MORFELD: Are we good? Are we? OK. Well, welcome to the Education Committee public hearing. My name is Adam Morfeld from Legislative District 46. I serve as the Vice Chair of the committee. Chairman Walz is not feeling well today, so she could not make it and asked me to chair. So let's first, first thing, first things first. The committee will take up the items in order on the pro-- posted agenda. Today's hearing is for invited testimony only. Also, to better facilitate today's proceeding, I ask that you abide by the following procedures. Please turn off and silence any cell phones and electronic devices. Move to the chairs in the front of the room when you are ready to testify. If you have written materials that you'd like distributed to the committee, please hand them to a page to distribute. Pages are right over there. We'll introduce them in just a minute here. Also, we need ten copies for all committee members and staff. If you need additional copies, please ask the page to make copies for you now. When you begin to testify, please state and spell your name for the records. Please speak directly into the microphone so that our transcribers can hear you and hear the testimony clearly. Finally, please be concise. Testimony will be limited to five minutes. We'll be using the light system. Green means five minutes remaining, yellow means one minute remaining and please wrap up comments. Red means stop. Also want to introduce our committee members that are here with us today, one that's going to be introducing and testifying, but first to my right.

SANDERS: Good afternoon. Rita Sanders, representing District 45, which is eastern Sarpy County, Bellevue-Offutt community.

LINEHAN: Good afternoon. Lou Ann Linehan, District 39: Elkhorn and Waterloo.

MORFELD: Awesome. And my name is Adam Morfeld. Again, I'm District 46: northeast Lincoln. And Senator Day will introduce herself in just a minute, but I'd like to also introduce the committee staff. To my left is research analyst Nicole Barrett, and also to my left is committee clerk Noah Boger. Do I say your last name right, Noah? Awesome, good. And then our pages, I think, are Jason and Natalie, right? Jason and Natalie. Well, thanks for being with us today. Please remember that senators may come and go during the hearing as they have-- well, they won't have bills introduced in other committees, I don't think, but you never know. I'd also like to remind our committee members to speak directly into the microphones and limit side conversations, making noise, making noise on personal devices as well. We are an

electronics-equipped committee and information is provided electronically as well in paper form. Therefore, you may see committee members referencing information on their electronic devices. Be assured that your presence here today and your testimony are an important test and crucial to our government. And with that being said, Senator Day, welcome to your Education Committee. You're welcome to open, I think, on LR213, but the next one's yours, so you pick.

DAY: Good afternoon, Vice Chair Morfeld and members of the Education Committee. My name is Jen Day. That's J-e-n D-a-y, and I represent Legislative District 49, which covers part of north-central Sarpy County, including the areas of Chalco and western Papillion and La Vista. I'm here today to introduce LR213, which examines the mental health needs of Nebraska students and the role of school psychologists in meeting these needs. One of the reasons I initially ran for Legislature is the issue of student mental health. As someone whose life has been touched personally by mental illness and understands the necessity of mental healthcare for young people, it's important to me that we adequately meet this need of our students. Last session, I brought two bills to provide for greater mental health access for students, and as dire as I thought this issue was before, it's even more clear now that we are in the midst of a severe student mental health crisis. One in five Nebraska high school students have reported that they've contemplated committing suicide in the past year. In 2018, suicide was the second leading cause of death for youth ages 10 to 20 for Nebraska, and suicide among Nebraska youth has been steadily increasing since 2009. Many of these issues are exacerbated in the rural areas of our state, and our capacity to solve these challenges is constrained by our chronic workforce shortages in mental health. But we heard these statistics last session. In talking with many of you about this issue, we all agree the need is clear and, as members of this committee, our task is finding the best way to solve this issue. Unless we are resigned to these numbers, I think it's worth considering the tools we already have to, to address this ongoing tragedy. In 2014, the Centers for Medicare and Medicaid Services released guidance to clarify that states have the authority to allow schools to request reimbursement for any Medicaid-eligible, school-based health service in alignment with their approved state Medicaid plan. Since then, most states have adjusted their state plans or passed legislation for CMS approval for this change, leaving Nebraska as 1 of only 12 states that does not utilize this option. I don't believe there is only one way to solve our student mental health crisis. However, we are doing a disservice to our kids if we don't use

every tool available to us. And I filed LR213 as a way to study how we can utilize the infrastructure we already have created in our schools to best help the needs of our students. Today you will be hearing testimony from Dr. Lisa Kelly-Vance and Dr. Brian McKevitt from UNO and Mikayla LaBorde with ESU. I'm happy to answer, I'm happy to, to try to answer any questions you may have, but we'll tell you that they are the experts in this area and will likely answer many of your questions with their testimony.

MORFELD: Thank you, Senator Day. Any questions for Senator Day? Senator Linehan.

LINEHAN: Thank you, Chair Morfeld. Can you repeat the part of your testimony about CMS?

DAY: Yes. In 2014, the Centers for Medicare and Medicaid Services released guidance to clarify that states have the authority to allow schools to request reimbursement for any Medicaid-eligible, school-based health service in alignment with their approved state Medicaid plan. Since then, most states have adjusted their state plans or passed legislation for CMS approval for this change, leaving Nebraska as 1 of only 12 states that does not utilize this option.

LINEHAN: OK, thank you.

DAY: Yeah.

MORFELD: Any other questions for Senator Day? OK, seeing none, are you going to join us behind here to--

DAY: Yes, I will.

MORFELD: --ask questions? OK.

DAY: Thank you.

MORFELD: Thank you, Senator Day. And as noted, we have invited testimony only. The first invitee is Dr. Lisa Kelly-Vance. Welcome, Doctor Kelly-Vance.

LISA KELLY-VANCE: Good afternoon to all of you members of the Education Committee. My name is Lisa Kelly-Vance, L-i-s-a K-e-l-l-y-V-a-n-c-e. I'm a professor of psychology and director of the School Psychology Graduate Program at UNO. I am a past president of both the National Association of School Psychologists and the Nebraska

School Psychology [SIC] Association. I'm honored to be here with you today, and I appreciate the opportunity to share information about school psychologists and our ability to provide mental and behavioral health services in schools. With the increase in mental and behavioral health needs in our students, school psychologists can be part of the solution in addressing these needs. Schools are in a unique position to play a critical role in addressing the mental and behavioral health needs of children and youth. Research tells us that approximately 20 percent of students suffer from a mental health disorder, and only 20 percent of students who need support receive it. Importantly, the vast majority of students who do receive mental health services get them at school. For Ne, for Nebraska, this means that five students in every classroom need mental and behavioral health supports, but only one will get the help they need. This speaks to the dire need to provide students with increased access to mental and behavioral health services within the school setting. School psychologists can be part of the team providing these critical school-based services. So school psychologists are a part of a team that provides comprehensive school-based mental and behavioral health services. And these efforts are imperative-- excuse me-- and these efforts are imperative in improving students ability to learn. There's a common misconception that school psychologists are only able to provide-- to conduct evaluations for special education, but we are trained to do so much more. Specifically, school psychologists receive graduate-level training in a wide variety of skills that pertain to improving mental and behavioral health of children from birth through young adulthood. We conduct universal mental behavioral health screenings for all students with the goal of finding the students who are in need of interventions and supports. We provide a continuum of targeted individual and group services for those students in need of support. Examples of these evidence-based interventions include: applied behavioral analysis; cognitive behavioral approaches; and social and emotional skills training. In addition, school psychologists conduct evidence-based threat assessment and suicide risk assessments, and we provide crisis preparedness and response when needed. Unfortunately, school psychologists are often underutilized as school-based mental health professionals due to misunderstanding of our role and our training. The support school psychologists can provide for mental and behavioral health needs of our students is clear. Our skills are consistent with, and complementary to, the other community and school-based mental health professionals. A current barrier to the full utilization of school psychologists is the inability for schools to be reimbursed for these services through Medicaid and public

