office at times, Miss Chaffee and I, that we really ought to have some form that's on the refrigerator. Because I, too, had a family member who was visiting me--my mother--and collapsed and I mean, we had nothing. All of it was in my brother's papers in a safety deposit box. I mean, he knew at that point, but we had

no papers. So when the emergency responders came, they did exactly what you're saying. I mean, they treated it as a resuscitate and that whole thing. But I'm trying to figure out where this would be. [LR596]

LISA WEBER: Okay. Well, let me... [LR596]

SENATOR CAMPBELL: You know, it's like then what if you're in a car accident and you're on I-80? You know, do you carry this with you? That's my question. [LR596]

LISA WEBER: Right. Yeah. We in Columbus, Grand Island, and some of the other communities have done really extensive. The education wasn't only with providers and people to fill out the forms but also, in the process of doing that, developed a community education program. We were fortunate in Columbus that between the hospital and the auxiliary for the fire, I think, did some fund-raising and we have magnets and the magnets are big. They're about half the size of this piece of paper and the POLST form slides in there. And on that...I didn't bring them because they're really kind of heavy. But there's a checklist. They put their name, who their emergency contact person is, and who their provider is, and then there's a check. Do they have a POLST in there? Do they have...is there a power of attorney in there? And then is their list of current medications in there? And then the paramedics or emergency medical technicians, the families, then pull that off the refrigerator and bring that with them. So it's easily accessible. Now, yes, there is the issue of if they're not in the home. And that was when the development process, the...our emergency medical technicians questioned me a lot about that. They said, you know, that's going to be really great if they're at Walmart. And I said, well, really the form...we want people to be mobile and do these kind of things. Some people make a copy, they put it in their purse, that kind of stuff. But most of these people that have the forms are not real mobile. They are staying in their homes because they are of advanced age and advanced illness. [LR596]

SENATOR CAMPBELL: Okay. Any other questions, Senators? Thank you very much.

[LR596]

LISA WEBER: Oh, you are more than welcome. [LR596]

SENATOR CAMPBELL: Our next testimony and it says someone from the Nebraska Hospice and Palliative Care. Are they here? [LR596]

NICK FAUSTMAN: Good afternoon. [LR596]

SENATOR CAMPBELL Good afternoon. [LR596]

NICK FAUSTMAN: I'm Nick Faustman, Nick, N-i-c-k, Faustman, F-a-u-s-t-m-a-n. I'm vice president of Government Affairs for the Nebraska Health Care Association, which is a parent association to a family of entities, including the Nebraska Hospice and Palliative Care Association, the Nebraska Nursing Facility Association, the Nebraska Assisted Living Association, as well as the Licensed Practice Nurse Association of Nebraska. As you can see, this is potentially a very complex issue. However, we see...we are very pleased with Senator Watermeier introducing this resolution because we see great value to any discussion when it comes to end of life care, end of life decisions and wishes that a patient or an individual may have. We have a great deal of interest in this because naturally as healthcare providers that specialize in the later stages of life, we are the ones who will be caring for these individuals in most cases. And so, if we can be of any assistance if Senator Watermeier does intend to follow up with any further legislation, or if there is another interim study, we would be happy to offer our resources. [LR596]

SENATOR CAMPBELL: Nick, in most of the facilities...in long-term care facilities, assisted living--I know that you have an umbrella for that--is there a discussion with the resident and forms available that you now utilize? [LR596]

NICK FAUSTMAN: Yes, but as stated earlier, there is no uniformity necessarily. [LR596]

SENATOR CAMPBELL: Okay. [LR596]

NICK FAUSTMAN: A resident in one facility may have a POLST or a DNR, others may have depending on, you know, location, of course. But they do have staffers within the facilities who do visit with the patients or the residents on their end of life wishes and oftentimes will help, to the extent that's possible, help fill those forms out. [LR596]

SENATOR CAMPBELL: Okay. Sue. [LR596]

SENATOR CRAWFORD: Thank you, Senator Campbell. Thank you, Nick, for being here. One of the questions Senator Watermeier asked is whether or not legislation would be necessary, whether or not this could be done with collaboration or coordination. Do you have any sense of that from maybe your efforts in other areas where this kind of coordination was needed? [LR596]

