ARCH: Good morning. Welcome to the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Day.

DAY: Senator Jen Day. I represent Legislative District 49, which is northwestern Sarpy County.

MURMAN: Senator Dave Murman from District 38, Glenvil, represent seven counties to the east, south and west of Kearney and-- and Hastings.

WALZ: Senator Lynne Walz. I represent Legislative District 15, which is all of Dodge County.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer, and the north portion of Buffalo Counties.

ARCH: Also assisting the committee is one of our legal counsels, T.J. O'Neill; our committee clerk, Geri Williams; and our committee page, Kate. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This morning we will be hearing two interim study resolutions and we'll be taking them in the order listed on the agenda outside the room. The hearing on each study will begin with the introducer's opening statement. After the opening statement, we will hear from a number of invited testifiers. The introducer of the study will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out, hand it to the page when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone, then please spell both your first and last name. And with that, we will begin today's hearing with-- on-- with LR143 and welcome, Senator Stinner.

STINNER: Good morning, Senator Arch, and thank you and members of the Health and Human Services Committee. For the record, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r, and I represent the 48th District, which is comprised of all of Scotts Bluff County. LR143 examines the

mental and behavioral health needs of Nebraskans; assesses the current shortages of providers, services, and resources; and determines what is needed to ensure an adequate behavioral/mental health delivery system for our state. As you know, Nebraska faces a critical deficiency in access to behavioral healthcare, including mental health and substance abuse disorder treatment. To assess the current delivery system in Nebraska, we brought together a group that represents providers and facilities from across the state. This working group illustrated to me that there is a critical need not only in rural Nebraska, but the entire state. Although specific needs may vary across the state, our working group concluded that there were several areas in which improvement is needed universally in order to best serve the people of Nebraska. These areas included collaboration between stakeholders, workforce retention and recruitment, communication of available services along the education pipeline, internships and fellowships for service providers, acute hospital bed capacity, improved access to care including alternative delivery models, and community involvement to foster philanthropy and reduce stigmas to mental health issues. The testifiers behind me will touch on these areas in more detail, but first I'd like to highlight a few of them that will be integral in-- to this initiative. The creation of a statewide network will provide unified infrastructure across the state, providing localized access to information, resources, education, and training. This would allow expanded access in a more organized manner while protecting limited resources. It's not anticipated that this network would be created from scratch. BHECN is located at the University of Nebraska Med Center and already has expansion projects in place. By giving them needed resources, they will be able to coordinate and access network and needed resources. BHECN would continue to work with other stakeholders to assess needs and to utilize existing systems where appropriate and find support for expansion if necessary. Using the existing behavioral health regions as guides, network hubs can be created. These hubs could be new facilities or be collocated. The specific role of the network and hubs would include the facilitation of outreach to communities, governmental agencies, providers, educational institutions to maintain the workforce pipeline and continuing education; information sharing with providers regarding access to financing programs and assistance with applications and other regulatory requirements; the creation and support of a hotline for primary care doctors, psychologists, and other providers to consult with psychiatrists as well as access to curriculum to promote integrated care; recruitment of community leaders to identify issues and guide the discussion regarding the stigma to reduce on mental health. Workforce retention and recruitment is a big item. The second component I'd like to highlight is workforce

retention and recruitment. Workforce shortages at all levels are negatively impacting the delivery of behavioral health services in Nebraska. To maintain a viable behavioral health system, we must find ways to recruit and retain workers. Financial barriers keep many qualified workers from completing education and training. The lack of support-- support services for existing workforce leads to burnout and resignations. More localized or alternative access to training and continuing education could be provided by network hubs. Finally, reducing barriers to licensure, streamlining the process, and providing income to those who are waiting full credentialing would allow more people to remain in the behavioral health workforce. Expanding or replicating programs like the Rural Health Opportunities Program, RHOP, to include behavioral health in all areas, the state would open the door to more candidates. Other successful programs have interested students participating in camps or mentors-- mentorship networks. Things that would benefit recruitment as well as retention-- as well as retention includes expanding eligibility and additional funding for loan repayment and forgiveness programs. An additional boost to workforce efforts would also include funding for paid internships and promoting an integrated care by offering providers payment for internships and access to continuing education. Mentorship and supervision support is also a valuable tool for both potential and existing workers. Network hubs could also facilitate partnerships between behavioral health disciplines and specific training programs to best meet diverse needs. Behind me will be more members from the LR143 work group to detail other components of this initiative. I look forward to this framework coming together for the health of Nebraskans. I appreciate your time and attention as we examine the state can improve our behavioral healthcare delivery system. Thank you and I welcome any questions.

ARCH: Thank you. Are there any questions for Senator Stinner? Seeing none, thank you very much.

STINNER: Thank you.

ARCH: We would like to invite the first testifier, Dr. Mike Vance from Children's Hospital.

MIKE VANCE: Good morning, members of the Health and Human Resources [SIC] Committee. My name is Mike Vance, M-i-k-e V-a-n-c-e. I am a child psychologist and the director of behavioral health at Children's Hospital and Medical Center, of whom I am testifying for today. As the safety net provider for children in Nebraska, Children's is dedicated to working with partners across the state to improve access to mental healthcare for children through better integration and coordination

with our community partners. No one entity can do this work alone, which is why we are so grateful that Senator Stinner, for his consistent efforts to create a broad stakeholder group together to reach a common goal. The trends in children's mental health were sobering prior to the pandemic, with one in five children experiencing mental illness, rates of major depression rising dramatically. Now there's a growing concern that the pandemic has led to increased mental health challenges and suicide risk among children. Across the country, mental health-related emergency room visits are up 24 percent among children ages 5 to 11; 31 percent for those 12 to 17. Suicide is now the second leading cause of death for youth, and the rates are up 67 percent for some of our youngest kids aged 10 to 14. Our depression screening at Children's Hospital across our enterprise definitely supports this increase, increased risk and increased identification. Every year we see hundreds of these children and teens in crisis in our emergency department. These kids were unable to get mental healthcare or adequate care prior to their arrival. In response, what we propose is the development of a pediatric mental health crisis center designed to screen, triage, and refer community-based resources, whether it be a day treatment program, outpatient support, a follow-up visit with their primary care doctor in the morning, or to the level of inpatient care. The emergency room is not the location, the best location for kids to encounter our mental health services. Children's mental health urgent care would act as a spoke to the pediatric mental healthcare access, offering 24/7 services that are less threatening, less costly, and would appropriately refer these children to the right place so that they can access the correct level of care, whether that's outpatient or inpatient level of care. Our intention is to initially start with one location in Douglas County, and second phase is to replicate this demonstration project to other areas around the state. Please understand this is only one piece of addressing the need, the mental health needs of children across this state. Thanks to Senator Stinner, he has convened a task force of providers and stakeholders throughout the state that will later testify to address areas such as mental healthcare gaps, education, workforce training, workforce retention, and capacity to acute beds. What I'd like for you to remember from my testimony and the others today is this is not a one entity solution. Children's and our partners in this demonstration project have been successful in building mental health services access points across the state of Nebraska. We have done this using virtual care. We've done it using in person, leveraging in-person care and even offering provider-to-provider consults, one of the pieces that Senator Stinner referenced at the end. And this supports the shortage of child psychiatrists in Nebraska, where a primary care doctor can talk

directly to that specialist while his patient is-- his or her patient is in an office. With a focus on prevention, Children's aims to improve the life of every child in Nebraska with a new and sustainable way to reach our patients across the state in different stages of needs, supports from the schools and the community partners. Together we all-- we all strive to achieve statewide screening, early detection, and meet these individualized needs of families through addressing social determinants of health interventions, developing new best practices to integrate mental healthcare into primary care, and to establish pediatric mental health urgent care sites across the state. These kids don't need to first be seen at an inpatient unit or in our emergency room. In conclusion, Children's is invested in the prevention of mental health difficulties and is grateful for the opportunity to partner with agencies across the state to meet the needs of children where they live. Mental health is in a crisis that our youth are facing currently. We really need to work faster, harder and more efficiently to make-- to give children this opportunity for a robust life. There is no better investment to us to make as a state than in the needs of our children. I'm happy to answer any questions that the committee would have for me.

ARCH: Thank you. Are there any questions? Senator Day.

DAY: Thank you, Chairman Arch. And thank you, Doctor Vance, for your testimony today and for being a leader in this important work of behavioral mental health care for children. Can you tell me a little bit more about the integrated model at Children's? Do you provide mental healthcare in your primary care offices?

MIKE VANCE: Yes, we do. So somewhat across the state and in metro areas in our Children's CP offices, we have either psychologist, psychiatrist, or mental health therapist or sometimes all three that actually provide care inside of that office. It's been a great model for us. It allows for warm handoffs from the physicians to the patients can engage that. Families seem a lot more comfortable coming to their primary care office for that care because it's not driving to the mental health--

DAY: Right.

MIKE VANCE: --center in town. It allows for really solid communication between the medical provider and that mental health provider. We do it both in person, we do it virtually, and in some offices we do a combination. The other part that we've recently built out of that is we have two of our psychiatrists, Doctors Daughton and McWilliams, who have set up a consultation protocol for physicians around the state.

And what they can do is they can send a consult to these-- to the two psychiatrists and they get back to that provider within an hour, real-time during normal business hours, to answer psychiatric medication questions. We were getting used about 20 to 25 of these a month. And it's interesting. When somebody uses it, they're our frequent fliers and they-- they really find it to benefit. I can't hire-- we can't hire enough child and adolescent psychiatrists, so we've got to leverage their skills better. And I think that-- that integration component truly is a direction we need to head.

DAY: Wonderful. Thank you.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, Dr. Vance. A quick-- you mentioned these statistics are sobering. They're more than sobering. Are we being able to identify any root causes that are leading to these increased numbers of mental health issues with children?

MIKE VANCE: There has been a lot of-- a lot of effort to look into that. I think that if we looked at the primary themes, all of us are under a great deal more stress in the last several years. Things are expected to be done yesterday. Families are not having family dinners together. If they are, they're on their electronic devices. We are-- parents are struggling listening to their kids. They may be talking to them, but they're not listening. I think that's a big factor. A lot of the unpredictability of the last two years has really hit children in a way that they can't cope with it the way that adults can. We at least feel we have some control over our daily routines. But kids were waking up in the morning wondering whether they were going to go to school that day, wondering whether they were going to have their football game on Friday night that they'd spent all summer in training. So I think those are big issues. We're also doing a better job screening. We're at-- we're getting out there in the schools. We're getting into primary care offices. We're asking these questions earlier, which I think is essential for us to get these kids to early intervention. So it's a combination of stressors that are there. And I think we don't do quite as good a job as we could in instilling resilience in our youth. And that's-- that's an area that a lot of us in the mental health community are working with, increasing that resilience. And then finally, I really do think we're doing a better job identifying and people are more comfortable talking about it.

WILLIAMS: Thank you.

ARCH: Senator Cavanaugh.

M. CAVANAUGH: Thank you, Chairman Arch. Thank you for being here. This is such an important issue and one that's very close to my heart. We have schools, have, you know, school-based counselors. And I just am interested to hear what type of relationship, if there is one, does the hospital have with them in the referral process and then additionally schools that have health centers at them as well? Is there a relationship there that's currently ongoing or is that something that we would be looking to do?

MIKE VANCE: Actually excellent question. Thank you. We've had a program partnership with Westside Community Schools, District 66 now for about five years. And what that program is, is we have clinical psychologists that are inside of their three, the junior high, their alternative school, as well as their high school. And they're two to three days a week and they take direct referral and provide direct interventions with those kids. And they then do collaborate with the school-based professionals so that there can be handoffs for these kids. We also do their crisis assessments for kids that have made threats and make sure that their safety plan for the kids to get back into school and assist in the transition with kids that have been hospitalized for suicidal ideation to make sure that transition is smoother. Soon to come in Westside in September, Dr. Jennifer McWilliams will be doing virtual psychiatry care to Westside District. And it's open to all the kids. We're still working on the transition plan, so that'll be a new piece. And then we have-- we have a partnership with OneWorld where one of our psychiatrists, Dr. Daughton, provides direct service provision to-- for Omaha west or south Omaha schools. And then I know that Charles Drew has some other partnerships with that OneWorld component. So we're able to cover a lot of those areas. And I would agree, Senator Cavanaugh, that there are some wonderful school-based programs. From what I've heard, Lincoln here has provided a mental health provider in each school this, as of this year that collaborate with the school-based professionals. We don't need to go in and do their job. They know schools. They know those kids. We just need to go and help them do their jobs stronger and better and faster and be there as that support network. And that's-- that's, I think, a model that's robust.

M. CAVANAUGH: I have a follow-up.

ARCH: Sure.

M. CAVANAUGH: Thank you for that. So as we've seen this increase, as Senator Williams pointed out, that's very startling numbers, are you

seeing that that relationship with the schools, are they playing a part in making in those early interventions and getting the kids the resources that they need outside of the school system?

MIKE VANCE: I'll speak to the districts that we've involved in from my-- my component, because I'm sure I don't know everything that Westside is doing or that OPS is doing. But from what we see, the school-based professionals are doing more structured screening programs throughout the school year that identify kids that are struggling. And then they've also done-- set up some monitoring programs to identify how long is that struggle? So Westside, for instance, will look at kids at two times during the year to see how their actual functioning is. And when you look at some of the data, the kids that actually get involved in health support systems, whether it's us or with the school, their coping levels and functioning levels increase. While some of the kids that didn't have that, even though they were maybe functioning better, as things got more stressful, their functioning decreased. So it really has to be a collaborative effort. We got to work with where kids are, which is there in schools. We get a much lower no-show rate and we get to see them in an environment they're there 40-plus hours a week. And the teachers sometimes know them equally as well, or at least differently than what the parents would know. So it's-- I think it's an invaluable relationship, just like the primary care piece.

M. CAVANAUGH: Thank you.

ARCH: Question, Senator Murman.

MURMAN: Thank you, Senator Arch, and thanks for your testimony, Dr. Vance. You touched on a little bit earlier, but I'm wondering how much of a factor that parents aren't as fully engaged or don't have the opportunity to spend as much time with their children and the breakdown of the family. How much of a factor do you really think that is? And, you know, for instance, kids at very young age are often put in daycare and-- and then during the school year, as they get older, they're just, you know, all three meals are quite often at the school. The parents just don't have opportunity to be with their children, if there are two parents, don't have the opportunity to be with their parent or their children as much as in the past.