schools. Currently, school psychologists are credentialed through the Department of Education. Unfortunately, this credential is not recognized by the state Medicaid plan. To remedy this, we propose that the National Association of School Psychologists be added to the provisional licensed mental health practitioner application process as one of the approved credentialing institutions. School psychologists would then fall under the umbrella of approved provider, and districts could be reimbursed by Med, by Medicaid in public schools for the mental and behavioral services they provide. To put this in a national context, 35 states and the District of Columbia receive Medicaid reimbursement for services provided by school psychologists. With your help, we can obtain a clear path to obtaining licensure. I very much appreciate that LR213 is addressing the role that school psychologists can have in making a positive impact on students. Having access to more school-based mental health professionals makes sense for Nebraska students. It's what's best for Nebraska and for our students. So I thank you today for your time and for your support of our Nebraska schools.

MORFELD: Thank you, Dr. Kelly-Vance. Any questions from the committee? OK. Seeing none, thank you very much.

LISA KELLY-VANCE: All right, thank you. Thank you very much.

MORFELD: OK. Our next invited testifier is Dr Brian McKevitt. Welcome.

BRIAN McKEVITT: Thank you. Good afternoon, Vice Chair Morfeld and members of the Education Committee. My name is Brian McKevitt, B-r-i-a-n M-c-K-e-v-i-t-t, and I'm a professor of psychology at the University of Nebraska at Omaha, and I'm one of three faculty in our School Psychology Program where I have been teaching for 15 years. I'm speaking to you today to represent the perspective of graduate educators, relative to the contents of LR213 sponsored by Senator Day. Thank you for giving us time to talk about the mental health needs of children in Nebraska and offer ways that school psychologists can address those needs. The state of Nebraska has three graduate training programs in school psychology: one at UNO; one at UNL; and the third at UNK. Faculty from the other training programs have reviewed and endorsed the statement I am presenting to you today. As Dr. Kelly-Vance indicated, school psychologists have a unique skill set that includes strong confidence in addressing the mental and behavioral health needs of children and youth in schools. Unfortunately, there are not enough school psychologists to meet those needs. The recommended ratio of school psychologists to a population

of students is 1 to 500. At last check, our ratio in Nebraska was approximately 1 to 1,200. At the start of the 2019 school year, there were 16.5 open school psychologist positions across the state, and that number has likely not improved. The shortage of school psychologists is a multifaceted problem that requires multifaceted solutions. There are several challenges confronting the profession of school psychology that contribute to these shortages. First, to be a school psychologist, students must attend a minimum of three years of full time graduate study. Our students sacrifice income to attend full-time in order to become school psychologists. Yet, as you know, the cost of education is high. While there are loans available to students, those loans are rare, rarely eligible for substantial loan forgiveness that is often available for other high-need professions. Another problem is that we do not have enough faculty to train more students. School psychology is a difficult yet important job that can impact many lives. Close supervision and careful training of students are critical. At this time, however, all three training programs are at capacity and do not have room for more students. Finally, retaining our graduates, once they enter the workforce is another issue that confronts the problem of shortages-- I'm sorry, another issue that contributes to the problem of shortages. All of our students must complete a full year of supervised internship, and we have been fortunate in the state of Nebraska that we have many school districts willing to hire interns. However, we still have many students who leave the state for higher paid internships or for internships where school psychologists have more opportunity to provide mental and behavioral health services for students than they do here in Nebraska. Fortunately, there are solutions to these challenges. Having a mechanism in our state to forgive students of some or all their loans in exchange for working in our public schools would go a long way toward offsetting the cost of their education and encouraging more students to enter the profession. Adding faculty lines dedicated to practitioner training at our three training institutions would be an important step in addressing the capacity we have to train students. Having additional faculty is the only way that would enable us to admit and eventually graduate more students while continuing to ensure high quality instruction for our students. One potential solution to promote retention of school psychologists in Nebraska is to have a consortium of school districts that are willing to hire interns and provide a high-quality internship experience. Internships should enable students to engage in the full range of services school psychologists are trained to provide. Having a financial incentive from the state to provide such internships would encourage districts

to hire interns, who then would be more likely to stay in Nebraska. This financial incentive to districts could offset the cost of the intern's salary or provide an additional stipend to the intern for staying in-state upon graduation. It could also provide financial incentive for required supervision for the LMHP credential mentioned previously by Dr Kelly-Vance. In summary, shortages of school psychologists can and should be addressed to better serve the mental and behavioral health needs of Nebraska's youth. LR213 is a wonderful first step to examine this issue. It is my hope the committee considers solutions such as loan forgiveness, increasing faculty, and creating an internship consortium as essential steps as future legislation progresses. Our students are counting on you. Thank you so much.

MORFELD: Thank you, Dr. McKevitt. Any questions? OK. Senator, Senator Linehan.

LINEHAN: Oh. Should she go first?

MORFELD: OK. Senator Day.

DAY: Thank you, Vice Chair Morfeld, and thank you, Dr. McKevitt, for being here today. So you said that school psychologists are required to complete a full year of internship, correct?

BRIAN McKEVITT: Um-hum.

DAY: And those are typically paid?

BRIAN McKEVITT: In, in Nebraska and many parts of the Midwest, they are paid, yes.

DAY: OK. And if you don't mind me asking, do the surrounding states pay more, less, or do we know where we fall in the spectrum of pay for those internships?

BRIAN McKEVITT: So our interns are typically paid on a teacher's salary scale,--

DAY: OK.

BRIAN McKEVITT: --so the scale would be, the, the pay, the pay would be what a, what a beginning teacher would make, so their salary would be comparable to what a beginning teacher would make. And so where

Nebraska falls in against the other states with teacher salary would, would be similar to where the, our intern salary would fall.

DAY: OK, thank you.

MORFELD: Senator Linehan.

LINEHAN: Yes. Thank you, Vice Chairman Morfeld. Can you-- and I just, 'cause I don't know-- the full range of services school psychologists are trained to provide, can you just run through for me what are the range of services that psychologists can provide?

BRIAN McKEVITT: Sure, absolutely. Thank you for asking that. So school psychologists are trained to provide mental and behavioral health services, which we've talked about, and Dr Kelly-Vance gave some examples of ABA interventions, cognitive behavioral approaches to addressing mental health needs. School psychologists address mental health through crisis prevention and response strategies. We also provide academic supports and so working with teachers and parents to support the academic needs of children by providing interventions, providing recommendations for strategies that could better academic performance for students. And then another primary responsibility of school psychologists is an evaluation role, particularly for special education. And so school psychologists collect a wide variety of data to support decisions made about students when we're considering educational needs that might go beyond the general ed setting.

LINEHAN: OK, so when there's an IEP, there's always a psychologist involved, I think, right?

BRIAN McKEVITT: typically at the evaluation process,--

LINEHAN: Right.

BRIAN McKEVITT: --there is a school psychologist involved, yeah.

LINEHAN: But you're not licensed to like actually provide counseling or medication or any of those things, right?