NICK FAUSTMAN: I think so. I know that there was a group that had been meeting for quite a while. They called themselves The End of Life Coalition, of which we do have representatives from the Nebraska Hospice and Palliative Care Association attend those meetings. I think that that is one of the issues that they've been kind of wrestling with in the past. One meeting that I attended recently was Senator Watermeier and his staff and others...other stakeholders, we did take up that issue. However, I don't know that it's known at this time if this can be done "regulatorily" or whether we can pursue any sort of uniformity without any policy being made. So I apologize, I don't have a direct answer. [LR596]

SENATOR CRAWFORD: That's okay. [LR596]

SENATOR CAMPBELL: One of the interesting things that our estate attorney had us do

was provide all directives and power of attorney electronically and ask that it be put in our electronic medical record with our physician. And also that we provide to the person who will handle the estate from our family, which in my case would be our son, and he now has all the passwords to get into those electronic records. So at any point with a phone he would know what we've said. So that's an interesting question in terms of as we start developing electronic medical records and what should be in there, it was an interesting point that I had not even thought of putting all of those in there. [LR596]

NICK FAUSTMAN: That's true. An important point to remember, however, is hospitals, generally speaking, are way ahead of the curve as compared to nursing facilities, assisted-living facilities, and for various reasons, but certainly should be part of the discussion, the ease of electronic health records. [LR596]

SENATOR CAMPBELL: Thank you, Nick. Our next testifier is someone who is coming from "It's All About the Conversation." Good afternoon. [LR596]

HELEN CHAPPLE: (Exhibit 9) Good afternoon. Thanks for having us. My name is Helen Stanton Chapple. Last name is spelled C-h-a-p-p-l-e, like apple with a CH in front. I'm assistant professor at the Center for Health Policy and Ethics at Creighton. I'm a nurse and an anthropologist who has specialized in death and dying for 30 years. And I facilitate Nebraska's statewide coalition called "It's All About the Conversation." Our group has been studying state policy needs relating to seriously ill, frail, elderly, and possibly dying patients since April of 2011. Lisa has been an active member of our group as well so we're very aware of the POLST. We've noticed in some of our research that we've done along the way that there's a surprising amount of confusion in the state regarding these tools that you mentioned and that Lisa mentioned: advance care planning, living wills, proxy appointments, advance directives, do not resuscitate orders, POLST forms and all their purposes. People mix them all up. And it's not just Nebraska, a lot of people do. But we've been particularly concerned that, unlike the six surrounding states, Nebraska has no statewide template for out-of-hospital DNR orders. And so, as

you have already heard, the most vulnerable patients in the state use these forms outside the hospital. Right now a particular provider could write a DNR order on his or her script pad. It's that, sort of. A research also shows that dozens, perhaps hundreds of different out-of-hospital DNR forms are used in Nebraska because long-term care facilities make up their own forms. And I've given you a couple of examples in my paperwork there. This variety results in readability challenges, possible confusion by first responders, and potential delays in the application of the most appropriate interventions, whether it's CPR or not CPR, when patients need them most. Our coalition believes that a consistent form or two forms, a statewide template for out-of-hospital DNR and a POLST, one of those two, would insert a measure of uniformity in this sort of strikingly inconsistent behaviors that we're seeing that you've already heard about. We like the Lancaster County out-of-hospital DNR form that I've also given you and I think you have in some other paperwork that you have. We would be in favor of using that form as a template for the state. Uniformity in these forms would make it possible to establish a statewide registry. The Nebraska Health Information Initiative, NeHII, is ready to incorporate advance care planning documents, such as the out-of-hospital DNR form, advance directives, and/or POLST into their electronic information networks. So they've been working with us right along. So they're already (inaudible) if it can get set up, they're ready to jump in. This would enable providers across the state, obviously, to check easily for such documents when patients present themselves to facilities across the state. We have a Web site, "It's All About the Conversation," and we would welcome your visiting it. We like for it to be Nebraska-based, but it has links to lots of other things and we provide community and clinician information, so many sets of people. Videos are there and that kind of thing. We're really emphasizing excellence in end of life care and recognizing that if the infrastructures aren't there, there's not a lot of point in having the conversation if we don't have the infrastructure somehow to respect those preferences once they've been expressed. So that's what we're interested in, in moving forward. So happy to take any questions that you might have. [LR596]