MIKE VANCE: So I think all of us in mental health would agree of the salience of the family and what role they play in our children's upbringing and our children's coping skills. I think a lot of it-- a lot of the impact deals with how parents explain and model coping to their kids. There are certain family circumstances that don't allow as

much time to be with those kids. And those families have to look at that time they do get with their kids differently and enrich it and do what best they can during that time and not-- not come home and say, OK, I've had a horrible day, you know, and then go to the refrigerator and grab an adult beverage and go sit on the patio rather than going and throwing a ball with your kid or, you know, taking them out and showing them something in the workshop that you're doing. But I think that engagement is important. But we-- we-- we just the way society is set up, we don't have the ability for everybody to be at home all the time with our kids. So really, it's how we explain our absences to our kids and then what we do together, you know, what do we get to enjoy, rather talking to our kids about what we can't do. I think that was a big message that we sent out a lot during the pandemic. We saw families that sat around and lamented everything that was being taken away. And granted, we needed to vent and we needed to do a little bit of that. But the families we saw that really shined were the ones that came up with new ideas. Hey, we're going to do family game night and you get to pick. And so the four-year-old got to pick the game one night, you know, and the teenagers, they're rolling their eyeballs, but they realized how much fun it was to play Chutes and Ladders again. And those sorts of interactions, I think, really need to happen. No, you don't have your football season. But, hey, you know, I used to be a quarterback. Let's go-- let's go out a couple of times a week and let's work on your drop-back pass and talk about what you get to do as opposed to what we don't get to do. And we need to give parents the support however we can so that they can, when they have that time with their kids, they can engage with their kids rather than working a third job or doing some of those other things. But that's a whole different line. But I-- I do think we need to-- to encourage parents to-- to listen to their kids, not just spend time with them.

MURMAN: I agree. Thank you very much.

MIKE VANCE: Thanks for the question.

ARCH: Any other questions? Seeing none, thank you very much for your testimony today.

MIKE VANCE: Thank you.

ARCH: Next testifier, Dr. Mark Hald from Options in Psychology.

MARK HALD: Morning, Senator Arch.

ARCH: Good morning.

MARK HALD: Committee members, thank you. I'm Dr. Mark Hald, M-a-r-k H-a-l-d. I'm a licensed psychologist and co-owner of Options in Psychology in Scottsbluff, Nebraska. Options In Psychology is a multiservice clinic supporting families, children, adolescents, and adults in western Nebraska. Our clinicians offer trauma informed, culturally competent evaluations, diagnosis and treatment for major mental illness, a range of behavioral, psychological and neuropsychological conditions. I would like to briefly highlight several points this morning, particularly doctoral psychology internships, specifically the one we're involved with, as well as the importance of ongoing evidence-based training for established mental health practitioners and psychologists, as well as a brief comment or two about mental health well-being and prevention for the broader Nebraska community. Another mission of Options is to provide supervision and training to doctoral level psychologists during their internship year. As part of their training, our psychology interns help us provide additional psychological services during the internship year. The greatest challenge for sustaining an internship is financial. The revenue for our internship site is currently dependent on Medicaid reimbursement based on the billable services completed by our doctoral interns. The average total annual cost to fund a placement is approximately $62,000 to $70,000. The revenue-- the revenue the intern generates within a year does not support the annual internship budget. We've now had three interns and we're in our fourth year. So far, the average annual revenue generated from the three years of internship at Options has been $25,000. Being dependent on Medicaid reimbursement for the basis of the internship revenue source has prevented many challenges and barriers. And I believe this is also why other potential agencies have said no to being a psychology internship site. Other established doctoral level internship programs in the state are supported by various types of grants or other institutional financial support. As a private practice entity, Options does not have the extra funds to fully support and sustain a doctoral level internship on its own. At the present time, we've been able to support an internship startup with the support we received during the first two years by having an internship salary paid by grants managed by the University of Nebraska Medical Center. Without that support, the pay-- to pay the interns' salary during those first two years, we would not have been able to begin. However, when you look at the total revenue we have accumulated compared to the internship expenses, we're operating under a deficit budget. We've elected to continue because it's the right thing to do for the community. Having an intern allows us to increase our capacity to offer psychological services and hopefully recruit and retain future psychologists for the area. However, running in-- running on an

internship budget deficit is not sustainable over the long term. Thus, as part of the broader discussion of the development of behavioral health workforce in Nebraska, there is a significant need to have a priority to support doctoral level psychology internship programs, to emphasize the recruitment and retention of doctoral psychologists not only in western Nebraska but across the state. I also want to emphasize the need for professional development and evidence-based practices for established clinicians. Several projects that I'm-- I'm aware of and involved in a couple of them are child-parent psychotherapy, trauma-focused cognitive behavioral therapy, and parent-child interaction therapy that are provided by various agencies in the state. Prevention and promotion of individual family and community wellbeing is another important part of behavioral health for the larger community. There are several projects within Nebraska that do this. Some I'm aware of are promoted by the Nebraska Children and Families Foundation, including the Sixpence program and the Rooted in Relationships Program, as well as other agencies providing the service known as Healthy Families America Program. Another important project important to me is the Circle of Security Parenting Program. This program is an evidence-based model that enhances parent-child relationships. Research and my direct experience has shown it to be a highly, highly effective model in helping strengthen parent-child relationships, which is one of the best things we can do in terms of supporting families and the overall well-being of communities. Thanks for the opportunity. I'll take any questions.

ARCH: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Dr. Hald, for being here. And thank you for being willing to work with a business model that doesn't really work because it's the right thing to do as you said. Recognizing that and recognizing that preceptorships for almost all of our medical providers is an issue in the state, is there some kind of a solution that is being looked at that we could encourage from a legislative standpoint?

MARK HALD: Not that I'm aware of, which is why I'm glad the question got raised within the committee. One, if you look at the document that Senator Stinner provided, a big part of our discussion was how do we create good quality internship sites, not only for doctoral level psychology, but also for master's level clinicians? You educate, you do your educational training, but then in psychology, you have a full year practice. Psychiatry has a three-year residency. A master's level clinician is required to have-- I think it's like 600 to 1,000 hours before they can graduate. And most of the master's level ones are

unpaid. And-- and to do that, people often have to-- they work jobs on the side. It's hard to do it full time. The psychology intern, we pay them a stipend. But what we're able to pay this year, we're paying $25,000. But in terms of being competitive to get the best candidates, a lot of sites are paying $30,000 and more around the state as well as around the country. So to be-- to be competitive, we'll continue to bill through Medicaid to generate some income. But if there was some way to receive other grants or stipends or a pool of money, one idea that was proposed was from the possible funds, could there be a pool of money that could be managed by BHECN or some entity in the state that then various internship sites could apply, say we have an intern. Could we supplement our budget with that income to help make up some of the difference? One other challenge related to that is in psychology, you have a postdoctoral year, so you graduate and then you get a provisional license. Some agencies-- so it's like a psychologist takes-- so there's several barriers there. One that happens in psychology for the intern is we have to credential them. Well, our current intern, we started in March doing that process through Nebraska Medicaid. There's several layers of that. And then there's three Medicaid providers. We have approval from two to begin billing her services. One has still not-- we still have not received approval for that six, eight months later. What happens with a postdoc, if we had if, say, this young lady this year decided I want to stay and work with you, because of the model we use, it's contract, they're independent contractors, we don't have the income to say we'll pay you for the first three to four months while you're trying to generate income and get licensed. Well, now we, I mean, this is direct evidence that it can take three to six months to get fully credentialed by the Medicaid providers. And that's just the Medicaid providers. Most of the private insurance providers credential very quickly, but there's lots of barriers like that.

WILLIAMS: Thank you.

MARK HALD: We're always jumping through lots of hoops that seem kind of silly lots of times. I could say a lot more about that.

ARCH: Are there other questions? Seeing none, thank you very much for your testimony.

MARK HALD: Yeah.

ARCH: Next, testifier, Beth Baxter from Region 3.

BETH BAXTER: Good morning, Chairman Arch and members of the Health and Human Services Committee. My name is Beth, B-e-t-h, Baxter,

B-a-x-t-e-r, the regional administrator for Region 3 Behavioral Health Services that covers central and south central Nebraska, the 22 counties in that area. First of all, I want to say that there are many innovative and effective services and initiatives across the state led by people who are dedicated to meeting the behavioral health needs of their neighbors, their families, their schools. They're partnering with universities and colleges. They're collaborating with-- collaborating with the justice system. And they work alongside our healthcare providers on a daily basis. They understand the needs, they live the challenges, and they are ready to be part of Nebraska's solution to improving behavioral healthcare in the state. Nebraska is a diverse state in population, resources, and needs. In 1974, the Legislature acknowledged this diverse nature of this state through the passage of the Comprehensive Community Mental Health Services Act. This act divided the state into six regions for the purpose of mental healthcare. Each of the 93 counties are a part of the region, and they appoint one county commissioner or supervisor to serve on the regional governing board that oversees the role and the responsibilities of the regions. I provided a map of the behavioral health regions, just for your reference, along with a graph that kind of depicts the flow within the system. In 1977, the responsibilities of the regions were expanded to include the coordination and oversight of substance use services. In 2004, the behavioral health reform process brought the passage of LB1083, the Nebraska Behavioral Health Services Act, that provided the framework and funds to develop and enhance community-based services so we could transition individuals who had historically been served in very restrictive levels of care back to their community and close to their families. This act reconfirms the authority that's provided to the regions and the governing boards, sets out how we have matching funds and various processes across the region. The regions appreciate Senator Stinner's introduction of LR143 and this committee's decision to examine the issues surrounding behavioral healthcare needs. The Nebraska Mental Health Initiative Committee or the LR143 Task Force examined the system needs of frontier, rural, and urban Nebraska. There are many, many services needs that are similar and the challenges are similar and there are some that are unique to certain parts of Nebraska. However, all are significant and have a profound impact upon the availability of behavioral healthcare services. This is a complex issue that will require a variety of solutions to address the multiple layers of need. I'm going to focus on the public behavioral health system that serves as a safety net for Nebraskans with complex behavioral health needs. Through contracts with the Department of Health and Human Services, Division of Behavioral Health, the Behavioral Health Regions each manage a network of provider organizations that deliver an array of

behavioral health services for families and individuals who are uninsured, who are underinsured because of high deductibles and those who are considered indigent. The infrastructure of the regional behavioral health system has been developed over the years and is well established to serve as a foundation for addressing the needs of Nebraskans. The regions partner with the Division of Behavioral Health to maximize the funding and resources allocated to the system. The six regions collaborate on the identification of needs and gaps and barriers, do planning and coordination with the intent of providing a seamless system to Nebraskans. However, the diverseness, the distance, and varying resources often create barriers to gaps in capacity. Currently, there's a shortage of psychiatric hospital beds for individuals needing immediate access to stabilization. This service shortage is just exacerbated by the shortage of healthcare workers, which reduces the immediate access to hospital capacity. This can back up the system from one end of the state to the other. We also experience a shortage of certain residential services that provide a structure and treatment for individuals with both mental illness and substance use disorders. Many provider organizations have positions that go unfilled for months and not able to fill positions, then impacts the capacity and access. It looks like I'm about out of time, and so I'll just let you read the rest of this. And I do just want to-- to say that this morning that even if we have adequate funds within the system, we have to provide a system that allows for flexibility, for creativity, and people to-- to work in communities to take care of their own citizens. I want to thank you for this opportunity to share some of these thoughts with you and will endeavor to ask-- answer any questions that you might have.

ARCH: Thank you. Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you so much for being here. What-- do you have some recommendations on what the flexibility would look like from a legislative perspective?

BETH BAXTER: Well, within our system we operate under regulations and those regulations generally provide some-- some area of flexibility. Then-- then we also work within service definitions. And honestly, within our system at this point, we're finding the-- the development of new service definitions that really should be just a guideline for service delivery becoming more and more complicated, more and more restrictive and really micromanaging. And when you-- you take rigid processes and you apply-- try to apply them to a system that has a workforce shortage, it just makes it extremely difficult to be able to get the job done.

M. CAVANAUGH: Thank you.

ARCH: Other questions? I have one question, and that is your identification of a shortage of psychiatric beds.

BETH BAXTER: Yes.

ARCH: Is that true for both adults and children, adolescents?

BETH BAXTER: Absolutely, yes.

ARCH: OK. Thank you. Seeing no other questions,--

BETH BAXTER: Thank you.

ARCH: --thank you very much. Next testifier, Dr. Jones-Hazledine. And I apologize at the beginning if I mispronounced your last name.

CATHERINE JONES-HAZLEDINE: Didn't do too bad.

ARCH: Oh.