BRIAN McKEVITT: So school psychologists are credentialed by the State Department of Education and, under that credential, school psychologists can implement school-based services for mental and behavioral health. So school psychologists can and do provide counseling services, as an example, in a school setting. School psychologists are not currently externally licensed by Department of

Health and Human Services to provide those kinds of services outside of a school setting.

LINEHAN: Are they in any state?

BRIAN McKEVITT: Yes, they are.

LINEHAN: OK, what states?

BRIAN McKEVITT: Oh.

LINEHAN: Or can you give me examples?

BRIAN McKEVITT: California has a credential called a licensed educational practitioner, I believe, and so they can set up private practice to do educational and psychological services. Off the top of my head, that's the only one I can think of, but I know there are others and I can--

LINEHAN: That's OK.

BRIAN McKEVITT: --certainly investigate that for you.

LINEHAN: All right. All right. No, that's fine. That's very helpful. Thank you very much for being here.

MORFELD: Senator Pansing Brooks.

PANSING BROOKS: Thank you, Senator Morfeld. Thank you for being here today; appreciate it. So along those lines, I have some questions, as well. It does say that-- I think that our last testifier, Dr Kelly-Vance, mentioned that 35 states do have a credentialing, as well as the District of Columbia, and they receive that Medicaid reimbursement for services, provided by the school, of psychologists. So I think, number one, I'm interested in what's the difference of a counselor versus a school psychologist. I know, I know education has to be different, but can you explain that to me?

BRIAN McKEVITT: That's a great question and one that we get asked very often. So a school counselor, when we think about that role, we typically think about a person who has a teacher education training background who provides guidance services to students, oftentimes going into classrooms and providing guidance lessons. Counselors also often have the role of helping students select courses and college preparatory kinds of activities. Where the two, two positions overlap

are in many of those mental and behavioral health services that we talked about. So both school psychologists and school counselors can perform small group interventions with students, perhaps see students one-on-one if they're experiencing some sort of a difficulty that they need to talk through or problem solve. And then where school psychologists have a unique role, as compared to school counselors, would be with our knowledge of the academic intervention piece and consultation with teachers about curriculum instruction, academics, probably a bit more thorough understanding of how behavior support plans work for students and, of course, the role of evaluation in special education and IEP development. Counsel[-- their, our counselors don't often have as large of a role as school psychologists in that.

PANSING BROOKS: So you said the school counselor is usually a teacher with got, with, so a teacher that has special lessons or special certification. Is it a certification for counselors?

BRIAN McKEVITT: It is an endorsement, yeah.

PANSING BROOKS: It is.

BRIAN McKEVITT: So, so up until a couple of years ago, to get an endorsement as a school counselor, you had to have had already a teaching certificate as a classroom teacher. That changed in rule four or five years ago, I think. I'm not sure. So now, school counselors can enter graduate training without having been a classroom teacher. But it is a separate endorsement that they must earn through a master's degree program.

PANSING BROOKS: OK, so is that certification credentialed and recognized by the Medicaid plan, the one for counselors?

BRIAN McKEVITT: It is not--

PANSING BROOKS: --Not [INAUDIBLE].

BRIAN McKEVITT: --only if those counselors also hold the licensed mental health practitioner credential through DHHS.

PANSING BROOKS: OK.

BRIAN McKEVITT: So--

PANSING BROOKS: Go ahead.

BRIAN McKEVITT: I'm sorry.

PANSING BROOKS: No, go ahead.

BRIAN McKEVITT: I was just going to add, so, so currently, any credential through the Department of Education, which our school counselors would have, which school psychologists have, that is not recognized through DHHS for the reimbursement through Medicaid, but the licensure through the LMHP credential is. And school counselors may have that, they may not.

PANSING BROOKS: OK. So OK. One other thing that I just wondered. So are the school psychologists, do they go to school, to the school of psychology rather than the teacher school generally? Or-- I'm trying to grasp that.

BRIAN McKEVITT: Yeah, great question. And that's, that's one of those "it depends" answers, depends on the university. So at UNO, our program is actually housed in our College of Arts and Sciences and our psychology department.

PANSING BROOKS: OK.

BRIAN McKEVITT: But at UNK, their School Psychology Program is housed through their School of Education, and it really just depends on the institution. The training really looks the same regardless of if it's housed in a psychology department or a college of ed, because our accrediting body, our National Association of School Psychologists, is what outlines the required courses and the scope of our training, and that doesn't change based on where that program is housed.

PANSING BROOKS: OK, just one more thing. So a master's of psychology or a doctor of psychology is different from a school psychologist degree, how?

BRIAN McKEVITT: So school psychologists earn a master's in psychology typically, and then a, a degree called an Ed.S, an educational specialist degree, and that is earned after a minimum of 60 graduate hours. So it's a master's degree, plus some, some extra. If you were to get a degree in psychology, you could get a master's degree in psychology that's comparable to what our school psychologists would earn, and then go on to a doctorate degree or a Ph.D. degree that would be offered in school psychology, much like the Ed.S is, except it would just have a res, additional research requirements and course requirements.

PANSING BROOKS: OK, thank you for answering all those questions.

MORFELD: Thank you, Dr. McKevitt. Thank you, Senator Pansing Brooks. Any other questions? Yep, Senator Linehan.

LINEHAN: Thank you, Vice Chairman Morfeld. LMHP, licensed mental health providers.

BRIAN McKEVITT: Yes.

LINEHAN: So they are covered by Medicaid if they're working in the school.

BRIAN McKEVITT: That is correct. That--

LINEHAN: OK.

BRIAN McKEVITT: Yes, that's my understanding.

LINEHAN: OK, that makes sense. OK. All right. Thank you very much.

BRIAN McKEVITT: Thank you, everybody.

MORFELD: Any other questions? OK, thank you very much, Doctor. OK, our next invited testimony is Mckayla LaBorde with ESU number 3. Welcome.

McKAYLA LaBORDE: Thank you. Good afternoon, Vice Chair Morfeld and members of the Education Committee. My name is Mikayla LaBorde, M-c-K-a-y-l-a, LaBorde is L-a-B-o-r-d-e, and I'm the executive director of student services at Educational Service Unit Number Three in La Vista, Nebraska. I am also the current president of NASES, which is the Nebraska Association of Special Education Supervisors, which is an affiliate of the Nebraska Council of School Administrators. I'm honored to join you today as a Nebraska educator and a school administrator in support of the important work of school psychologists, and to advocate for the health and well-being of students across Nebraska. These past few years and education have been anything but typical, but Nebraska schools have forged on and adapted to meet the ever changing needs of our students. And now, more than ever, those needs are inclusive of mental and behavioral health. School staff face challenging circumstances each day, from students with crippling anxiety who refuse to come to school to disruptive classroom behaviors that are a result of toxic stress or trauma in the home. Although the pandemic has magnified the intensity of the mental and behavioral health needs of our students, educators are rising to