SENATOR CAMPBELL: Any questions, Senators? Thank you very much for your testimony today. [LR596]

HELEN CHAPPLE: Okay. [LR596]

SENATOR CAMPBELL: And then...I don't...Senator Watermeier, am I supposed to have someone else from the Nebraska Medical Association? Dr. Rauner, are you here for the Medical Association? I didn't mean to just pick you as the Medical Association, but I didn't know if you were representing them today. Okay. [LR596]

BOB RAUNER: (Exhibit 10) Yeah, okay. Dr. Bob Rauner, Rauner is R-a-u-n-e-r. I'm actually representing the Nebraska Medical Association and the Nebraska Academy of Family Physicians. I'm testifying in support of the POLST and a statewide standardized form. One of the primary causes of bad outcomes in healthcare is a lack of standardization and a lack of clear communication. And the form such as this, that's really important that it be clear and concise. And that's one of the benefits of having the POLST form to be fairly standardized, and frankly not just within Nebraska but even nationally. There are efforts actually across the country. I believe Nebraska is only one of six that does not have an organized POLST effort started and so it's that common. Even West Virginia is ahead of us on that one. (Laughter) And these are real situations. I'll start with...my interest started with a situation exactly like Senator Watermeier described. When I was a family physician in Sidney, Nebraska, I was on an ER call one night and a guy came in. The squad had brought him in, he was intubated and they were doing chest compressions and breathing for him and we were continuing the code like we were supposed to until the family came rushing in and said, would you please stop. And it turned out the back story was that this guy had terminal cancer and they were driving across the country in their RV in his final days. But, of course, they didn't want anything done should he die. Well, they stopped at the rest stop a couple miles east of Sidney and someone nearby said, oh, something bad has happened, they called the squad. And the squad's default was always resuscitate people and so they brought

him in resuscitated. But when we found out what the story was, of course, we stopped and he just died peacefully like he had wanted to, but unfortunately, didn't happen. And that's where a standardized form that's recognized, easy to interpret, because one of the things some squads...because legal reasons are always going to do everything because they don't want to get sued, same with the hospital, same with an ER. And so by having a standardized form that's accepted, recognized, and clear to understand, it solves those issues. Yes, there are some legal documents, but lawyers are not on call in the ER to interpret what those mean to us. This is written in medicalese that doctors, paramedics, nurses, can understand and that's why it's important that it be in this format. It also has places where you actually list, not just the patient's signature but their loved one, usually their power of attorney, and the medical person whose signature would be accepted by an ambulance squad or hospital to approve the form. That started my interest and I've been using a form very similar to what Lisa's passed out. Actually that article I handed was from this coming Nebraska Medicine issue I wrote in combination with Deone Anderson. She's a social worker at one of our clinics in Kearney that they're pushing this exact form out. And I describe a story where it happened correctly, in which case I use a story where I had an elderly couple, a lot of chronic diseases. We discussed this with them. We had the forms written down. And then one night he got very sick and in the ICU at St. Elizabeth's--unfortunately, she was not able to be there because of her conditions and how fast things were happening--the granddaughter started panicking. And in those situations where the family disagrees, it can be really awkward. And it was nice I could...basically, we had an electronic medical record. I faxed it directly to the ICU nurse, ICU station, here's what your grandparents said they wanted in this situation. It made it very clear for them because they can understand it too. It's also not just lawyers that have to understand it, but the patients have to understand it. And so that's why it's a very useful form and so I'd strongly encourage it. The only thing that I'd say, I might change actually is I might change the terminology from DNR, do not resuscitate, because that sometimes is misinterpreted as do not care. So there's a little movement to change it to AND which is allow natural death. But beyond that, I like the standardization because it prevents so many