CATHERINE JONES-HAZLEDINE: Hello, Chairman Arch and members of the Health and Human Services Committee. My name is Dr. Catherine Jones-Hazledine, C-a-t-h-e-r-i-n-e J-o-n-e-s-H-a-z-l-e-d-i-n-e. I'm a licensed psychologist and the owner and director of Western Nebraska Behavioral Health Clinic centered in Rushville, Nebraska. I would like to thank members of the committee for the opportunity to speak today regarding LR143 and to thank Senator Stinner for introducing this study exploring behavioral health delivery in the state of Nebraska. This study is of particular interest to me as a native Nebraskan and someone who has spent my career working to establish and improve behavioral health access in underserved areas of the state. I'm originally from Rushville and graduated from what used to be Rushville High School. I received my doctoral training at UNL, interned at the Munroe-Meyer Institute with UNMC, and then returned to Rushville to establish outpatient behavioral health clinics in collaboration with Munroe-Meyer. I've spent the last 17 years growing those clinics. Those of you who know MMI Psychology know that they specialize in providing brief, empirically supported treatments to children and families. On average, they meet for six, eight sessions with clients. I mention this because I wasn't out in the rural areas very long before I realized that that clinic model was not going to work for us. While the problems that brought our families into the clinic may have originally started as relatively uncomplicated issues, years without treatment due to lack of available services, distance, cost, and

stigma had caused many of the problems to grow and layer and become more entrenched, sometimes to become generational issues. We have found ways to maximize the service that we can provide, working within primary care settings, participating in multidisciplinary teams. We've established collaborations with local schools, providing direct care, training teachers and paras, and implementing stigma reduction coursework. Working in the same small communities for 17 years, I've seen teenagers as clients and had them years later bring their own children to our clinic. I consider that to be a victory. Though the family issues are not resolved, the parents of this generation know that there is help to be had, where to find it, and are in many cases able to access it for their children years earlier than it was available for them. And I think that really that continuity and availability of care over time and across the state is what we need in order to make our residents as healthy as they can be. The type of hub and spoke model suggested by this study can help to make sure that the needed services are in place and connected in a way that won't leave areas of the state without care or resources over time. Working with generations of a family over time has also made me aware of how time is passing and that I'm not getting any younger. This makes workforce development an ongoing priority for my clinic and for many areas of the state. Over the years, I have been blessed to be able to participate in the training of students at all levels, helping to train some 35 clinicians. In collaboration with BHECN, my colleagues at WNBH and I have also established the FARM CAMP Program, which identifies high school students interested in behavioral health careers and provides them with a week-long connection with behavioral health providers, information about behavioral health, and ongoing mentoring towards a possible behavioral health career. This summer, we held our eighth annual camp. Working with students and trainees over the years has highlighted for me the need for a number of things that are proposed within the goals of the Nebraska Behavioral Health Collaborative: increased funding to support trainees at all levels, as Dr. Hald discussed, and the importance of placing interns within as many behavioral health practices as possible because we know that that increases the likelihood that those students will remain in that area to provide care; student loan repayment for providers across disciplines; and ongoing outreach to students to make them aware of the possible career opportunities available in behavioral health. Five minutes isn't long to talk about a topic this large and this complex, but I appreciate the opportunity to share these thoughts and experiences. As the committee moves forward in considering the goals of the Nebraska Behavioral Health Collaborative, I want to assure you that my colleagues and I are all in for the ongoing challenge of

providing and improving behavioral health access across our state. Thank you.

ARCH: Thank you. Are there questions from the committee? Seeing none, thank you very much for your testimony.

CATHERINE JONES-HAZLEDINE: Thank you.

ARCH: Next, testifier, John Mentgen from Regional West.

JOHN MENTGEN: Good morning, Chairman Arch, members of the committee. It's a pleasure to be with you today. I'm John Mentgen, J-o-h-n M-e-n-t-g-e-n, president and CEO of Regional West Health System in Scottsbluff, Nebraska. I would like to recognize and thank Senator Stinner for his leadership for this very important issue in our state. Regional West is an independent community health system. We are the largest employer out in the Panhandle in Nebraska, about 2,000 employees. We have a medical center. It's 188 licensed beds. It's a tertiary center, level II trauma center, and other care services. Regional West also sponsors 8 critical access hospitals in our region, and that is called Rural Nebraska Healthcare Network, and I'm the president of that organization. So we are a multihospital system. We have long-term care facilities, insurance company, a multispecialty primary care physician group, critical access hospitals as part of the network with us. Regional West Medical Center operates an acute care inpatient behavioral health unit. The next closest inpatient behavioral health unit in Nebraska is three hours to the east in North Platte at Great Plains Health. So both of us have a large geography out west that we try to provide inpatient behavioral health services to. We have a critical situation in Scottsbluff and across the state, and it's the access to behavioral healthcare services, in particular the acute inpatient beds, for behavioral health. I would like to bring to your attention the critical situation today in our state and the significant shortage of mental healthcare providers, both on the inpatient and outpatient basis, the significant shortage of mental health services that doesn't meet the demand, and the lack of an adequate mental healthcare provision system that begins to meet those needs for the services. Nebraska and western Nebraska currently has a significant demand for mental health services, and we cannot meet that demand today. There is a critical shortage of mental health beds in many of the areas in the state and in particular in western Nebraska. The challenges to this situation are multiple. However, there are two key factors, I think, that are significant: the lack of trained providers, nurses, techs, and support staff for a mental health program and the lack of inpatient mental health beds that are staffed to meet the demand. So we really need Nebraska to invest in

educational support for mental health providers and support staff to help meet patient demand for services. We need to enhance the educational funding for students so they have opportunity to get the education. We actually need to enhance the opportunities and include instructors and class sizes so we have more people to provide the services. And we need to enhance the clinical learning opportunities for skill advancement. We also need to invest in additional inpatient behavioral health beds to help meet the demands for those services. We could add beds to existing inpatient behavioral health programs, or we could even add new beds in higher demand locations for services. But the addition of inpatient beds must be supported by the availability of mental health trained professionals, or the additional beds will be unstaffed and we won't be able to meet that demand for service. We are currently experiencing a critical mental health situation due to the lack of inpatient beds being available. Lack of inpatient beds being available means when a mental health patient comes to an emergency department at a critical access hospital or an acute care hospital like Regional West, they have to wait several hours before they can have a bed available. That is not the best place for that patient having an acute episode to receive care. The transport, once the bed is located, could be several hours for that patient before they reach the destination and get their inpatient service. And so that's really not an optimal outcome for those patients. Nebraska has a great opportunity to help improve and impact our mental health patients who need access to the care. We have several key healthcare people, educators, providers, legislators, and others who are energized and interested and committed to improve this situation. The risk and ramifications for mental health patients will amplify rapidly if we don't engage and support improving our situation today. The demand for mental health services are going to continue to increase, and the demand for providers, qualified, trained staff and the inpatient beds are also going to continue to grow. So we have an opportunity to improve and have a positive impact for our mental health population. And I'm hopeful you'll support the legislation to do so. Thank you.

ARCH: Thank you. Are there questions? I have one question. I-- I'm not aware. Do you have inpatient psych beds at Regional West?

JOHN MENTGEN: Yes, we do.

ARCH: If you were to expand those, could you staff that?

JOHN MENTGEN: It would be a challenge. No question. And that's why I'm testifying with you today. Staffing the beds are a problem. But if we had the physical beds, if we had the staff, Chairman Arch, they would fill.

ARCH: OK, thank you.

JOHN MENTGEN: Thank you.

ARCH: Seeing no other questions, thank you for your testimony.

JOHN MENTGEN: Thank you.

ARCH: Next, testifier, Katie McLeese Stephenson from NABHO. Good morning.

KATIE McLEESE STEPHENSON: Good morning. Good morning, Senator Arch and members of the Health and Human Services Committee. My name is Katie McLeese Stephenson and that's spelled K-a-t-i-e M-c-L-e-e-s-e and Stephenson is S-t-e-p-h-e-n-s-o-n. I'm pleased to join you this morning regarding this important issue. I serve as the executive director of HopeSpoke here in Lincoln. Our organization was founded in 1949 as the Child Guidance Center. We rebranded in 2018 as HopeSpoke. Our mission is inspiring children and families to move forward. In the recent most-- in the most recent fiscal year, our organization provided services to nearly 1,500 individuals; 78 percent of those were under the age of 19. Since our inception, we have provided outpatient therapy services; and for the last 25 years, we have also provided on-site outpatient therapy in Lincoln's public schools at the elementary, middle, and high school levels. This past year we had services in 23 LPS schools. During the 2021 fiscal year, we provided nearly 10,000 hours of telehealth across all of our programs. From March of 2020 to March of 2021, our outpatient services were provided exclusively through telehealth. For over 25 years, we've provided suicide risk assessments and therapy to youth that are detained at the Lancaster County Assessment Center. For 27 years, we've provided behavioral health services in our extended day treatment program for children ages 5 to 12 who have significant emotional dysregulation issues with 17 to 20 hours a week of individual group, family and milieu-based therapy. For 28 years, we have provided a therapeutic group home for 12 adolescent males from across the state who are referred to us by the courts and juvenile probation for intensive individual group and family therapy focused on their sexually reactive behaviors where they have harmed others. We are the only provider of services in our community at the detention center extended day treatment program and across the state at the therapeutic group home level, specialized in treating males, adolescent males who have sexually harmed others. Today I am representing the 52 behavioral health organizations, large and small, rural and urban, that comprise the membership of the Nebraska Association of Behavioral Health Organizations, commonly referred to as NABHO, including Children's

Hospital and Region 3 that were represented earlier. I serve as president-elect of this association. During the last 17 months that the pandemic has impacted our lives, we across NABHO, have worked to provide uninterrupted behavioral health services to the thousands of Nebraskans that live with mental health and substance use disorders. This has required all of us to be innovative as we strive to provide the highest quality behavioral health services while keeping our clients, our staff, and the community safe. Prior to the pandemic, it was thought that one in five of us lived with a mental health or substance use disorder. Since the pandemic, that figure is now thought to be one in three. I would challenge all of us to think that we have all likely experienced some level of anxiety and/or depression since March of 2020. The number of individuals in need of our services have skyrocketed and those that were already in services have had exacerbated needs for their mental health and substance use disorders. Our own organization has seen our outpatient waiting list grow from an average of 30 most years to a record high of 170. The average time between an individual experiencing mental health and substance use disorder symptoms and seeking services is eight years. By the time someone reaches out for services, it's critical that our service system has the capacity to respond. In Lincoln, many people are waiting up to six months for services. That's why LR143 is so important. Across all sectors, there's a critical shortage of workforce. This is especially evident in behavioral health. Our dedicated staff are underpaid for their important work. Many of our organizations have-- have seen growing turnover. At HopeSpoke, we experienced nearly a 50 percent turnover of our therapists that were providing school-based services this last year. We started the year unable to work with established clients in many schools. To combat the workforce issues, our organizations have increased staff salaries to retain our talented professionals. We have also given hazard pay and hiring bonuses. And we have continued to give our staff salary increases to hopefully keep up with inflation. That is all at the time that our revenue has remained relatively flat. I see that I'm out of time so I'll conclude. I would just say that in my nearly 40 years of providing services to children and families through the state, through the judicial branch, and through the nonprofit sector, I think this is the most challenging time that I've ever experienced. And LR143 provides a great opportunity for innovation and can allow us to have a more robust and effective behavioral health system for Nebraskans. Thank you so much for your work and I'd be happy to respond to any questions that you might have.

ARCH: Thank you. Are there any questions? Senator Murman.

MURMAN: Thank you. Senator Arch. You mentioned that you have school-based mental health services. How does that work? Does school personnel recommend the services to certain students and then they're referred by their parents or just exactly how does that work?

KATIE McLEESE STEPHENSON: Yeah. It-- it can happen in a variety of ways. A student can be referred by school personnel. And then, as you stated, of course, the parent would need to give permission for that young person to be seen in services. Sometimes students go to their counselors and say, I need therapy and we get the referral that way. Sometimes we have parents that call us and say, my child needs therapy. And as we're talking with them, we realize, oh, we're at Elliott Elementary School. Would it be more convenient for your family if your son or daughter was seen during the school day? Because one of the things that we find, as I think Dr. Vance mentioned earlier, is the no-show rate is less when you're already in school. And how we structure it is we're in a school at least two days a week. So if we're there Monday, Wednesday, and Johnny is sick on Monday, we can see them on Wednesday. And so that's really important. And for some families, they would not refer themselves to a mental health clinic, but school-based feels better because everybody goes to school. It's a universal setting. And so while they might not walk through our doors at 2444 O Street, they are willing for their child to be seen in school. And also they may be juggling three jobs, don't have reliable transportation, have four children; and to get to another appointment after their workday and the school day can be really challenging. So school-based services have a lot of benefits.

MURMAN: Could I ask, so the parents are always notified if--

KATIE McLEESE STEPHENSON: Yes.

MURMAN: Sometimes notified and sometimes the parents actually do the referring.

KATIE McLEESE STEPHENSON: Yes.

MURMAN: But their own parent-- parent or parents.

KATIE McLEESE STEPHENSON: It's a legal requirement to provide services to a minor child to have consent from their legal guardian. There are instances where it's a crisis situation and we need to provide services and we will do so and then let the parent know after the fact. You know, if a child is experiencing a mental health crisis in one of the buildings that we're in, we can work with that child based on the crisis. But before we would do any ongoing services with them,

we would need their parental or guardian permission. And sometimes that's the state in Nebraska, sometimes that's their probation officer in addition to their parents. So there's a lot of different possibilities of that.

MURMAN: Thank you.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for your testimony today. You mentioned the-- that your services, you provide services in the community detention center.

KATIE McLEESE STEPHENSON: Yes.

M. CAVANAUGH: Could you specify what that is or where that is?

KATIE McLEESE STEPHENSON: Yes. So that is out near the prison. It's the youth detention center, Lancaster County Youth--

M. CAVANAUGH: OK.

KATIE McLEESE STEPHENSON: --Assessment and Detention Center. And we were asked to start providing services over 25 years ago after there was a completed youth suicide in the facility.

M. CAVANAUGH: OK.

KATIE McLEESE STEPHENSON: And so we provide a suicide risk assessment within two hours of every young person coming into the facility. And then we are available to provide brief therapy to the youth while they're at-- while they're detained.

M. CAVANAUGH: And so you provide therapy for adolescent males that have sexually harmed others. Do you do any work out at Whitehall?

KATIE McLEESE STEPHENSON: Yes. We've been-- we've been working on a consultation basis at the request of the Department of Health and Human Services with the staff and administration at Whitehall. Our services are very focused on trauma-based therapy. And we are community-based in that our-- our group home is in the middle of a neighborhood. We scoop snow for the neighbors. We take them cookies. We help mow lawns. We-- and so we work really hard to establish those relationships and we're considered a step down from that level at Whitehall that's 40 hours a week of active treatment. We provide 20 hours a week of active treatment. But essentially we are serving many of the same youth. And in fact, there are young people that are

referred to that program that are not accepted into services, but are accepted into our program.

M. CAVANAUGH: So youth that are sent to Whitehall when they are being discharged,--

KATIE McLEESE STEPHENSON: Yes.

M. CAVANAUGH: --is there a partnership there?

KATIE McLEESE STEPHENSON: Yes. We often receive referrals from the Whitehall program and the consultation relationship that we've had over the past year, our clinical director and assistant director have been going on to the Whitehall campus, either in person or through Zoom on a weekly basis and helping to staff those young people that are there. My understanding right now is they only have five youth at the facility, but we've been involved in weekly clinical consultation. And so that's been great because we know the youth, we know their circumstances. And so that transition and discharge to our program can happen very seamlessly.

M. CAVANAUGH: I have just one more question. You also mentioned eight years of between experiencing a mental health and substance abuse disorder--

KATIE McLEESE STEPHENSON: Yes.