the challenge to provide prevention and intervention where it's needed most. And our secret weapon just may be school psychologists. School psychologists are uniquely trained to provide a wide spectrum of services. Not only are they trained to provide school-based mental and behavioral health, but their expertise is critical in helping students learn and helping teachers teach. School psychologists provide leadership in areas such as academic interventions and instructional supports, services to promote safe and supportive school buildings, and database decision-making, just to name a few. With such versatility, my first call for help with a problem or crisis is to the school psychologist. But unlike many other states, Nebraska school psychologists do not have a clear path for licensure, which can create barriers to accessible services in our schools. And as my colleagues have shared today, staffing shortages make it very difficult for school administrators to hire all the school psychologists that we truly need. In the absence of enough school psychologists, some districts have partnered with community providers to address the mental and behavioral health needs of the students. In fact, one of my own schools filled a counseling vacancy with a community provider several years ago. While this staff member brought knowledge and skills to the table, it was difficult for them to navigate the school context. I was very fortunate this year and able to fill my position with a school psychologist who had extensive experience within a school environment. But many of my colleagues in other districts were still searching for a school psychologist when the school year began. That's part of why I'm here today. School administrators across the state are in dire need of school psychologists. Their special training and leadership abilities make them invaluable in a school. Regardless of the specific goals that a school building may have to improve learning for students, school psychologists are part of the solution. They are experts in learning, behavior, mental health, and the systems needed to organize and implement the limited resources available to schools. Although a rigorous training program and preparatory coursework has long been in place, the role of the school psychologist has been evolving, and Nebraska needs to take note. I'd like to personally thank Senator Day for initiating LR213, as this is a step in the right direction. My sincere hope is that, as a result of this study, Nebraska will do the following: 1) provide students more access to mental and behavioral health services and support in the form of school psychologists; 2) recruit and retain more school psychologists by recognizing their value to schools and responding with efforts to remove barriers and provide incentives to join the profession; and 3) establish a clear path to DHHS licensure so that they can do more of

what they are trained to do. In Nebraska, schools can access much needed federal Medicaid reimbursement. LR213 is a welcome opportunity to shine a light on the needs of our students and how school psychologists can play a key role in addressing those needs. If we work together, we can help Nebraska students thrive.

MORFELD: OK, thank you, Ms. LaBorde. Any questions? Senator Pansing Brooks.

PANSING BROOKS: Thank you.

McKAYLA LaBORDE: Hi.

PANSING BROOKS: Thank you for coming, Ms. LaBorde.

McKAYLA LaBORDE: Thanks.

PANSING BROOKS: Nice to see you. Has there been an effort, effort to bring the Board of Education and DHHS together to work out some sort of agreement or plan, prior to a legislative fix?

McKAYLA LaBORDE: You know, there have been some efforts to explore opportunities for licensure for these very trained and highly qualified individuals, but just-- we've been met with some resistance as far as finding a way to actually make that happen.

PANSING BROOKS: And can you explain what some of the resistance you hear is?

McKAYLA LaBORDE: You know, there's a couple of solutions that might address the licensure issue. So one of those would be amending our state Medicaid plan, as we alluded to earlier in the, in some of the previous testimony with my colleagues, and so you know, that's one solution. A second solution would be to offer these highly trained folks an opportunity to be licensed as a LMHP, or licensed mental health professional. So the resistance--

PANSING BROOKS: Within their educational programming? Is that what you're saying?

McKAYLA LaBORDE: Through DHHS.

PANSING BROOKS: Oh, through DHHS. OK, sorry.

McKAYLA LaBORDE: Yeah. And some of their resistance has come from-- you know, we first explored an option to add a separate licensure category. And it just, it sounds as if that would be too much, too much work to enable, you know, to move forward with that. So that's kind of why we're exploring some of these alternative pathways.

PANSING BROOKS: Thank you. That, that helps a lot. Thank you.

MORFELD: Any other questions? Senator Sanders.

SANDERS: Thank you, Vice Chair Morfeld. Thank you for your testimony. Thank you for taking the time to be here today. I have a pre-COVID, COVID, and, hopefully, post-COVID question.

McKAYLA LaBORDE: Yes.

SANDERS: So I believe all of this data and the need probably before COVID, correct?

McKAYLA LaBORDE: Correct.

SANDERS: And then during COVID, would you guesstimate the increase of the need has been?

McKAYLA LaBORDE: I think we are seeing-- you know, we roughly estimated 20 percent. So I know that we're seeing an increase in that, in that the pandemic has intensified the needs that already existed. And then we have more and more students who maybe had been previously functioning just great are really struggling now. So you know, I would say it's somewhere in that range, 20 to 30 percent we would estimate, are really struggling. And, and that doesn't even take into account the behavioral difficulties. We talked a little bit about classroom, disruptive classroom behaviors. So mental health and behavioral challenges, they, they show themselves in lots of different ways. And so sometimes those are internalizing and sometimes they're externalizing, and our schools make it really tough for kids to learn.

SANDERS: And then when we get to post-COVID,--

McKAYLA LaBORDE: Yeah.

SANDERS: --do you see the numbers tapering and slowly dropping, or will we maintain that need, post-COVID?

McKAYLA LaBORDE: I really appreciate you asking that. Our sincere hope, as educators, is that we're not only going to intervene with the students who need that intervention right now, but prevent. And so we're working on a multi-tiered system of support where we can try to get in early and prevent those difficulties, thus seeing a decrease in the number of students. But it sure would be great to have more school psychologists to help us in that work.

SANDERS: Thank you,

MORFELD: Senator Day.

DAY: Thank you, Vice Chair Morefeld, and thank you for being here today; appreciate it. So a few of the testifiers have mentioned the ability of school psychol, psychologists to provide school-based mental and behavioral health and academic interventions. And so I would assume this is from their training, which is something that an LMHP does not receive.

McKAYLA LaBORDE: Correct.

DAY: So that would be my question is, what are the advantages of utilizing a school psychologist in a school setting versus utilizing a community provider LMHP in a school setting or outside of a school setting?

McKAYLA LaBORDE: That's a great question. That really rigorous training program that school psychologists have not only incorporate those behavioral and mental health issues, but all of those academic learning, brain processing. And so they are just so versatile in addressing all the needs that a school might have. One of the key components that school psychologists can bring to the table is their systems thinking. And so, you know, they help with the whole child learning, you know, behavior, mental health, and really can be a part of the leadership team in those school buildings to try to move the entire building forward. And so as I mentioned, our licensed mental health providers are community providers. They're fantastic, and they have wonderful skills in providing direct services to our youth with mental and behavioral health needs. But that school context and that versatility is something that I think is unique to school psychologists.

DAY: Great. Thank you. And I just wanted to clarify Senator Pansing Brooks had asked a question about the licensure through DHHS, and I

don't want to put you on the spot on this, but I just wanted to clarify exactly. So you said that when you're met with resistance, that's from the Department of Ed or from DHHS?

McKAYLA LaBORDE: Yes, good question. So DHHS is responsible for that licensure in its entirety. And so really, our efforts to advocate for additional licensure for school psychologists have been met with resistance by HHS and,--

DAY: OK.

McKAYLA LaBORDE: --you know, indicating it's a laborious process.

DAY: OK.

McKAYLA LaBORDE: And so that's where we're trying to take maybe an alternative pathway to provide that opportunity for school solid, psychologists who are already credentialed with the Department of Ed. They have everything they need in the eyes of the Department of Education. It would be the HHS license, licensure that would then be kind of a game changer when we're looking at Medicaid at public schools.

DAY: OK, wonderful. Thank you; appreciate that.

McKAYLA LaBORDE: Yeah

MORFELD: Sarah Linehan.

LINEHAN: Thank you, Vice Chairman Morfeld. Wouldn't some of the-- I'm just guessing here, but I'm not longer on health and the Health Committee, but isn't some of the resistance coming from probably licensed mental health providers?

McKAYLA LaBORDE: You know it might be. I can't answer that for you, but we could follow up and kind of let you know,

LINEHAN: All right.