miscommunications. There's also a story about La Crosse, Wisconsin. If you ever look up, they have perhaps one of the best and most mature programs around and they use the refrigerator magnet approach so the EMT guys know, go look in the refrigerator magnet, that's where the med list and POLST form is. And so we would definitely encourage a statewide form. Could it be done without state, you know, mandate or control? Yeah, but it's probably going to take five, ten years, and it might not happen, whereas, if there was some legislative administrative authority it could happen in a year or two and not have to dink along for another five or ten years. There's been efforts. I know Kevin Wycoff in Hastings has been pushing that. I know there are several of the physicians in Columbus. Kearney is now working on it. We used it for a while in Lincoln but couldn't get it across the board or get all the nursing homes to use it, for example. And so if there was something from above that would help make it happen faster, I think there's enough grass-roots backing already for it. So, thanks. [LR596]

SENATOR CAMPBELL: Great. Thanks, Dr. Rauner. Questions from the senators or anything? Thank you. And is there someone else in the audience that wishes...yes, would you come forward, please. [LR596]

KATHLEEN HARNDEN: (Exhibit 11) Good afternoon. I'm Kathleen Harnden, K-a-t-h-l-e-e-n, Harnden, H-a-r-n-d-e-n. I'm a longtime nurse, also social worker. Now I'm working on my doctorate, and this is my subject of interest. Just a little bit about real-world, reaffirming what's has already been brought to light. But one little point that I'd also like to add is on this entire advance directive concept there are some people that have actually fraudulently misrepresented that advance directive and it's led to really awful care. I've cited that in that information that I've given you today. So, I think we really need to also tighten up that whole network so that the person's wish is really protected and it limits all these opportunities for reactions at the last minute and things like that, that can happen. And we have had little groups--thank you, you've joined us--and other discussions with people in our community that really are concerned that they've gone through the steps of the powers of attorney, the living wills, the advance

directives, and then at the moment if they sign that down in Kearney and they're having dinner in Omaha, no one knows about it. So all of that planning is just for naught. So I really feel very comfortable in saying that the grass-roots is real, but we really need help from the bigger part to make it happen in a timely manner. Thank you. [LR596]

SENATOR CAMPBELL: Thank you. Anyone else in the hearing room? Okay. Senator Watermeier, did you want to add any comments? [LR596]

SENATOR WATERMEIER: Thanks for listening, and I think I learned more and more as I sat and listened to the peers around us. And the one thing I was just sitting here thinking about, though, as you look at the demographics in Nebraska, and what we have in Nebraska for aging, elderly, our population is barely gaining, this is where we need to have this. We had discussion because just in our testimony before we were talking about 1,800 people involved in the behavioral...or, excuse me, the foster care issues. This is going to affect a third of our population right away. So I'd be anxious to have any more input from other senators that want to become involved. That's kind of gone back-and-forth. When we first got started talking about it, we...I was, in my mind, thinking we're going to jump right in and do this POLST and I'm glad to hear the discussion coming back to the DNR, maybe changing the DNR. But I really would welcome lots more input and we'll just have to see what happens between now and January 8th. And if we need to do something, I'd be glad to do that, so. [LR596]

SENATOR CAMPBELL: Thank you, Dr...Dr. Watermeier. (Laughter) [LR596]

SENATOR WATERMEIER: I was hoping there was another senator that was a doctor (laughter) and then you might have someone more qualified to do this. [LR596]

SENATOR CAMPBELL: Really, and I like that. Senator Watermeier, thank you for bringing the topic forward. It's far more important to a lot of families across Nebraska that we have these conversations and talk about it. It's been very helpful. Thank you.

[LR596]

SENATOR WATERMEIER: Right. I had no idea there was this discussion behind the scenes and if that's what it takes is a little push at the state level to get it going, you know, sobeit. Because they're probably correct, we could do it behind the scenes, but it might take five years and there's no reason for that. If we need to have a little gentle push to get it done within two years, let's get it done. [LR596]

SENATOR CAMPBELL: Okay. Thank you. That concludes our hearings for the day from the Health and Human Services Committee. Thank you very much. Have a good weekend and go Royals and the Huskers. [LR596]