M. CAVANAUGH: --and seeking services. Is that-- is that because they-- the individual is not seeking services or that they haven't been identified as needing the services? Or is that because of a gap of services?

KATIE McLEESE STEPHENSON: Senator Cavanaugh, I can-- I would say it's maybe all the above.

M. CAVANAUGH: OK.

KATIE McLEESE STEPHENSON: You know, I think if we think about ourselves and we have something going on physically, it likely wouldn't take us eight years to seek services from our primary care physician or whomever. But there's such a stigma with mental health that although I think-- I think that's one of the shining lights if there, if you-- if you will, from the pandemic is it's helped all of us to know that mental health is real and that we all experience mental health concerns. But I think someone might be having concerns or issues, but they might not recognize it as a mental health issue.

And so that primary care physician or provider is essential in that piece because, you know, a patient might come in to them and they have a lot of somatic complaints. And-- and after they've ruled out X, Y and Z physically, if they're attuned to mental health issues, they can make a referral or a suggestion that perhaps that might be helpful to that individual. But then it takes that individual-- individual to make the call. It takes that parent, if it's a minor child, to make-- get that arranged and then it takes an individual following through. And then on the other end of the phone, when you finally make that call and in some places you're told, well, we can get you in in six months and you're there, you're ready, that-- that isn't good enough.

M. CAVANAUGH: Thank you.

ARCH: Other questions? I see none. Thank you very much for your testimony.

KATIE McLEESE STEPHENSON: Thank you.

ARCH: And Dr. Marley Doyle from UNMC.

MARLEY DOYLE: Good morning, Chairman Arch and members of the Health and Human Services Committee. For the record, my name is Dr. Marley Doyle, M-a-r-l-e-y D-o-y-l-e, and I am an adult psychiatrist and the current director of the Behavioral Health Education Center of Nebraska, or BHECN. Thank you, Senator Stinner, for introducing this interim study. And thank you for including BHECN in the working group as we can come up with ideas to examine the behavioral health service delivery in the state of Nebraska. Nebraska will never have enough behavioral health providers and has never had enough behavioral health providers. BHECN does a workforce data analysis every two years, and we see this again and again where we are improving, but we will never have enough. In fact, 81 of our 93 counties are designated as mental health shortage areas; and this problem, as you might expect, is even more dire in our rural areas. And as we heard today, we expect this problem to get even worse with the pandemic as rates of depression, anxiety, and substance use disorders increase. So we need behavioral health providers more than ever. At BHECN, we have a mission to recruit and retain behavioral health professionals across the state. And we have been around for the past decade and have really made an effort to provide training opportunities for students interested in behavioral health, provide mentorship opportunities. We provide free continuing education for current behavioral health providers, as well as networking opportunities for providers in rural areas, among other things. But those are kind of our main buckets, if you will. And you know, we have been tracking this data for the last 10 years. According

to our most recent survey data, the number of behavioral health providers in the state has increased by 40 percent. So we are very proud of this fact and we do not intend to stop there, however. We also know that we have not done this work alone. And I think part of the reason that BHECN has had success is because we have very strong relationships with stakeholders across the state. So today I would like to explain to you a few of our really successful collaborative programs and our plans to expand on those programs, to continue to grow the behavioral health workforce so we can meet the needs currently, but also the expectation of needs that we will have in the future. So one thing that we've heard a little bit today is about the hub and spoke model. So this idea that we have kind of a central hub and then we have spokes that are in different areas across the state to meet the needs for those specific communities. Beth Baxter mentioned how diverse our state is, and it's absolutely true. The needs that we have for behavioral health providers in Omaha are very different than the needs that we have in Scottsbluff. And so in order to address this, one thing that BHECN has done that's been very successful is to come up with satellite sites. So BHECN Central, I guess, is founded-- was founded at the University of Nebraska Medical Center in Omaha. And we have developed two satellite sites over the past decade. The first one was developed in Kearney. And so this was about five years ago. We developed BHECN Kearney, which is located in the University of Nebraska-Kearney. And two years ago we expanded to BHECN Panhandle, which is operated out of Chadron State College. Both of these satellite sites operate independently to meet the needs of the community and the academic institution that they work for, but also operate under the larger BHECN mission. So we-- they come to our meetings. We have a shared strategic plan and goals, but then they have the independence and freedom to use their funding and come up with programming that makes sense for their area. So, for example, BHECN Kearney did this, well, they've done a lot of neat things. But one thing that they did last year was work very closely with UNK to develop a behavioral health minor. And this is open to all undergraduate students. And you can do this minor in combination with any major that's chosen. And this has been a tremendous success. Students are very interested in this. And we've seen over a hundred students so far that have signed up for this minor and not all of them are behavioral health majors. So we think that this is a really promising program that could maybe be implemented in other academic institutions. We would like to expand this model. We have in the works plans to expand to a BHECN Wayne. But we also see a role for expansion to BHECN Scottsbluff, BHECN North Platte, as well as other areas. We want to mirror this to pair with the behavioral health regions because that model has worked well for service delivery. And we think it could

also work well for workforce development. Another hub and spoke type program that we've implemented is an academic network. And this is something that we call the Nebraska Behavioral Health Education Partnership, or NeBHEP. And this is a consortium made of the 18 behavioral health graduate programs across the state. And what we've done is bring this group of education leaders together. We meet on a quarterly basis. We have a conference. And we get them all together to talk about creative and innovative ways to work with students and really shore up the career pathway. And so there's been a couple of really neat programs that have come from this consortium. So we have developed a student advisory board from this partnership and now we have direct student input on development of our programs, which is invaluable. We've also developed a BHECN app for students so they can get on, this will be launched in the winter, but they can get on, find a mentor, network with each other, take a Career Pathways quiz, and figure out what career fits them best. And this-- this is all directly because of this consortium. So we would also like to expand this. We're currently in the process of expanding this to nursing programs. And so we are calling that NeBHEP Nurse. And there's another interim study going on right now looking specifically at the nursing shortage. But it is a very real problem that has limited a lot of acute care settings in the ability to take patients. So we are working on that from the workforce development perspective. But we also want to expand to undergraduate programs, too, to make sure that we are reaching students as early as possible.

ARCH: I'm going to have to ask you to wrap up your-- your comments.

MARLEY DOYLE: Yep. Yep. So there's a lot more that we could talk about here today, and there's a lot more that's in the written testimony that I'll just ask you to refer to for reference. But we are very excited to be part of this-- this idea and this think tank and want to take the opportunity to answer any questions or concerns you might have.

ARCH: Thank you. Are there questions? Senator Walz.

WALZ: All right. Thank you. Thanks for coming today. In your outline, you talk about a behavioral health model, which you call BHOP.

MARLEY DOYLE: Yes.

WALZ: And I was wondering if you could elaborate or talk about that a little bit more.

MARLEY DOYLE: Yes. So there's a program in existence right now that's run out of the University of Nebraska system, which is called RHOP, the Rural Health Opportunities Plan. And essentially what this does is identify students in high school who are interested in rural health careers. And so they apply to the program and get a free ride to either Chadron state or to Wayne State. And I mean, you have to meet-- it's a competitive program. You have to be a good student. And so students that get in have their tuition covered and then if they continue to meet a certain GPA, they get automatic acceptance into one of the University of Nebraska Medical Center programs. So this could be nursing school, allied health professional, medical school. And then they train there and then they don't have a requirement to go back to rural areas because that's very difficult to implement. But 75 percent of them do. And so that's really been a striking number to me. And I think it just goes to show that people tend to stay where they are from or they want to. And if they have training opportunities to do so, then they will. So we would like to replicate this and do a behavioral health opportunities plan where it would be a very similar model, except the students would have automatic acceptance into one of the behavioral health graduate programs. And we would like to pilot it first at University of Nebraska-Kearney because we have the infrastructure and connections there and think that would be a nice opportunity for students to be able to train in central Nebraska.

WALZ: That's awesome. Thank you.

ARCH: Senator Murman.

MURMAN: Thank you. I'm not sure how well you can answer this question, but everyone has talked about the shortage of healthcare providers and especially behavioral healthcare providers in the state. With the vaccine mandates coming out, how much do you-- how much of an effect do you see that having on the shortage of healthcare workers?

MARLEY DOYLE: Oh, gosh. Yeah, I'm not sure I would be the best person to answer that question. I think that it's a concern. But I think that as far as the problem goes, from our perspective, the number is more related to having enough students that are coming into the pipeline and retention is always something that we're looking at. But I think if we can get more students to kind of enter, I think that's where we're trying to focus our efforts, because it seems like that's where the biggest payoff is or the most success we've had, I guess.

MURMAN: Thank you.

ARCH: Any other questions? Seeing none, thank you very much for your testimony.

MARLEY DOYLE: All right. Thank you.

ARCH: That will include-- conclude the invited testimony for LR143. Senator Stinner, you're welcome to close.

STINNER: Thank you, Senator Arch. First of all, I want to thank the testifiers for taking time out of their day. If you've noticed, there's three of them from a long way away, western Nebraska. So I want to especially thank them for-- for coming in. I can tell you it's one day in and one day here and one day back. So that's quite a-- quite a commitment. And it's a commitment because I think this is important. I think as legislators, as decision makers, we have to define a problem and do we have a problem? And obviously, yes. And I think everybody understands. Now in the priority of things, where does this problem fall? And this is something that I deal with from the appropriations side. Mental health and behavioral health, I think, is either one or two of the biggest problems we have in the state. And I think you've heard a lot about the fact that we're short of workforce. And so we need to continue to work on the workforce side of things. And that's one of my takeaways from talking to the folks that-- and we had three or four Zoom meetings. So I got a really an education, I guess, for lack of a better word, and what we have available in the state and what we don't have and what the voids are in our state. And as you go around regionally, there are specific needs. There is, I can tell you in western Nebraska, for example, I think Regional West Administrator John Mentgen talked about the fact he's 100 percent full all the time in his acute beds. So is Kearney, so is North Platte. But a lot of that has to do with workforce. Can we build the workforce around that? Can we build some more beds? I did find out from the Hospital Association it's $265,000 to build an acute bed. So that's capacity. And, you know, and when you look at mental health, there's a spectrum of things that acute care is at the top of that. It has specialized care. Do you think that there's parts in the state of Nebraska that are going to be adequately staffed for psychologists and psychiatrists? The answer really comes back is no, not right now. So what's the answer? Do you put somebody at the top to coordinate a BHECN who has kind of a structure already in place? Do you create a spoke and a hub, a hub in different parts of Nebraska because of the similarities, the voids there and leverage off of a Boys Town, Children's Hospital? Because Boys Town has 13 psychiatrists. Western Nebraska has zero. We got two slots open, but that's a revolving door. And I think I've talked about that from time to time. So does this

make sense? Is there dollars that we can provide for BHECN to organize something along these lines? Is there dollars we can provide as a grant program for acute beds? Are those deliverables that we can do within the Legislature? Can we do a BHOP program? Can we also do some kind of expanded loan program for forgiveness if you go to rural Nebraska and fulfill your obligations there? That's always something that we just put extra dollars into those, by the way, but expand these paid internships I think you heard about? Now, it's costly to bring Ph.D. students, but they provide you manpower. They provide capacity. Maybe that's some of the answer. Maybe that's a deliverable that we can as legislators do. So that's, I guess, what-- what I'm trying to get through on the LR is the education piece. Then we got to sit back and say, what's deliverable, what isn't? And if this is a top priority, which in my estimation it is, then we need to do something about it. ARPA funds might be an answer to that, at least on a temporary basis, but on a continuing basis comes back to some level of appropriations. And I don't know what those numbers look like yet, but we do have an opportunity. And so you may see something as we move to the next-- next legislative session concerning this as far as in our request, as well as maybe Appropriations request as well. I haven't formulated all of that. This is an area that since the beginning, since I started at the Legislature has been an area of interest for me, mental and behavioral health. Actually, we started Panhandle Beginnings. It's actually financed by the Sherwood Foundation right now. And it's a day center for kids that are in school and normally you'd expel. They got behavioral problems, get them out of here, but they need clinical help. So this is a day center that they can get their clinical help. But there's an educational component to that keeps them age education eligible. So if they're out of school for 90 days in this-- this environment, they get the clinical help that they need, but they also get the educational piece so that they don't fall behind. So that-- that was maybe a pilot program, if you will. We'll see how it evolves. It's got tremendous support locally. And I have talked to WNCC provides a two-year program. This is the workforce possibly for the acute care help that fills the network force. I've also talked to the high school, put together a career academy lane for behavioral health, and they're all excited about getting that done. So these are things that you can talk to-- talk to people at the local level, at your own local level about getting an interest in behavioral and mental-- mental healthcare. So that's-- that's enough of my sermon for today. I've got another LR and I'm running out of time as well so.

ARCH: Are there questions for Senator Stinner? Seeing none, thank you very much. And this will close the hearing for LR143. And if Senator Stinner is ready, we will open the hearing for LR163.