McKAYLA LaBORDE: Would it be helpful if we provided just a summary?

LINEHAN: No, we, we can check.

McKAYLA LaBORDE: OK.

LINEHAN: But from my time on the committee--

McKAYLA LaBORDE: Yeah.

LINEHAN: Yeah.

McKAYLA LaBORDE: Yeah.

LINEHAN: OK, thank you.

MORFELD: OK, any other questions? OK, seeing none, thank you very much.

McKAYLA LaBORDE: I appreciate it.

MORFELD: And that will end our invited testimony on LR213. And then next up is LR149, which Senator Day will also introduce. Welcome back, Senator Day.

DAY: Thank you, and hello again, Vice Chairman Morfild and members of the Education Committee. My name is Jen Day; that's J-e-n D-a-y, and I represent Legislative District 49, which covers part of north-central Sarpy County, including the areas of Chalco and western Papillion and La Vista. I'm here today to introduce LR149, which looks at the potential for statewide early, for a statewide early childhood autism spectrum disorder screening. Pursuing this LR was important to me because, as with the previous LR, my life has been touched personally by autism, and this is a condition so prevalent that nearly all of us know an adult or a child on the autism spectrum. Though in Nebraska, we're on the lower end of nation, the lower end nationwide-- excuse me-- in autism spectrum diagnoses, 1 in 128 children in Nebraska are on the autism spectrum. Additionally, in 2015, 3,068, or 6.48 percent of special education services went to Nebraska students with autism. To put in perspective the scope of what we face, nationwide, direct and indirect costs of caring for children and adults with autism in 2015 were estimated to be $268 billion, more than the cost of stroke and hypertension combined, and it's projected, in 2025, the total combined cost of care for those on the autism spectrum will be greater than diabetes. Fortunately, our state already has a significant infrastructure to provide services for those with autism. Since LB254 passed in 2014, insurance has been required to provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder for anyone under the age of 21. Moreover, since 2016, the state's Medicaid State Plan has covered applied behavioral analysis and behavior modification services such as day treatment, community treatment aides, and outpatient therapy. Furthermore, the Nebraska

Department of Education's Autism Spectrum Disorders Network offers training to schools and families, and supports children with autism spectrum disorders through regional autism centers. While it is great that our state has made this significant investment in ensuring that those on the autism spectrum can receive the care that they need, none of this care is relevant if a diagnosis is never given. Autism spectrum disorders vary widely in symptoms and can go easily undiagnosed in young children, leaving them without the necessary supports to be successful academically, socially and later in life as adults. Currently, the American Academy of Pediatrics recommends that general autism surveillance be done at every healthcare visit, in addition to specific screenings at 9-, 18- and 30-month visits. Generally, screenings consist of parent-completed questionnaires to identify traits associated with risk of autism. While every child is different, early identification of those with autism is critical for the development and quality of life for those on the autism spectrum. Children who receive autism-appropriate education and support at key developmental stages are more likely to gain essential social skills and adjust better in society. Identifying and diagnosing autism early is among the biggest steps to help those on the autism spectrum to have a successful life. As we know, many of those on the spectrum will go on to successful careers and social lives when provided with the appropriate supports. However, in talking with educational and medical stakeholders, we've seen that, especially outside of the urban areas of our state, many cases of autism are not being diagnosed until the child is well into grade school. Additionally, increasing numbers of adults are being diagnosed. Diagnosis can go completely missed or can also be misstated as a developmental delay or another issue, such as anxiety or ADHD. This misstep denies the child their best chance at learning the skills necessary to adjust to society and thrive. With all of this in mind, it is worth exploring whether the state should have a requirement that screening be conducted at some point early in the child's life. There is precedent for this requirement, as Nebraska's statute currently requires all children enrolled in kindergarten to have a physical and vision screening. While kindergarten would be outside of the best practice ages for autism spectrum diagnosis, even this option would provide a failsafe that, that could help countless kids living with autism but who are not receiving services, greatly enhancing their quality of life. Today, you'll be hearing testimony from stakeholders in the autism advocacy, medical and educational communities about the opportunities we have for early screening. And I'm-- and with that, I'm happy to attempt to

answer any questions you may have, but they are the experts so they may be more equipped to answer.

MORFELD: Thank you, Senator Day. Any questions for Senator Day? OK, seeing none, our first invited testifier is-- and I'm going to get these last names probably wrong-- Katy Menousek with Boys Town. Hello, welcome.

KATY MENOUSEK: Hello, and thank you for having me-- excuse me. All right, so I'm Dr. Katy-- you did a very good job at my name.

MORFELD: Oh, did I?

KATY MENOUSEK: I'll, I'll, I'll--

MORFELD: [INAUDIBLE].

KATY MENOUSEK: --pronounce it the--

MORFELD: I'm sorry.

KATY MENOUSEK: Yeah, it's, it's Czech, so. So my name is Dr. Katy Menousek, and it's spelled K-a-t-y; last name is M-e-n-o-u-s-e-k. I'm a licensed psychologist and board-certified behavior analyst. I am working at Pediatric Neurology at the Boystown National Research Hospital, and I specialized, for about the last five years-- take a breath-- in the clinical diagnosis of autism spectrum disorder and other related disorders. I provide autism evaluations for children, as low as-- the lowest that I've gone is 14 months, up to 21 years. Autism spectrum disorder is a neurodevelopmental disability that's characterized by impaired social interaction and communication and stereotypic or repetitive behaviors. Symptoms typically present around two years of age. Impairments in social communicative and stereotypic or repetitive domains can often result in deficits in educational, social, and occupational functioning, according to the American Pediatric Association. The prevalence of autism has increased significantly in the last decade, from 1 in 50 nationally to, in about 200, 2005, to the current estimate of 1 in 54 nationally, according to the Centers for Disease Control. The increase in prevalence is partially a result of improved identification and an awareness of the disorder, which has led to a greater number of children seeking services across the nation. OK. Although there has been an increase in identification for children, many children are still missed and not identified as meeting the criteria for autism until they are approximately nine years old. This could be due to many reasons. The

first reason could potentially include the fact that children are typically verified under the disability category of developmental delay when they are seeking out services as early as age three or younger. This verification of developmental delay, although autism is considered a developmental delay, sometimes is not reconsidered until the child is approximately nine years old, due to the requirements of individualized education plans for the department, the department of Nebraska. According to the Department of Education in Nebraska, most schools, most students are able to have that verification of developmental delay until they're nine years old. Typically, when parents, when children turn nine, parents then typically have to seek out an evaluation to continue services for their child. So this, this time of, of age is when the brain is less neuro, neuroplastic and the child is less likely to receive the gains that different services for children with autism could provide at a younger age. A second reason for a delay in clinical evaluation could be attributed to the parents' lack of understanding of their child's developmental skills. If there were skilled and trained assessors in early identification and screening, and then less information could be weighed through the use of parental report. Oftentimes, children are missed due to parents' educational level or lack of understanding of the early signs of autism. A third reason for potential delay in the diagnosis of autism could be attributed to the fact that, although autism is considered a developmental delay, families may be given a false hope with this verification that their child might grow out of these concerns, and then not seek out additional services, for example, early intensive behavioral intervention, which may substantially impact the child's ability to function independently in the compute, community and later in life, for example, have less of an impact financially on the state later on in life. If parents were aware of their child's diagnosis of autism at an earlier age, the family could potentially gain access to other services avail, available through the state, for example, disability services, respite services, and other private services that are funded through insurance. Finally, universal screening could help facilitate the process of getting children evaluated for autism through a medical diagnosis from a licensed psychologist, neurologist or developmental pediatrician. Medical diagnoses help parents obtain private services while they maintain their services through the school district, for example, early intervention such as applied behavior analysis, speech therapy, and occupational therapy. When these services are obtained, while the brain is highly neuroplastic at a younger age, these therapies are much more effective, effective at improving the child's likelihood of living her or her or her, his or

her-- excuse me-- most meaningful and independent life, as opposed to when a child is diagnosed at a later age. I think I'm running out of time. But in conclusion, the earlier children are identified and meeting the diagnostic criteria for autism, the more services the child would be able to potentially receive from the school and private insure, insurances and services. Research strongly supports that these services lead to increases in social, emotional, and cognitive skills. In most states, private or public insurance may cover the cost of home and center-based services. Again, early screening could help parents attain more, more services, as well as school-based services, which would all lead to a more successful future for parents, teachers, and the child. Thank you.

MORFELD: Thank you very much, Doctor. Any questions? OK, Senator Linehan.

LINEHAN: Thank you, Vice Chairman. So you're saying nine, so they are fourth graders. So what-- I know that there's-- every child is special and different.

KATY MENOUSEK: Of course.

LINEHAN: But what, what would be some of the things that would happen at nine, when they would realize something's not going right?

KATY MENOUSEK: So for a verification of a developmental delay, it can only last until a child-- through his or her eighth, eighth year of life. When the child gets close to nine, they can't have that verification anymore. So a lot of times parents are scrambling because they know their child still needs an individualized education, but they can't get services anymore with that verification. So then they come to people like me seeking out an autism eval. And lo and behold, the child has had autism all of his or her life, and they've missed out on that critical period where the brain is amazing and grows at rapid speeds. And oftentimes they're very frustrated as why did no one tell me that my child had this, this disability? And it's because they, they've had this developmental delay verification. And the educators, probably could--

LINEHAN: Who, who does that, who gives them-- I'm sorry.

KATY MENOUSEK: Yeah, it's confusing.

LINEHAN: Well, no. You're-- excellent testimony. Delayed development verification, who would do that?

KATY MENOUSEK: The school. So schools verify. Clinicians like myself diagnose, and there's a difference between the two. So a verification can get you-- and all of the educators talk more about this-- that could get you services at school. A medical diagnosis you would need in order to get private insurance to approve and pay for certain services that individuals with autism need and that are accepted through insurance.

LINEHAN: So delayed would be like they can't read. They're not-- they don't know their alphabet. What, what are--

KATY MENOUSEK: Typical, so a developmental delay-- well, I'll just talk about clinically what a global developmental delay means, if a child is five or younger, they have fine, gross or, and/or speech delays, so across-the-board delays in, in development. For the school, the verif-- I can speak on this a little bit because my background is actually in school psychology, that's how I was trained. But for global developmental delay, I believe if a child is three, that means that they're struggling in at least speech or another avenue of delay, which children with autism also have those delays.

LINEHAN: I see. That was very helpful.

KATY MENOUSEK: You're welcome.

MORFELD: And any other questions? Senator Day.

DAY: Thank you, Vice Chair Morfeld, and thank you for being here today; appreciate your testimony. So I had mentioned in my, my opening that the American Academy of Pediatrics recommends general autism surveillance be done at 9-, 18- and 30-month visits.

KATY MENOUSEK: Yes.

DAY: And that's a parent-completed questionnaire. So if we're looking at a child who has been verified with a developmental delay by the school, but hasn't had a medical diagnosis of autism, but we find out later that they have had autism, is one of the reasons for that being that there is no standardized screening for autism and we require parents to? It's a self-reporting system, essentially.

KATY MENOUSEK: So there's-- so the screening process itself is usually done at doctors' offices. Oftentimes, moms are given the handout for the screener in the waiting room with the child with potential autism and potentially for other children, trying to fill out these

questionnaires. And so he or she might be distracted or reading level might be-- or oftentimes parents are in denial. So we've found, working through Millard Public School, with, with the educators doing it, that it's worked very well. Oftentimes, it''ll say on a questionnaire, you know, does your child do any repetitive behaviors and they say, Oh no, never. And the child is in the corner doing repetitive behavior. And I say, what about that? Oh, yeah, they do that all the time. I think oftentimes it's a lack of understanding what the early signs look like. And if we had skilled professionals that could objectively say, your child has met, because at 14-- and 12 is the cutoff-- you should go seek out an evaluation. We found, we found that to be-- and again, I'll let them talk about that if they were planning on it. But, but that, that's a good way to go about it when someone else outside who knows the early signs of autism is able to point that out.

DAY: Wonderful. Thank you very much.

MORFELD: OK. Any other questions? OK. Thank you, Doctor.

KATY MENOUSEK: Thank you.

MORFELD: OK, the next testifier that we have is Dr. Jean Ubbelohde. I really hope I said that.

LINEHAN: Good job.

MORFELD: Welcome, Doctor. Feel free to begin whenever you'd like.

JEAN UBBELOHDE: OK. Good afternoon, Vice Chair Morfeld and members of the Education Committee. Thank you for the opportunity today to discuss the need for autism screening. My name is Dr. Jean Ubbelohde, J-e-a-n U-b-b-e-l-o-h-d-e. I've been a special educator for over 30 years, and I'm currently the coordinator of early childhood in Millard Public Schools. In that position, a few years ago, I became aware of the work in southwest Arizona to screen all young children for autism, which in my opinion, is incredibly important for children and schools. What we know as educators is that the sooner a child is identified as being on the autism spectrum, the better the educational outcomes are for that child. In Nebraska, we often identify children as developmentally delayed, which can provide special education services or early intervention, but also can be misleading and not a strong approach when actually we see potential autism spectrum disorders or ASD. When we suspect ASD, we can identify interventions that are

specifically tailored, so we need to understand how to better identify ASD at an early age. Based on the Arizona work and my knowledge of the impact early identification can have, in collaboration with Millard's Clarke Community Initiative, we wrote a grant to discuss autism screening protocols for Nebraska. In 2019, we were fortunate to receive a grant from the Weitz Family Foundation, and we formed a steering committee comprised of medical community, school districts, and community organizations. The committee spent three years looking into this issue and concluded that the problem is we are not identifying children with autism at an early age. The problem is threefold: first, many families are not actually getting their children screened for signs of autism and may not recognize the signs themselves; second, the work of doctors is siloed from the work of schools, which often means that a child that does exhibit signs of autism is not necessarily referred to schools, despite the school's obligation to engage in ChildFind. Essentially we have an obligation to find and serve all children who have challenges that prevent them from accessing their education, whether or not we have a diagnosis, and I think NDE can speak to that more regarding this obligation. And finally, we are finding children far too late. Even age four or five is later than desired, but we are seeing children getting their first diagnosis much larger than that. The bottom line is we are not identifying all children with autism at an early age. The older the child is before being identified, the more difficult it is to change that child's trajectory. The lack of early identification or miss can result in reduced educational outcomes for the child, as well as a greater burden on parents, schools, and the medical community. The steering committee discussed the challenges of obtaining consistent screening and referral for further evaluation. We also learned that schools with training have the capacity to administer initial screenings, and we began to do so at Millard Public Schools. So do clinics, medical providers, and others. In our work, we know that autism doesn't play favorites, yet children who are getting identified later do not have the opportunity to receive early intervention through the school district and medical providers. In our work, we have found that often the children that are identified later may come from families with less resources and are more likely to be children of color or children who don't have a medical home. The window of opportunity to identify a child with autism starts as young as 8-- 15 to 18 months old. When a child is identified early, families and children are connected to services within the school and the community. We want all children to have this opportunity to receive early intervention, and one way to do this to ensure a screening is

done for every single child before they begin school, and ensure all children exhibiting potential signs of ASD are referred to school districts and medical providers. This is no different than what we do for hearing and vision. All children are screened for hearing and vision. There are a variety of ways to get to the autism screenings, but without a requirement, it just isn't going to happen. A screening doesn't take long and staff training is easily implemented. I support moving in this direction and would be happy to answer any questions you may have.