STINNER: Thank you, Senator Arch. Good morning. Members of the Health and Human Services Committee, for the record, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r, and I represent District 48, which is all of Scottsbluff County. LR163 is an interim study which examines postacute placement challenges in Nebraska's healthcare system. What we've attempted to look at are current barriers to timely placement to better inform future legislative or administrative actions to improve the transition to postacute care for patients in Nebraska. Following a hospitalization for injury or illness, many patients require continual medical care, either at home or in a specialized facility. Postacute care refers to a range of medical care services that support the individual's continual-- continued recovery from illness or management of a chronic illness or disability. The transition over to postacute care remains a significant challenge-- transition over the postacute care remains a significant challenge, especially for wards under the state, with the Office of Public Guardian, some of whom are on a waiting list. Patients with complex problems result in extended labor intensive discharge planning, long lengths of stay and increased costs to the state and our hospitals. Barriers to timely postacute placement are many. Many wards of the state need postacute placement or assistance, but face significant financial barrier to discharge. In some cases, there's no payor to cover the care-- for the care, or they are placed on a waiting list pending a payor source delay-- delaying much needed care. In other cases, there's significant legal barrier to discharge. Some patients have no legal guardian or power of attorney, yet these patients still need care. However, the Office of Public Guardian has no further capacity to serve wards of the state in postacute care. Additionally, some of the patients needing care are either not a citizen or need to be discharged to another country, or the patient remains unidentified. Other barriers that have presented themselves include either competency or family barrier to discharge. In some instances, the patient is either not competent due to mental illness or is in question. In other cases, the patient is not compliant with the discar-- discar-- discharge plan, putting their care in jeopardy. Other instances have shown family not to be a-- not to be cooperative with the discharge planning. Behavioral health barriers to discharge is also a present problem. Some providers do not have services for mental health or addiction treatment, which is common among wards of the state. In other instances, providers are not properly equipped to provide the type of treatment, making them noncompliant to provide-- to provide care. Other discharge facilities and services will not take some patients due to mental health and addiction issues. The Office of Public Guardian also reports an average ratio of 20 cases per multidisciplinary team member. During the most recent report period, November 1, 2019, to October 31, 2020,

the Office of Public Guardian operated at capacity in many service areas and referred 66 cases to the waiting list. As reported in previous years, the Office of Public Guardian has experienced difficulty in receiving updated guardian ad litem reports for information unique to the Office of Public Guardian waiting list cases and it remains a serious issue. Updated information provides the office in making the level of need determination on who is most at risk and most in need of services. Behind me will be some testifiers from UNMC and the Office of Public Guardian to lay out the difficulties experienced on the ground. I appreciate your attention to this critical issue as we look at how to best serve those most in need. Thank you and welcome-- I would welcome any questions. And I cannot stay for closing so.

ARCH: Are there any questions for Senator Stinner? Senator Walz.

WALZ: Welcome, Senator Stinner. Thanks for coming.

STINNER: Yes.

WALZ: And maybe you want me to wait-- wait on this question, but you talked about the inability to receive postacute care after discharge. Do you want to elaborate a little bit on that or do you-- would you like somebody else? I'm really concerned about the care and them going back into school without any--

STINNER: Yeah. UNMC and the testifiers in back of me--

WALZ: OK.

STINNER: --will give you a really good idea of what that looks like--

WALZ: OK.

STINNER: --and what that's all about.

WALZ: All right. Thank you.

ARCH: Any other questions? Seeing none, thank you very much.

STINNER: Thank you.

ARCH: First invited testifier, Andrea Lonowski.

ANDREA LONOWSKI: Can you hear me OK? Good morning, Chairman Arch and members of the Health and Human Services Committee. Thank you for holding this important hearing today. I am Andrea Lonowski, spelled

A-n-d-r-e-a L-o-n-o-w-s-k-i. I'm the care continuum director for Nebraska Medicine. Nebraska Medicine is a nonprofit integrated healthcare system affiliated with the University of Nebraska Medical Center. I'm also testifying today on behalf of Nebraska Hospital Association. This interim study is focused on the postacute placement challenges Nebraska Medicine and hospitals across our state are facing. These postacute placement challenges continue to be compounded during COVID-19. Nebraska's healthcare system needs structural changes to make sure that together we are treating patients in the right care setting at the right time and getting the most of the healthcare dollars. Annually, Nebraska Medicine experiences about 14,000 avoidable hospital days. These are days where patients stay after they are ready to discharge-- to be discharged to a more appropriate level of care, postacute care because of discharge challenges. These delays cost our health system alone over $18 million a year. Given our healthcare-- given our average length of stay these past few years, that ranged between five and a half to six days. These 14,000 avoidable days equals approximately 2,300-plus patients we do not have the capacity to care for each year in the acute care setting. In these situations, we are inefficiently using our healthcare dollars and patients are not in the care setting that would best serve them. Within these avoidable days I mentioned previously, are days accrued because of our complicated to discharge patients. These are cases that need our attention and state action. The average length of stay for Nebraska Medicine patients considered to be complicated to discharge is over 60 days. And we recently had a case where a patient was with us for 416 days. There is an abundance of literature that outlines the consequences for patients with prolonged extended stays, such as increased risk of hospital acquired infections, pressure ulcers, decreased mobility function, increased problems with sleep patterns, and social-- social isolation for long periods of time. I want to discuss some of our biggest challenges in discharging these patients when they are medically stable. One of the most time-consuming challenges is discharging a patient whose medical condition has resulted in a prolonged or permanent change in their capacity. These patients often require a guardian for medical decision making, completing payor source documentation, and/or disposition placement approval. My discharge team will initially complete an extensive search with the family or close friend to take on this role. But when no one is found, a guardian must be appointed by the cour--, the court or a public guardian. Once the initial process has started and a patient is accepted by the Office of Public Guardian, they are frequently placed on a-- on their waiting list for assignment. When a guardian has room to take another client, the Office of Public Guardian will prioritize who receives the next guardian off that list.

As a result, some of our more stable patients who continue to have no capacity to make decisions could remain in the hospital on the list longer than others that are prioritized to the top. You'll hear more from the Office Public Guardian office today. Another challenge surrounds postacute placement for specific populations such as undocumented residents and individuals with criminal histories. When undocumented residents are admitted and it's-- and if it is foreseeable that they will require postacute needs, we immediately refer them to the Immigrant-- Immigrant Legal Center to determine if there is a path to citizenship that converts to a payor source. Due to the lengthy process and frequent determination that no payor source is available, these patients typically rehab at our hospital until they can return home with little to no support. Patients with criminal histories such as sexual assault are often not accepted by any postacute facility due to the safety risks that they take on themselves. So they end up usually, these patients stay extended stays at Nebraska Medicine. Payor sources and processing time for urgent developmental disabilities determination is frequently a challenge. We have seen an increasing number of young adults that are not connected to developmental disability services who are brought to the hospital due to having more needs than their family can address, especially behavioral needs. This process requires the hospital staff to work with the family or guardians to obtain background school information, past medical records, and complete applications for DD services before a decision is made. If they qualify, then it takes additional time to determine the level of services they qualify for, identify the location, and if there is an availability in that location. We have had patients admitted and hospitalized for over one year awaiting this process. Everyone can agree that the inpatient hospital environment is not the appropriate home for these young adults with no acute medical needs. If there was more time, I would discuss the challenges we face with medically complex patients and placing them in postacute facilities that are challenged with taking these patients on. Or I'd talk more about individuals with behavioral health issues that do not fit the criteria for inpatient psychiatric placement, but they're too resource intensive for the standard postacute care facility. Because of these challenges, I would request that you consider, number one, increasing capacity for the Office of Public Guardian by increasing their funding and look at any potential streamlining for their overall process and their needs. Number two, evaluate the process for developmentally disabled patients that acutely need access to services. Number three, designate funding for postacute facilities to support specialized training for medically complex patients and cover expenses necessary to care for them appropriately. And when I say that, I mean equipment. Number four, utilize innovation to design

postacute facilities for special populations and no payor sources. I'd like to thank you for your time and I'm open to any questions.

ARCH: Thank you. Are there questions? Senator Hansen.

B. HANSEN: Thank you, Chairman Arch. Thanks for your testimony, appreciate it. In your slideshow that you provided, your slides that you provided here on page 3, you have "Barriers to Discharge - Legal." You have guardianship, undocumented residents, criminal history. And I think you touched on each one of those a little bit. In your opinion, what percentage would you say each one of those is when it comes to the problems that you're seeing? Is most of it guardianship? Is it most undocumented residents? Is it mostly criminal history? [INAUDIBLE] giving the recommendations on maybe where we should kind of focus our attention and so--

ANDREA LONOWSKI: Right, right.

B. HANSEN: --I'm curious to know in your opinion which one's worse.

ANDREA LONOWSKI: Terrific question. I wish I could give you exact percentages. I can tell you that the numbers for guardianship and undocumented residents, well, all of them are smaller compared to the bigger picture for us, but they're the ones that acquire the most days. So when I talk about the guardianship, we tend to find that it takes us three to six months to get those particular patients that need a guardian a placement. And that's because usually it's not just a guardian problem. And there's other things we are waiting on actually, signing them up for their payor source. But you can't do that till they have their guardian. We can't move them out of a facility until they have their guardian. Then you go through this next step. So usually our complex patients have three or four things going on with them. So it's kind of hard to say, oh, this is the percentage you should focus on, the higher percent, because all of them are smaller numbers to our bigger picture, but they take up most of the days if that makes sense.

B. HANSEN: It does make sense. It's not so much on the treatment end like you might see with more complex patients. It seems like it's more on the caretaker end.

ANDREA LONOWSKI: It's-- it's, yes.

B. HANSEN: And what we do with-- do with them after we have taken care of them and done our job and so I think--

ANDREA LONOWSKI: Within our job--

B. HANSEN: OK.

ANDREA LONOWSKI: --within the acute care setting.

B. HANSEN: Yeah.

ANDREA LONOWSKI: Then we're having trouble transferring them to a postacute setting because of all of these difficult challenges.

B. HANSEN: OK, all right.

ANDREA LONOWSKI: And that's what racks up those avoidable days--

B. HANSEN: That makes sense.

ANDREA LONOWSKI: --for us.

B. HANSEN: Yeah, OK. Good.

ANDREA LONOWSKI: That we can't treat other patients because they sit in the beds.

B. HANSEN: OK. And there's nowhere like a state facility you guys can transfer them to like a-- like--

ANDREA LONOWSKI: Well, if they need a guardian, we need permission from the guardian to actually transfer them. So they have to sit in the hospital until we actually get a guardian, a public guardian, if there's no family or friend that can step up to that, to that role.

B. HANSEN: OK, good, appreciate it.

ANDREA LONOWSKI: And please keep in mind that we do evaluate their capacity on a routine basis in hopes that maybe it does return and they can make these decisions on their own. But that's pretty rare.

B. HANSEN: OK, thank you.

ANDREA LONOWSKI: Um-hum.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

ANDREA LONOWSKI: Thank you.

ARCH: Next testifier, Mel McNea from Great Plains Health. Morning.

MEL McNEA: Good morning, Senator Arch and members of Health and Human Services. I've got information both on the behavioral health perspective of discharging to postacute care and also just-- just some of our routine discharges each day. Great Plains Health is-- I'm sorry. My name is Mel McNea, M-e-l M-c-N-e-a, and I'm chief executive officer at Great Plains Health. We service an area about 17 counties in west central Nebraska and eight counties in northern Kansas. We have a 116-bed acute center with a 19-bed psych center. We work closely with our critical access partners in our area of the state. And one of the unique things that we do is called an interdisciplinary team meeting, which I participate every five weeks. We go for a whole week, seven days a week. We talk about every single patient in the hospital and we look for barriers for discharge. The three I really want to focus on and Leah Wescoat, our case manager, will follow up on some, too, is the current process that we have in the state-- in the state for PASRR screening. Its P-A-S-R-R and that is a screening before people are discharged, are sent to nursing homes or long-term facilities. That process, there's significant delays in us getting the results. So we end up sometimes keeping patients five to ten days unnecessarily because we're awaiting results from the PASRR screening. Probably a little more inefficient for western Nebraska than the eastern part of the state, but that process, a similar process in another state, adjoining state, is a very quick process to go through. I've often challenged why our psychiatrists at our institution couldn't do that evaluation right on-site. We can get those patients discharged to the nursing home or the long-term care facility. And I've always been told it's a conflict of interest. And my question is why? They treat other patients. They give other professional diagnosis. Why can't they be a part of that process to improve it? If you take a look at, and I'm being kind of conservative, about $2,500 for room and board for one extra day and you're talking five to ten patients are five to ten days. And it is a very common occurrence, I'd say probably four to five times a week we encounter that in our interdisciplinary team. The other discharge problem for us is the guardianship program for Nebraska. We have one individual in North Platte that is caretaker for 60 patients. When we ask for direction or ask for discharge, that individual can sort of push aside our desires and work on their own time frame. So we end up holding patients again in our hospital waiting for that guardianship or that guardian to be-- work with us. I think the guardianship program in Nebraska needs to be looked at. Even the state shared some information with us that even some of the guardians have been charged with criminal activity or theft of the people they're taking care of and are still appointed as guardians in our state. That came from the state of Nebraska. The final challenge I'd speak to regarding strictly just routine patients

for us is COVID-19. Right now, there are-- it's probably been most severe time in clinically as far as discharging patients, not only because of staff shortages, but the staff shortages in the nursing homes. Many nursing homes went away from their red zones and that they had set up earlier in the year. So the difficulty now in discharging patients can go up to 10, 14 or 21 days, depending on the rules and regulations that each nursing home has prior to accepting that patient. The other issue that I would share with you is on our behavioral health unit and we have a 19-bed behavioral health unit. We're very, very blessed that we have three psychiatrists and probably the only adolescent psychiatrist on staff in western Nebraska. Enclosed you'll see some graphs that show the violence that is occurring on our unit. The last page of the graph actually shows the assault. And they've significantly gone up during the course of this year, probably due to COVID, but also a little bit of mixture of what's going on with mask wearing, things like that. What we struggle with is patients that need postacute care. When we try to refer those patients to the Lincoln Regional Center, right now there's a waiting list of over 90 patients. The last patient that caused an assault on my staff and also caused about $5,000 damage on the unit itself is because we couldn't transfer that individual. It would be like me trying to take care or do an open heart procedure if I don't have the staff, the equipment to take care of that type of patient. So there's a delay in transfer to the Lincoln Regional Center, which was supposed to take those more postacute care patients from a behavioral health perspective. But right now, their volumes are so high. I would answer any questions that anybody have.

ARCH: Thank you. Are there questions? Senator Walz.

WALZ: Thank you. One guardian for 60 people?

MEL McNEA: Um-hum.

WALZ: What-- can you-- what makes up that population of people there?

MEL McNEA: The population of people is people that are not able to make medical decisions for themselves or decisions, nursing home care or postcare. There are individuals that are-- have been deemed not competent for that.

WALZ: OK, that includes people with developmental disabilities.

MEL McNEA: Yes.

WALZ: OK. All right.

MEL McNEA: Yeah.

ARCH: Other questions? Seeing none, thank you very much for your testimony today.

MEL McNEA: No, thank you, sir.

ARCH: Leah Wescoat from Great Plains Health.

LEAH WESCOAT: Hello, Senator Arch. Thank you for--

ARCH: Welcome.

LEAH WESCOAT: --hearing testimony. My name is Leah, L-e-a-h, Wescoat, W-e-s-c-o-a-t. I'm backing-- I'm a colleague of Mel that just spoke from Great Plains Health in North Platte, Nebraska. I just wanted to briefly touch on a couple more of challenges that we see with postacute discharge. I am the director of case management at our facility and our team works hard every day. As we discussed on the IDT team, we discuss each patient daily and try to speed the discharge as much as we can and provide the safest discharge that we can, but come up against the barriers. A challenge, major challenge that we see is postacute placement challenges with specific individual-- individuals such as sex offenders, patients on dialysis, or morbidly obese patients go into a postacute facility such as a skilled nursing facility. Two specific examples of sex offenders that needed skilled nursing facility or long-term placement. One individual we had at our facility over three months without any resolution. He eventually became critically ill and had to have a surgery and we transferred him out and so we weren't able to ever find him a long-term placement. A second individual we have in our community now that lives in his own residence, which is a hotel room, he's been admitted to our facility numerous times with the need of a postacute placement. But due to his sex offender status within the last five years, there's no facilities in Nebraska that are willing to take him or able to take him because of the laws surrounding that. His last day, he-- we did contact over 100 facilities in Nebraska by individual phone calls and all declined his admission just because of his sex offender status. So there's numerous sex offenders in the community that are aging out and need someplace to go. And until they are disabled and unable to make decisions or unable to move, there's no place for them to go. We have to either hold them in the hospital or discharge them back to their home with home healthcare services, which is usually inefficient. A second discharge barrier that we run into is patients, a very large increase in the amount of Medicare Advantage patients. Patients are able to sign up for Medicare Advantage or straight Medicare. And many

don't know the barriers to Medicare Advantage, which in our-- in the hospital situation causes many delays in discharge because they require preauthorization for the postacute care facility. So the Medi-- Medicaid, Medicare just goes straight into the facility and pays for that. Medicare Advantage plans require preauthorization can-- which usually takes at least three to five days' delay once-- after they've already had a discharge order in order to get that preauthorization to-- from the facility to know that they'll pay for them to go there and authorize that. Medicare Advantage also has restrictions on what services are available, and numerous services require preauthorization and are not able to be used because they won't give that preauthorization. So that is a huge barrier to discharge also. And lastly, Medicaid reimbursement for postacute discharge, there are three levels of discharge or multiple levels of discharge. Three of the top are going to a skilled nursing facility, a long-term care facility, acute care facility, which is a shorter amount of time and an acute rehab facility. Medicaid reimbursement does not recognize LTAC, which is the long-term acute care facilities, and will not pay or authorize for those services. So there's a gap in coverage for patients that need postacute services there. We didn't want to come here today only to speak with challenges, but offering ideas for improvement. As an institution, Great Plains Health is always striving to improve processes to make things better for our patients. Our mission is to put patients first, always. Here are a few ideas we would like to offer as solutions. For the PASRR process that Mel spoke about previously, what we have seen in other states is the removal of the third party. Currently our third party is Kepro. So it's the state that has Kepro do our reviews and that's where we have started seeing delays of that three-- three to ten days' delay in that. So looking at the state, not having a third-party review system. Difficult to place patients: Many nursing homes aren't able to take morbidly obese patients because they don't have the equipment or the staff to manage their care as well as the sex offenders and the PASRR screening patients. We have thought of increasing the higher reimbursements to those postacute care facilities in order to accept these populations, such as dialysis, obese, and sex offenders. Guardianship: We have seen examples in other states of contracting directly with a guardianship advocacy organization. This helps with the direct point of contact, and it builds accountability and the level of screening appropriate for the guardians. This year we did see an improvement in throughput for VA patients within this last year; 72-hour notification line has been established and patients are able to throughput through facilities much quicker. Previously, we're seeing hours of hold time in the ER to be able to get them to the VA center. So that was a good win for the state. Again, as Mel stated, we

appreciate the Legislature for conducting this review and thank you for hearing our testimony. I'm open to any questions.

ARCH: Thank you. Are there questions? Seeing none, oh, wait.

WILLIAMS: I do have one.

ARCH: Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, Ms. Wescoat. We've seen a significant increase in the marketing efforts for Medicaid-- Medicare Advantage programs, and you're talking about discharge issues. But is that giving you other issues with your medical center, with more people coming in with that kind of product?

LEAH WESCOAT: Yes, there's numerous financial issues that are incorporated or found. Medicare Advantage also has to be in network or out of network. So each region has their own specific plan. But if someone transfers in, emergency services are paid for on their plan, but after that, then you see stop in payment from Medicare Advantage plans. And I know when individuals sign up for the plan, it has to be an unbiased person signing them up so there can't be any direction. But there has been a numerous amount of marketing for Medicare Advantage. And this year we saw a huge increase in the amount of patients that have it.

WILLIAMS: I'm just asking that question to point that out to the members of the committee. I've heard from several of my hospitals about that now that Joe Namath is not doing us any favors right now.

LEAH WESCOAT: Correct.

WILLIAMS: Thank you.

LEAH WESCOAT: Yes.

ARCH: Thank you. Other questions? Seeing none, thank you very much for your testimony. Michelle Chaffee.

MICHELLE CHAFFEE: I'm going to-- my name's Michelle Chaffee and I'm the Public Guardian, M-i-c-h-e-l-l-e C-h-a-f-f-e-e. I apologize. My phone went off a little while ago, but I wanted to give you a real-time example of what the issue is. This is not any of the people who are here as far as hospitals. So and I'm not going to use the patient's name. We have a 28-year-old woman who the Office of Public Guardian is their guardian. She has a diagnosis of borderline personality disorder, schizoaffective disorder with bipolar 2

depression, PTSD, anxiety, substance abuse with meth, marijuana. She was a child ward of the state and she was under adult guardianship since she turned 19. So she got out of the foster care system and at 19, got an adult guardianship. Her adult guardian, due to the problems in providing care for her, she ended up withdrawing and we were nominated to become her guardian. She has had-- her trauma screen is that she has been physically, sexually, emotionally abused, neglected. She's had sexual and physical assaults. She's had the death of loved ones. She's been the victim of crime. She's been a victim and a witness to community crime. She's had sanctuary trauma and she has an incarceration of a parent. We've had her since January of 2020. She-- about one year and eight months. In that time frame, we have tried to place her in 20 different placements. Her longest placement was for seven months, and that was because the woman who was married to the director worked in the home and she took her 24/7 Monday through Friday. All day she spent with this young woman and her behaviors were ,because of the attention, were greatly reduced. But in the nights and weekends, she would act out. She has been in Community Alliance. She's been in five different group homes. She's been in Golden Manor, Princess Anne, Immanuel psychiatric unit, International Behav-- Integrated Behavioral Health Services. Bryan West, CHI Bergan, St. Monica's Treatment, Fremont Medical, St. Elizabeth's, Crossroads, A Better Way Therapy, Omaha Insomnia and Psychiatric, and we've worked with UNMC extensively with Dr. Garlinghouse, also Lasting Hope Recovery, and Mental Health Respite. She has been admitted into four hospitalizations for over two weeks at a different time for those four weeks. She's had 28 emergency room visits and which-- in which she had observation. About a month ago, she swallowed two batteries and was taken to the emergency room. And we were not notified, but they did-- they did surgery on her to remove her, the batteries. But they did not make her a inpatient patient. She was under observation status and therefore she was discharged without our permission or really they didn't need our permission because she was under observation to homelessness. It took us a while to find her. Most recently, she took an overdose of medication and she is now finding herself. She has been in the hospital for about a week and a half. They want to discharge her. But as you've identified, we're responsible to try and find her placement and assist with that. And we have denied, and this is one of the issues that a guardian is a good person for the hospitals and a guardian can be a bane of their existence because we refuse to allow her to be discharged into homelessness. So my problem today is what to do with her and how to assist her. Because the last time when she was discharged to homelessness and then she came into contact with the police, the police were so upset at the-- at her condition that they reported the Office of Public Guardian to Adult Protective Services

for not taking care of our ward. So that is just one of my problems just today. So I have one-- I have used up my five minutes. So I want to tell you that I have provided to you written testimony-- my written testimony. I'm sorry I didn't get to share it with you, but I think that was more important. I've also provided you in the-- the first part, a-- the different issues that are challenging to guardianships, both private, public and the problem of the lack of guardianships. I provided you with research based upon different states and different types of solutions that other states have-- have identified. And I've provided you with possible policy considerations to look at that. After five years of being the legal counsel of the Health and Human Services Committee, I do try to bring solutions to the problems. So I'm not here to lobby. I'm not allowed to lobby as a member of the judicial branch, but I'm here to at least provide you with alternatives and options. I have provided you also with six different tabs of information that I think you find information helpful. And there's a summary of that-- of the different snapshots at the end of my testimony. Welcome any questions.

ARCH: Thank you. It's complicated.

MICHELLE CHAFFEE: It is, yes, it's very complicated. And I think that if you take a look just for a minute at the second page at the bottom of where our annual reports, I know there is discussion about our capacity. I don't know if you'd like me to give just a few statements about.

ARCH: Yeah, please do.

MICHELLE CHAFFEE: OK. Since we-- this is from 2020, our ability to have care for people. We have had 705 accepted nominations since we started taking cases in November of 2015. So of those, 249 were accepted from hospitals. So about a third of our-- our individuals do come from hospitals. And we have, during that last year, we had 66 review-- referred to our waiting list, 13 were denied, 11 removed, 11 accepted, and 31 continue to stay there. One of the things that it, just to highlight, is we have a limit of 20 wards per associate public guardian, and that is the national criteria and best practice. And part of why we do that is because if you look at page 32 of our annual report, we served 310 wards in 2020. And of those they had 960 complex issues, 960. And if you look at the-- there, it's in your side pocket here, looks like this. If you open it up and go to page 32, you'll see that those include 226 medical conditions; 37 that were Board of Mental Health commitments; 251 were serious mental health diagnoses; 92 were substance abuse diagnosis; 87 were criminal involvement; 184 were cognitive, usually TBI issues; and 83 were developmental

disabilities. So those 20 are like this individual. I have a great deal of difficulty keeping associate public guardians. In 2018, we had not reached our capacity in regards to the numbers and we were full staffed. We could have taken 340 individuals, but I lost 8 associate public guardians that year. And so from March until the November, I couldn't take any additional individuals. And that capacity issue is based upon most definitely the problem with not being able to find care for our individuals' mental health issues. Mental health issues are also the reason that we have private guardians and family guardians who no longer want to take care of their individuals and nominate us. And it's also the reason that they-- that I have such turnover and the difficulty in finding placement for individuals. The one thing we need the most is trauma-based long-term care. That's a secure unit that is involuntary to the individual. But because they can't make decisions, we are the guardian and we should have the ability to have them placed in a place where they're going to be safe and then have trauma-based care, which usually takes an extended amount of time to work through this kind of trauma, for someone who is-- and that is what we need the most. Instead, they're looking at assisted living. And she'll, that would not be appropriate for her.

ARCH: Are there other questions? Senator Hansen.

B. HANSEN: Like a quick question, if that's OK. You're talking about your biggest need that you're talking about is the long-term involuntary to some extent secured facilities.

MICHELLE CHAFFEE: Um-hum, right.

B. HANSEN: Didn't-- didn't-- didn't we used to have those? Have we gotten rid of those?

MICHELLE CHAFFEE: They were-- they were more of institutional that had like no end in sight and kind of warehouse kinds of situations. What I'm talking about is, is identified care for-- it-- it's-- it's similar in the sense that it's in-- it's secure facility. It's different in the sense that the type of treatment and services that would be provided would be the oversight of the guardian involved with wanting to get the person out into the community.

B. HANSEN: OK.

MICHELLE CHAFFEE: It's-- you'll find that, as most things, 10 percent of the individuals probably cost 60 to 70 percent of the cost. If you would add up the cost of all of these hospitalizations and placements and failed and ER visits, it would be millions of dollars. And she is

no better today than she was when she was 19 years old and came into adult guardianship, because there's just nothing that can, at this point, that can continually be done to meet her needs. We've asked to look at out-of-state placement, but then you have to go through Medicaid managed care to try and get that.

B. HANSEN: OK, all right. Thanks. I was just kind of curious to know your thoughts. Thank you.

ARCH: Other questions? Senator Walz.

WALZ: Thank you. Thanks for coming today.

MICHELLE CHAFFEE: Sure.

WALZ: I think that one of the most important people in a person's life is often a guardian. The gentleman who testified earlier talked about a person, a guardian that had 60 people. What-- what's the current backlog for guardians? How long is it? Do you have a--

MICHELLE CHAFFEE: Oh, I don't. They don't really keep the data. We're really the only people who have data for statewide types of issues. Guardianship, adult guardianship is under the probate court, so it's under the county courts. And so you have, you know, 56 different county courts that have different identification. I can tell you that for us right now, if we have had over 100 individuals that are above of what we can provide services for. We have a natural attrition, unfortunately, either death or termination of guardianship. We've had people who've recovered their capacity of about 25 people a year. So that means that there's 75 people that-- that have been identified to the Public Guardian that would need assistance. It would take three times my staff to be able to get to a point where I could have 100 people at natural attrition to take the additional 100 that come in nominated every year because you could add, you know, enough for me to take care of them next year, you know, 3 more associate public guardians. The next year there'd be another 100 and the next year. So it would take about that amount. I can say to you that we have actually taken a look at some of the data in regards to county guardianships. There are some individuals who have 90 on their caseload. There's some that have 60. The courts just don't have anybody else to pick. So they-- they think at least someone's better than no one. And so that's how we became a part. We had an individual out in Scottsbluff who was guardian for 250 people and she began to steal their money. It wasn't a lot of money. They get $50 a month and she'd take maybe $20 or $30 here and there. And so that's how the

Office of Public Guardian came to existence. We were the last state in the Union to have a public guardianship office so.

WALZ: So the idea of having the same person for 250 people is better than having no one as a guardian?

MICHELLE CHAFFEE: That was the assumption back then. At this point, that's why we were appointed to know that there are individuals that have no one in their lives. And the thing that's been the biggest shock to me is you would think that they were all poor people who were, you know, the bums on the street. And they're not. We've had three attorneys. We've had a judge. We've had multiple teachers. We-- they simply don't have anyone in their life to take care of them at the end of their lives, and they need someone to do that.

WALZ: Can I--

ARCH: Yes.

WALZ: --continue? So with that backlog, how do you determine who-- who gets priority?