MORFELD: Thank you very much, Doctor. Any questions? Ok, Senator Sanders.

SANDERS: Thank you, Vice Chair Morfeld. Dr. Ubbelohde, thank you so much for testifying this afternoon. When you said children of color or children don't have a medical home. Can you identify a medical home?

JEAN UBBELOHDE: So a child that doesn't have a regular pediatrician, so children that potentially don't get regular well-baby checkups, or maybe their medical home is an urgent care or some other type of, you know, freestanding institution and not a regular pediatrician.

SANDERS: OK, thank you.

MORFELD: OK. Any other questions? Senator Linehan.

LINEHAN: Thank you, Vice Chairman Morfeld. So who-- you said the schools could do the training with Millard's, evidently.

JEAN UBBELOHDE: Yes.

LINEHAN: You set up Millard-- the screen?

JEAN UBBELOHDE: Yes. So--

LINEHAN: What do they--

JEAN UBBELOHDE: I'm sorry.

LINEHAN: No. Go ahead.

JEAN UBBELOHDE: So back in 2019, when we received this grant, we-- for the children that are already referred to Millard Public Schools because there is some type of concern within their development, we are-- as part of our, our initial evaluation, we are including the

MCHAT, which is that screening tool that Dr. Menousek referred to that is used and recommended by the American Academy of Pediatrics. So we are just pushing that, pushing that into our process. It's a, it's a simple screening tool and our providers, our special educators, speech language pathologists, occupational therapists were trained on how to give this and then have that conversation with the parent, and also-- and Dr. Menousek referred to this--understanding those questions so that when they're asked, when parents are asked a certain question, being able to clarify that a little bit for a parent, give them examples of what that question is actually asking.

LINEHAN: So children who are-- like speech, let's say they're three and they're not speaking, they frequently, if they're going to the doctor, can be referred to Millard for speech.

JEAN UBBELOHDE: Correct.

LINEHAN: Other schools.

JEAN UBBELOHDE: Yeah, other schools.

LINEHAN: So do they do that then, when they get a referral for a child who's delayed, whether it's speech or whatever delays are going on? Do you do the screening at three or four or do--

JEAN UBBELOHDE: We repeat it. So we do it at that initial referral, in addition to our other screening and assessment tools, and then we repeat it at-- so depending on when the-- so we'll do it at those same intervals that the American Academy of Pediatrics recommends so 18, 24, 30 months. Now, when they're 36 months and above, we have a different tool that we are using to screen for autism.

LINEHAN: Excellent. Thank you very much for being here.

JEAN UBBELOHDE: Yes.

MORFELD: Any other questions? Senator Pansing Brooks.

PANSING BROOKS: Thank you. Do you have a feel for the percentage of those students without a medical home?

JEAN UBBELOHDE: I honestly don't, but I'd be happy to research that and get back to you.

PANSING BROOKS: OK. Thank you so much. Thank you for being here today.

MORFELD: Any other questions? OK, Senator Sanders.

SANDERS: It sounds like the chicken and the egg thing, which comes first. So if I'm a young parent and I suspect, and I take my kid to the pediatrician, and maybe he's not hearing or whatever the identification marks are. And the pediatrician hits the tuning fork on the table and the kid turns because he feels the tuning fork, not, not because he didn't hear. And I say as a parent, no, he did that only because you hit the table, but he, he cannot hear. And the pediatrician-- ah, don't worry about it, he'll grow out of it. So as a young parent, you continue to hope and think, maybe there's nothing wrong until he gets to that school where he can find services. You know, the mother doesn't know about that until a pediatrician probably makes the recommendation-- here's a program. Is that how that initially works?

JEAN UBBELOHDE: Yes. Yes, Senator Sanders. That's exactly what happens, and sometimes a pediatrician will say, you can-- let's just wait and see. And there, there really is no reason to wait and see. There is no harm in getting that evaluation through the school district. It's free, birth to 21. So it's really important that we don't wait. Now to further answer your question, hopefully, that young parent will go back for another well-baby check, and then maybe they will get the referral then. Also, the school district's responsibility is that ChildFind. So we are always trying to find new and better ways to get the word out to families, grandparents, aunts, uncles, whoever it may be that, did you know, your child can have a free evaluation through your public school. So we're always, again, looking for new and innovative ways to get that message across 'cause often families, parents do not know that a school district is there for them starting at birth unless they've had a personal experience, either the, their personal family or maybe a friend or family, other family member.

SANDERS: Thank you.

MORFELD: Any other questions? OK, thank you, Doctor.

JEAN UBBELOHDE: Thank you very much.

MORFELD: OK, the next invited testimony that we have is Michaela Ahrens. Welcome, Ms. Ahrens.

MICHAELA AHRENS: Good afternoon, members of the Education Committee. Thank you for having me. My name is Michaela Ahrens, M-i-c-h-a-e-l-a

A-h-r-e-n-s, and I'm the senior director of programs for Autism Action Partnership, a nonprofit in Omaha. So I represent the perspective of a community organization who is working directly with families. We field several calls every week from families who have just received a diagnosis oftentimes and are looking for services, resources. Many of those families have young children, but there is a startling number of calls who, that come in with-- from families who have children who are in their teens, young adults, even some adults themselves. And we know that the older they get, the less resources and services we're going to be able to recommend to them, refer them to. It's just so critical that they get services early. I have some examples of, of families who have come to us, families we've worked with that I thought I'd be able to share. We have a workforce development program that serves adults with autism. And so we probably get more of those calls for newly diagnosed adults or families who have young adults who are newly diagnosed. So they've left the school system and now they're realizing that their loved one or themselves are really going to struggle in terms of being able to work independently and live independently. But to be able to access services after they've left the school system is an incredible challenge. If they are looking for, let's say, to apply for DD services at that point, they're looking at landing themselves on a waitlist that I think is like eight years long. So if you're thinking about a 19-year-old who now is waiting until they're 27 to access-- and that's only if they qualify. So it is imperative that we get those kids accurately diagnosed while they're in the school system, and the schools can help provide some of those early interventions and supports or certainly services at an earlier age. I recently had a call from a mom who was extremely distraught. I didn't even recognize before hearing Dr. Menousek talk about the 9-year-old, the cut off for a 9-year-old to have that developmental delay, diagnosis or verification-- sorry. But this mom had a 9-year-old who was recently verified for autism, and she was so frustrated and felt so guilty that her son had not received accurate or adequate supports up until this, this point in time. And I thought to myself about LR149. What would have happened had there been a screening for him earlier, a screening specific to autism? You know, potentially he would have had years more of, of services. I have another mom who-- she has a three year old little boy. He's really young, right? That's the perfect age to be thinking about what's normal development and where your concerns are. So he's three years old, and she had been on top of his development, had some concerns for the last year and a half that she was talking to her pediatrician about. Just before his three year[-- he turned three, he had a well visit. The pediatrician did the

screener, the MCHAT, and recommended a full evaluation. So he now has an appointment. This was at the end of August. He now has an appointment for a clinical evaluation, March 17, 2022. So at that time, he'll get his evaluation. If he, if he's diagnosed with autism, there's likely he's going to find himself on a waitlist for additional services. Thankfully, she was in contact with us. She went to the school. She's getting a full evaluation at the end of October, and, hopefully, that little boy will have some services earlier. So there's lots of avenues for addressing this. You know, if we're talking about catching autism early, there's lots of avenues. It's parent education, it's engaging pediatricians. This is just one more step. And when Jean talked about those minorities and people of color, I think about the language barriers, you know, getting parent education and pediatrician engagement. We might not get to those families with language barriers or who aren't regularly keeping up with their well visits, but maybe we could catch them as they enter school. So I appreciate your time and your consideration, and happy to answer any questions if I can.