MICHELLE CHAFFEE: OK. I would-- my suggest-- my solution to this is, first of all, take a look at what I've identified. We need four different things. We need the ability for people to make plans before they become crises. So we need to have a massive societal recognition that you need to identify who's going to be your guardian or power of attorney or power of attorney for healthcare. Many people get to the end of their life, haven't done that, and there we are. OK. The second thing is that we need to stop-- we need to have enough mental health services that private guardians, family guardians can take care of their loved ones, that they don't just walk away. And so that's the second thing. The third thing is that we need to continue to take a look at you need to make a decision on how the Office of Public Guardian is going to be determined to take cases. Right now, we don't have any priority system per se. We can take anybody from 19 to prior to death. We-- and if you take a look at our breakdown of services, you'll find that we, as I've identified, we have some individuals that have developmental disabilities whose parents have just walked away from it or don't want to be the guardian anymore. They simply want someone else to do it. And so initially we were-- had openings and we'd take those cases. You have to realize that that's something we're more than willing to do. But when you make that decision, those-- right now we have 28 20-year-olds in our-- in our care. They're going to be in our care for 50, 60 or 70 years. So how do you want us to take care of individuals? We're going to, if you look at tab 3, you'll

see that in Nebraska, we're going to go from the-- having 42,000 above 85-year-olds this year to 30 years from now having 103,000, 85 and older. So at that age, 50 percent are disabled; disabled cognitive, Alzheimer's, etcetera. They are going to need guardians in their lives; 50,000 in 30 years. So you need to make decisions about who are we going to serve and how many of the public guardian are you going to provide?

ARCH: Thank you.

MICHELLE CHAFFEE: Yeah.

ARCH: No?

MICHELLE CHAFFEE: Any other? Thank you.

ARCH: Other questions?

MICHELLE CHAFFEE: Right now, we serve the-- in the waiting list, the most-- the most crisis, the ones who are near death, who are Adult Protective Services and identified as vulnerable individuals who have been abused or neglected.

ARCH: Seeing no other questions, thank you. Thank you for your testimony, Dr. Tony Hatcher.

ANTHONY HATCHER: Good morning, Chairman Arch--

ARCH: Welcome.

ANTHONY HATCHER: --and members of the Health and Human Services Committee. I appreciate the opportunity to testify on behalf of acute facilities from across the state of Nebraska and Nebraska Health Care Association. I am Anthony Hatcher, A-n-t-h-o-n-y H-a-t-c-h-e-r. I'm the chief medical officer for Hillcrest Health Services, a certified medical director for five long-term care facilities, as well as a member of the Nebraska Health Care Association. Hillcrest Health Services, a senior living company that currently cares for over 950 seniors in our independent living, assisted living, memory support, and skilled nursing facilities, with an additional 550 seniors cared for through our home healthcare, hospice, and private duty services. All told, we're responsible for the lives of over 1,700 seniors in Nebraska each and every day. Enhancing the lives of aging adults is our mission. State of Nebraska currently has 204 licensed skilled facilities with 15,402 beds and 19 facilities with special care units. The average number of residents per nursing facility in Nebraska is

55, compared to a national average of 85. Primary source of payment in Nebraska for these residents is Medicaid at 54 percent, Medicare is 11 percent, and other payor sources represent 35 percent. Nationally, that breakdown is 62 percent Medicaid, 12 percent Medicare, and 20 percent-- 26 percent other. State of Nebraska has had 34 nursing facilities that have closed since 2015, with 17 of those closures alone in 2019. Over 10 percent have closed in the last several years. We acknowledge that placement of some postacute patients after an acute hospitalization can be challenging at times. But our goal is to always provide the highest quality care while ensuring that they are receiving the right care at the right place. Many of these patients are very medically complex, highlighted by the fact that nationally over 21 percent of all Medicare beneficiaries, just Medicare alone, are admitted to postacute care, are readmitted to the hospital within the first 30 days of discharge. This number even is higher when you look out 90 days posthospital discharge. This is a trend that has not changed, even though several years ago CMS implemented a value-based payment program that financially penalized facilities for not meeting a reduced readmission metric each year based on peer performance from across the country. There are many reasons that we have difficulty accepting these referrals to include the medical complexity of these patients that exceeds our ability to care for them in a safe environment. We don't have the same staffing ratios as an acute care provider, and often our clinical staff do not have the specialized training to deal with many of these complex medical conditions. Other common reasons for difficult placement, many alluded before my testimony today: behavioral diagnosis, lack of a payor source, need for one-to-one sitter, prior sex offender, and individuals that need two-person assist. All these issues are only exacerbated by the chronic lack of staffing that has only been made worse by the current pandemic. Without adequate number of staff, we're unable to educate and train them to care for these medically complex conditions, deal with significant behavioral issues, and provide necessary support for those residents that need one-to-one assistance or two-person assist to prevent falls and injuries, resulting in rehospitalizations and poor outcomes. Once someone is admitted, we are legally bound to ensure the resident has a safe discharge or we are required to keep them until they can-- this can be arranged. This can result in a significant burden for the facility. It's not uncommon for these residents to stay for extended periods of times or become long-term residents, putting significant stress on our staff and performance of the facility. The bright spot in the current pandemic, it has brought acute care and postacute organizations together, as we acknowledge, the care of our fellow Nebraskans does not stop when they are discharged from the hospital or from one of our facilities. A

collaborative approach to care is what results in the best outcome for these patients, along with the reduction in overall cost of care. Expansion of telehealth services with providers and staff who have expertise in their medical condition is an imperative going forward, along with enhanced transfer of real-time medical information so that our clinical decision making in the postacute facilities is done based on accurate and up-to-date clinical information. Investments in education, training, infection control, and electronic medical records is something we would recommend be considered as we move forward with shared outcomes of this interim study. I support and we support the Nebraska Medicine's request as these are needs that need to be addressed; and the request is consistent with our facility administration's request for funding of staff, education, and infrastructure to improve infection control within our long-term care facilities. Staffing is of prime importance to all of us. As without additional staffing, we will not be able to maximize support to the acute care providers to accept these often difficult referrals. Thank you very much. And I'll entertain any questions that you may have.

ARCH: Are there questions? Senator Murman.

MURMAN: Yeah. Is there not going to be a vaccine mandate and how will that affect this lack of staffing you talk about?

ANTHONY HATCHER: I believe there will be a vaccine mandate. I believe that will come out in the next couple of-- the next two or three weeks. I can tell you that many of the organizations that I represent or that I work with, we've all grappled with that. Because we believe that when that vaccine mandate does occur, we will leave some-- some team members and staffing. Our-- our organization, we have focused a great amount of effort around that. We've got over 80 percent of our team members are vaccinated and 96 percent of our residents that are living in our facilities are vaccinated as well. Having had those one-on-one conversations with those individuals, I don't think they will change their mind. So I think some people are very hard and set. So I think we will lose some staff, which will further exacerbate our problem with short staffing and ability to care for people.

MURMAN: Thanks.

ARCH: Other questions? I have one. Senator Hansen asked this question earlier, and that is you listed a number of reasons why you're unable to take patients, referrals. How would you rank those as far as-- as far as what's-- what's-- what's the biggest-- what's the biggest hurdle in those referrals?

ANTHONY HATCHER: I would say probably the two biggest hurdles would be the ability to meet their medical needs.

ARCH: OK because they're medically complex.

ANTHONY HATCHER: Medically complex individuals. We're simply not-- we don't have the staffing or the expertise to take care of some of those. I think some of that can be remedied if we have a closer relationship with the acute care providers in regards to telehealth and help us at least piggyback on that care. I think that would be helpful. Second thing is with some of those medically complex and behavioral issues, they may need to have a one-to-one sitter. We simply don't have the staff to do that or two-person assist. You know, we talked-- somebody talked earlier about morbidly obese people and that kind of stuff. Getting those people moving, getting them moving and going to the bathroom, those kinds of stuff requires a lot of-- a lot of staff.

ARCH: OK. Thank you. Any other questions? Seeing none, thank you very much for your testimony.

ANTHONY HATCHER: Thank you.

ARCH: And Patti Jurjevich from Region 6.

PATTI JURJEVICH: Good morning, Chairman Arch, members of the Health and Human Services Committee. My name is Patti Jurjevich, P-a-t-t-i J-u-r-j-e-v-i-c-h. I'm the administrator for Region 6 Behavioral Healthcare, which includes Cass, Dodge, Douglas, Sarpy, and Washington Counties in eastern Nebraska. I'm here today on behalf of the Nebraska Association of Regional Administrators, which is comprised of the six administrators of the behavioral health regions. So as this, as you're aware, Nebraska is split into six regions for the delivery of mental health and substance use services. State statutes define the regions' responsibility for planning, coordinating, developing, and evaluating the publicly funded behavioral health service system. Regions are local units of government that the Nebraska Department of Health and Human Services Division of Behavioral Health contracts with to engage in planning and service implementation. Each county is part of a region; and as a result, appoints one county commissioner or supervisor to serve on a regional governing board. Those elected officials represent that county and participate in the decision making of the board. The regions use contracts to purchase services from community-based providers in their area and across the state as necessary. So we appreciate Senator Stinner's introduction of LR163 and this committee's decision to examine the issues surrounding

postacute placement of individuals being discharged from hospitals. You have heard from the Office of Public Guardian as well as hospitals who are facing these postacute placement issues. You also heard from representatives of Great Plains Health about the lack of postacute placements. And I'd like to provide the committee with some context from the mental health side. When LB1083 passed 17 years ago, one of the major concerns that many of us had was the sufficiency of beds for those suffering from acute mental illness. During those discussions, there was an agreement that hospitals would contract with regions to care for individuals across the state but there would be a place, a safety net, which hospitals could discharge individuals to, enter Lincoln Regional Center. As part of that behavioral health reform effort, there was a commitment that there would be 100 beds at Lincoln Regional Center for those individuals deemed in need of those services and beds would be allocated based upon the behavioral health region. Further, during the behavioral health reform planning process, regions identified the need for long-term residential resources in our communities and were told by DHHS officials in place at that time that the state would develop these programs. Unfortunately, that was never done. So over the last 17 years, due to court-ordered commitments and other factors, the number of beds at Lincoln Regional Center available for individuals on a Board of Mental Health commitment has declined to about 40 to 50. I will note that the current renovation process and workforce issues at LRC have added to reduce bed capacity at the facility. It is important to note that this is not just a healthcare issue. It is a county correctional issue as a number of individuals are waiting in county jails for court-ordered competency evaluations and restoration. As of June 9, Lancaster County reported that they had 19 individuals in their correctional facility waiting for a bed at the Lincoln Regional Center. These individuals comprised a total of almost 3,500 days in that facility. Douglas County reports there are currently 15 individuals waiting in jail for an LRC bed and wait times in 2021 have been as high as 190 days. This, in our opinion, is unacceptable. Correctional facilities are not the appropriate place to house individuals with acute mental illness. This reduction in the number of LRC beds reduced capacity with other providers in the community due to workforce shortages. And the lack of long-term residential services have made finding postacute placements very difficult. We know our partners in the hospital system are at their wit's end and with good reason. I did want to just stop for a moment and-- and give you a picture of how this looks in Region 6. So there are individuals in psychiatric acute care settings and we recognize we've got some reduced capacity, bed capacity in acute care based on renovations and some workforce issues, too. But individuals, once it's determined that they are appropriate to go to some postacute

placement, if that can't happen, they are remaining in that hospital bed, which means somebody then who needs that bed can't get in there. And so what we see in Region 6 then are folks waiting in the emergency departments for an acute care bed. Monday, so there's a call every morning with the hospital folks and they talk about, you know, how many folks are waiting, what's the capacity, what's the utilization? Monday, 22 individuals were waiting in either an emergency department or a medical bed for an acute care bed. So this is how everything-- this is kind of the consequence of folks not being able to get out of an acute care bed into an appropriate postacute placement. It just, the whole system begins to back up. And it's not right for individuals to be waiting hours or in some cases longer in an emergency department for an appropriate acute care bed. So with that, I have run out of time. There's a little bit more testimony there, but I'll stop.

ARCH: Thank you.

PATTI JURJEVICH: Answer any questions certainly, if you have them.

ARCH: Are there questions from the committee? Seeing none, thank you very much for your testimony.

PATTI JURJEVICH: Thank you.

ARCH: This concludes those who are scheduled to testify, but we want to also offer an opportunity if there's anyone else that would like to testify [RECORDER MALFUNCTION]

ARCH: Well, good afternoon. Welcome to Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County. I serve as Chair of the HHS Committee. You'll notice that we have three members here today from the HHS Committee. I will tell you that one of the things we learned about special sessions is when the Speaker says now be sure and do everything on the same days. We have got meetings happening all around the building right now and some of the members are in those and they might drift in a little bit later. So don't be surprised with that. But we are, we are here today. And I'd like to invite the members that are here to introduce themselves starting on my right with Senator Walz.

WALZ: Hi, I'm Lynne Walz. I represent Legislative District 15, which is all of Dodge County.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36, which is all of Dawson, Custer, and the north portion of Buffalo Counties.

ARCH: Also assisting the committee is one of our legal counsels, Paul Henderson; our committee clerk, Geri Williams; and our committee page, Caroline. A few notes about policies and procedures. First, please turn off or silence your cell phones. This afternoon, we'll be having hearings on nine gubernatorial appointments and taking them in the order listed on the agenda outside the room. The appointee will begin with an opening statement. And after the opening statement, the committee members will have the opportunity to ask questions. Then we'll hear from supporters of the appointment, from those in opposition, followed by those speaking in a neutral capacity. If you plan on testifying, please fill out a green testifier sheet located on the table near the entrance to the hearing room. Hand it to one of the pages when you come up to testify. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last names. This committee has a strict no props policy. And with that, we will begin today's gubernatorial appointments with Georgina Scurfield. Welcome, Georgie. One of my constituents, by the way.