MORFELD: Thank you for your testimony, Miss Ahrens. Any questions? OK, thank you. OK, our next invited testimony is Haleigh Carlson. Welcome, Ms. Carlson.

HALEIGH CARLSON: Thank you. Good afternoon, Senators. My name is Haleigh Carlson, and that's H-a-l-e-i-g-h C-a-r-l-s-o-n. I'm an attorney at Perry, Guthery, Haase and Gessford, and also a member of the Nebraska Council for [SIC] School Attorneys. I'm here to testify on subsection (1) of LR149, which is a review of Nebraska's responsibilities under the ChildFind mandate and the Individuals with Disabilities Act. And I will say with only five minutes, it truly is an overview, and this should not be a replacement for legal advice or for a full, comprehensive analysis of the state's obligations under there. Under the Individuals with Disabilities Education Act, or IDEA, each state is required to develop and carry out programs designed to locate, identify, and evaluate children who are in need of special education services. This requirement is referred to as ChildFind. The individual-- or the IDEA has two, has rules for two groups of children. First, there's rules for children aged 3 through 21, and this is commonly referred to as Part B. Then there's also part C, and those rules apply to children aged birth through 3. Both Part B and Part C of the IDEA have their own requirements for states in regards to ChildFind. The ChildFind mandate under part B of the IDEA requires states to have policies and procedures to ensure that all children with disabilities in the state who are in need of special education services are identified, located, and evaluated. And this requirement

applies regardless of if the children are homeless, wards of the state, or wards of the state, and it applies regardless if the child is attending private school and regardless of the severity of their disability. This requirement also applies to children who are suspected of being a child with a disability and in need of special education, even if the student is advancing from grade to grade. It also applies to highly mobile children, including migrant children. Typically, states implement their ChildFind responsibilities under Part B of the IDEA through lead education agencies, or LEAs, that receive an IDEA subgrant. In layman's terms, it's basically school districts where the parents of the child with a disability reside is typically responsible for ensuring that a child is identified, located, and evaluated. In fact, LEAs are also responsible for having their own ChildFind policies that are consistent with the state's policies. Under Part C of the IDEA, the ChildFind rule mandates that states must make early intervention services available to infants and toddlers with disabilities and their families. This includes Indian infants and toddlers residing on a reservation within the state, as well as infants and toddlers who are homeless, in foster care or wards of the state. Part C requires that the ChildFind system meets all the components of the system requirements in Part B, but Part C also has several additional requirements specific to identifying infants and toddlers with a disability who, due to their young age, are not affiliated with a school system yet and need to be identified through several other services, as opposed to their Part C peers or Part B peers. The first additional requirement of a state's Part C ChildFind system is that it must include an efficient system for making referrals to service providers. Specifically, Part C of the IDEA requires the state to have policies and procedures to ensure that primary referral sources refer potentially eligible children to a Part C child program within two business days of identification. And these primary referral services can be vast, includes hospitals and prenatal and postnatal care facilities, physicians, parent and child programs. The list-- I can provide a full list if you guys need. In addition, each state's ChildFind system must ensure that their ChildFind system is coordinated with all other major efforts to locate and identify young children, to ensure there's no unnecessary duplicate, unnecessary duplication of efforts, and to ensure that the state will make all of its resources available equitably. And finally, Part C also requires the system to have rigorous standards for appropriately identifying infants and toddlers with disabilities, to reduce their need for services in the future. Part C also requires a public awareness campaign in which the state provides information and

services to these primary referral services so that they can assist parents of infants and toddlers with disabilities in understanding what the disability is, what the early intervention process is, and how the child could be referred to those services. Let's see. With the time-- gosh. I can answer any questions.

MORFELD: Yeah, [INAUDIBLE].

HALEIGH CARLSON: As I said before, five minutes of the law is difficult for any lawyer.

MORFELD: Just imagine if you're in the Judiciary Committee. OK,--

HALEIGH CARLSON: Exactly.

MORFELD: --Ms. Carlson. Thank you for your testimony. Any questions? Senator Pansing Brooks.

PANSING BROOKS: I, I would love to get a copy of your testimony, if you don't mind, so--

HALEIGH CARLSON: 100 percent.

PANSING BROOKS: --if you could get that out to the whole committee, that would be great.

HALEIGH CARLSON: Yeah, when I get back to my office, I can provide a full copy--

PANSING BROOKS: Thank you.

HALEIGH CARLSON: --with citations and all. So give me--

PANSING BROOKS: That would be great.

HALEIGH CARLSON: --a day or two to make sure it's up to snuff.

PANSING BROOKS: I'm sure it's perfect, but I'd be happy to see it. So thank you, of course.

MORFELD: OK, Senator Linehan.

LINEHAN: I'm guessing you don't think we're doing a very good job at this.

HALEIGH CARLSON: I, I truly don't have an opinion--

LINEHAN: OK.

HALEIGH CARLSON: --on what the state, you know, how the state is handling it. I only know-- I'm only here to testify on what the federal law requires you to do.

LINEHAN: OK. Thank you--

HALEIGH CARLSON: Yes.

LINEHAN: --very much.

MORFELD: Thank you. Any other questions? OK.

HALEIGH CARLSON: And I will-- can you let me know how I can send this to everyone?

MORFELD: If you want to send it to the committee chair or actually--

DAY: We can-- Sam,--

MORFELD: Senator Day. And then--

DAY: Can-- can you have her email?

SAM HUPPERT: OK, I'll get it. I'll--

DAY: We can--

MORFELD: OK.

DAY: Yeah, we'll get it in here.

MORFELD: OK.

DAY: Yeah, we'll get it squared away.

MORFELD: Either Sam or the committee-- or the committee counsel or committee analyst.

PANSING BROOKS: OK. We could get it now, too.

MORFELD: Or we could have a page, but--

DAY: So many options.

MORFELD: --it sounds like she wants to--

DAY: So many.

MORFELD: Well, how about we do this? Send it to Senator Day,--

HALEIGH CARLSON: OK.

MORFELD: --and then she can get it out to the rest of the committee.

HALEIGH CARLSON: I will do that.

MORFELD: Thank you very much;--

HALEIGH CARLSON: Thank you.

MORFELD: --appreciate it, Ms. Carlson. OK. And to close, Senator Day. Senator Day waives closing. That ends our hearing today on LR149. Thank you, everybody, for testifying.