GEORGIE SCURFIELD: Good afternoon, Senator Arch. Good afternoon, Senators. My name is Georgie Scurfield. I've been a social worker all my career. I started out working in central London because I was growing up in the UK, spent 12 years doing that, then married my American Air Force husband, traveled a little, volunteered for a while, and then came to Sarpy County, where we've been ever since for the last 32 years. My work initially in, in Omaha was with children who were part of the system because they'd been sexually assaulted. And I did my master's in social work and did some therapy for three years with children who'd been through sexual assault. I then looked at-- I had been when I first came volunteering as a Court Appointed Special Advocate volunteer because it seemed like it was a good fit to what I knew and, and going to school. And then I did my three years doing therapy. And when the job of running the Court Appointed Special Advocate's program, the CASA program in Sarpy County, became available, I knew that was my place. And for the following 20 years, I ran that program. What I learned there was that child welfare is incredibly complex and incredibly expensive. And there must be ways that we can find to work with families that are more effective and less costly. And one of those, I believe, was having a Court Appointed Special Advocate volunteer, a CASA volunteer, who could get to know those children really well, but wouldn't be paid for that work, would

donate that work. One of the things that was great about it was that relationship that the adults formed with those children that the most important part of their work was that they could see the inside of the child welfare system as ordinary lay people and not as professionals. They could see the impact that was happening with families from a very different point of view from those of us who lived within it had been trained in social work and the law and therapy and other things. And we-- what I loved about the volunteers is that they came in with fresh ideas. One of the main things they taught me was that we have to do work for families that make sense to the family and that we can't begin to strengthen families and help them parent children without really having them engage. So there are some families that come into the child welfare system where really the best thing we can do for the children is to take them out of that family, that those parents have done such egregious things or such-- have such problems of their own that they're never going to be able to parent. But that if we're actually going to help families parent and prevent any future child abuse, we need to engage with families in a way that is helpful and positive and creative and meets them where they're at. So after I retired from my work at CASA after 20 years, I started work with Lift Up Sarpy County, which is a nonprofit that partners with the Nebraska Children and Families Foundation to do preventative work. And in that work, one of the examples I'd like to give you is about what we saw as transportation challenges for families in Sarpy County. In Sarpy County, there are a lot of work opportunities and it's a great place to live, but there isn't a lot of public transport. You need a car to get around. And for many of the families that I worked with, if they lost a job or after the floods a few years back and in Jack Link's where a lot of families were working closed, they needed a car to get to places so they could work in another job. And they had cars that they were buying often from the buy here, pay here places on L Street in Omaha and were paying interest rates that were staggering to us. They were paying 18 percent, 24 percent, 28 percent in order to have a car that worked. So we, in our wisdom, decided we would set up a plan to help families acquire cars. We would teach them about credit. We would help them with payments and how they would manage that. We would look at how they bought a good value car. We would have mechanics available to check out the car. It would take about a six-week program. They'd be committed to coming once a week to learn things. And we thought we had a great plan and nobody came. Nobody was interested because when we asked the families, they said, yeah, but I've got to go to work tomorrow. I can't wait six weeks. I have a family to support. I can't do that. It has to be now. So we had to rethink what we did and address what they actually needed as opposed to what we thought they needed. And that has been an additional lesson

for me. So my interest in the Child Abuse Prevention Fund Board is in how we fund programs across the state that can help families directly be better parents to their children, manage their family finances better, manage their own trauma, which is often what we're talking about when we're looking at families who are not parenting well, and we do it in a way that they can benefit from so that we're not creating things that are not real, that are not accessible to families, that are not useful to families, but we create programs that are truly going to make a difference because families will buy-in. So thank you for listening to me, as you can tell, kind of a passion. I'm delighted by this nomination from the Governor. It's exciting for me and I'm grateful for your consideration today.

ARCH: Thank you. Thank you. Questions for Georgie? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And, and thank you and I just want to thank that Air Force guy that brought you to this country and brought you and your enthusiasm and your interest to Nebraska. So just thank him.

GEORGIE SCURFIELD: Thank you. I'll let him know. Thanks.

ARCH: I, I have a question in, in your CASA experience.

GEORGIE SCURFIELD: Yes.

ARCH: So as you look at the families that we're serving in our child welfare system and, and you're very practical, you want to meet the need to help them, to help them and strengthen that family unit. Top three, what are those, what are those really big needs that you saw in families that, that, I mean, we could be doing a lot of different things in our policies and our programs. But could you share with what you, you observed.

GEORGIE SCURFIELD: I think for me is concrete support. So people have to have enough money to be able to pay the rent and pay for childcare. And so there has to be either available childcare they can afford or most of our families that we were working with in the, in the last few years are working two or more jobs for-- per parent, often four jobs for a family, and then we criticize them for not being able to parent their children well. And because they don't have time, they're trying to earn a living. And if they're only earning $11, $12 an hour, they can't do it. So that would be the first one. We have to have adequate concrete support, which probably means subsidizing childcare or increasing the minimum wage, something that allows them to work and parent their children. And the second one is there has to be support

for those parents because all parents, all of us who have parented know there are moments when you're out of your depth. Somebody says-- a child says something to you or a child behaves in a way that you have no idea how to respond. You're doing the best you can in that moment, but you really don't know. We need to have resources for families so that it isn't abnormal to come and ask for help. What people have become scared of Child Protective Services because they think if I ask them for help, they'll take my kids away. We have to teach people that it's fine to ask for help. I remember when my daughter, who Senator Arch knows, was two months old and I couldn't stop her crying. I put it down in the middle of the living room floor and watched her. But it was a bad moment. It was hard. I remember thinking, I do not know what to do with this baby. Here I am as a first-time mom. We both got through that. A spider crawled out across the carpet. I remember thinking, I don't know know if I'm going to kill that carpet-- that spider before it gets to her or not until a little closer and then I dealt with it and then we were like, OK. Because I really had no idea how to comfort this child. And I think people need to have lots of resources and places they can go to ask. And that's especially true of teenagers. So the first one is concrete supports. The second one is to make it normal for this to be difficult and to allow people with the questions to ask. And the third one is to address mental health, because for many of our parents, they have been through trauma of their own and they are trying to parent without good experience of parenting. And one of the things that happens very often is they will say, I don't want to be the kind of parent my mom was or I don't want to beat my kids like my dad beat me. But when you say to them, what are you going to do differently? They don't know. Because nobody's ever taken them along and walked that walk. And clearly it needs to be happening in high school and early and to allow people those things, those learning opportunities. But for me, those are the three, Senator Arch, that I would-- I'm going to say are important.

ARCH: Appreciate that. That's great input.

WALZ: Senator Arch, can we just keep her?

ARCH: Yeah, got a lot of experience, a lot of experience. Georgie, thanks for being willing to step up again and volunteer your time to--

GEORGIE SCURFIELD: Thank you.

ARCH: --to help, to help the--

GEORGIE SCURFIELD: And thank you.

ARCH: --the people of the state.

GEORGIE SCURFIELD: Thanks for listening.

ARCH: Thank you.

GEORGIE SCURFIELD: Thank you.

ARCH: Is there anyone that would like to speak in support of this nomination, the appointment? Anybody in opposition? Anybody in neutral? OK. All right. Thank you. We'll move to the next appointment. Dr. Nelson. Dr. Nelson. OK, we'll, we'll delay that, maybe he will show later. Jaime Bland. Welcome.

JAIME BLAND: Thank you. Good afternoon, Senator Arch and members of the Health and Human Services Committee. My name is Jaime Bland, J-a-i-m-e B-l-a-n-d, and I'm president and CEO of CyncHealth, which serves the state designated-- serves as the state-designated Health Information Exchange and the Prescription Drug Monitoring Program for the state of Nebraska. I'm here today to provide you an overview of my background and experience as you consider my appointment to serve as the representative for the state-designated Health Information Exchange on the Health Information Technology Board. I am honored to be nominated for this role and look forward to serving. I was appointed to my current position in 2018 and during that time expanded what was then the Nebraska Health Information Initiative, or NeHII, to include three entities: CyncHealth Advisors, CyncHealth Foundation, and the Nebraska Healthcare Collaborative. In addition, we have recently added the Iowa Health Information Network to the CyncHealth family. However, it is a separate entity with an Iowa board-- Iowa-based governance board. Prior to serving at CyncHealth, I've held leadership positions in regional, national, and international markets within both public and private sectors. I have extensive experience in establishing and leading technology, population health, and clinical quality initiatives. My education includes advanced degrees in informatics and a doctor of nursing practice in public health global health nursing from Creighton University in Omaha. My public sector experience began shortly after the events of 9/11 with a move to Doha, Qatar, with my husband and children. From 2002 to 2008, I worked for the U.S. Army as a civilian managing the clinic on the U.S. installation, as well as host nation care coordination efforts for service members and their families and civilians needing care in the host country capital of Doha. Due to my efforts to coordinate care in Doha, I became very familiar with the workings of the healthcare system in the country and was asked to be a part of the Women's and Children's Hospital Bill Project and the National Health Record Design

and Development Initiative for Qatar between 2008 and 2011. Once I returned from my time overseas, I continued my service with four and a half years supporting the Veterans Health Administration, regional efforts in where I was responsible for primary and specialty care transformation efforts, including varying complexities in data, performance metrics, care coordination, and population health. I believe that with over two decades of various complex healthcare roles, public service, and my time with CyncHealth gives me highly in-depth understanding of the operations of Health Information Exchanges, the exchange of health data compliance, state and federal policy regulations, and other technical nuances. This paired with my healthcare provider background gives me the ability to look at the issues from very different perspectives that must be considered as the board begins its work. I thank you for your time and attention and would be happy to answer any questions that you may have.

ARCH: Thank you. Are there questions for Jaime? I have one. I always have questions.

JAIME BLAND: Yes.

ARCH: As you-- I mean, you're obviously going to be very instrumental in the, in the HIT Board and, and setting up, setting up that oversight board. What do you see as some of the challenges, I think, that are going to come to that board? What types of decisions, what types of challenges do you think the, the board will have to, will have to wrestle with?

JAIME BLAND: I think that always the question around research and data and the use of data are always very complex considerations how we manage the data stewardship of the information and the transparency to that use, I think is a very critical component of the HIT Board. I think there's a lot of questions around population health, the health of Nebraskans by county, by statewide views and looks that we certainly can achieve. But the transparency in that decision-making will be one of the key components of the board as I envision it operating.

ARCH: OK, great. Thank you. Other questions? Seeing none, thank you very much. Jessika Benes. What's that? Oh, yeah, I-- is there anyone that would like to speak in support of Jaime's appointment? Or in opposition? Or neutral? OK, now.

JESSIKA BENES: My name is Jessika Benes, J-e-s-s-i-k-a B-e-n-e-s. I have a bachelor's degree in animal science from the University of Nebraska-Lincoln, and received my doctor of veterinary, veterinary

medicine degree from Iowa State College of Veterinary Medicine. I currently live in rural Juniata, Adams County, in the family farm that my grandpa grew up in. As a veterinarian, I care for both large and small animals. My work with horses, cattle, sheep, and goats most often includes setting up a vaccination protocol and herd health protocols, along with helping with reproductive issues, including abortions and difficulty giving birth. I am able to visit pets where they feel most comfortable in their homes for vaccinations or exams when feeling sick. Another service that I offer to all species is chiropractic manipulation. Furthermore, I serve the public at the Central Nebraska Humane Society in Grand Island. Much of my time there is spent addressing zoonotic diseases, especially, for example, the rabies virus, public safety issues, and performing surgeries. I currently serve on the board of directors for the Nebraska Veterinary Medical Association. For the past four years, I've spent much of my time working to improve access for rural Nebraskans to high speed broadband Internet, including testifying to the Transportation and Telecommunications Committee. The pandemic has shown us how vital technology can be in our daily lives. I am committed to helping rural populations have similar opportunities in healthcare to those in urban areas of Nebraska. I am excited to work with human medical professionals and I am gracious for being this-- given this opportunity. Thank you for your time.

ARCH: Great. Thank you. Questions? Senator Murman.

MURMAN: Thanks a lot for being here. I have a dairy farm in Glenvil, Nebraska, probably less than 20 miles away. And but my brother is operating the farm now, so I'm asking a question for him. Are you on call 24 hours a day?

JESSIKA BENES: So I am on call 24 hours a day. However, I am one person and can only be in so many places at a time. So I do help my clients when possible, but work, work with other local veterinarians in the community.

MURMAN: Thanks a lot. I'll pass the information on.

ARCH: Any other questions? I have one. Electronic medical records, obviously in, in healthcare that's a big thing. Is that happening in the vet world as well?

JESSIKA BENES: So it is and it isn't. So I would say very much so on the small animal side or myself where I'm ambulatory. So I'm going from place to place. So I don't want to have to go find some physical record. So there are a lot of components that exist that we do that,

however, a large portion of the veterinarians in the state are of the older generations who don't like computers, don't want to type things in. So in some aspects we're getting more electronic, in some aspects we're not at all. But the state has also done some things to help with that. We now have an app. I did some electronic health papers, those types of things. So then that's easy. I can just email them to my clients and as long as they don't forget their phone at home, then they have access to those records.

ARCH: Thank you. Any other questions? Well, thanks for being willing to serve.

JESSIKA BENES: Thank you.

ARCH: Thank you very much. Is there anyone else that would like to speak in support? Or in opposition? Or in the neutral capacity? Seeing none, we will move to our next appointee. Aimee Black.

AIMEE BLACK: Good afternoon, Chairman Arch and the members of the committee. I'm Aimee Black, A-i-m-e-e, Black is B-l-a-c-k, B-l-a-c-k like the color. I'm here today for appointment to the Health Information Technology Board. My background in healthcare has provided me with some perspective that I think will be helpful to serving on this board. I started my career in healthcare as an oncology nurse at Methodist Health System over 14 years ago. After obtaining my bachelor's degree in nursing, I went on to complete my master's degree in nursing and then most recently I completed my doctor of education, also with an emphasis in healthcare leadership. Throughout my tenure at Methodist Health System, I worked as a care coordinator, clinical documentation improvement nurse, a nursing operations leader, and most recently the director of Quality and Safety. Currently, I'm the vice president of Quality at Nebraska Total Care. I just recently started that job a few months ago. Working in healthcare, especially on the quality and safety side, I have been able to see how impactful health information technology can be to providing safe, high quality care to Nebraskans. One example, there are many examples that I have come across, especially in quality and safety, but one example that I think that a lot of people experience more often than they should is being readmitted to a hospital. Coming to the hospital and being remitted and getting a patient back to their home is a very complex process. It requires a lot of communication, a lot of coordination, and we really need good health information to safe-- safely transition our patients back to their homes. Unfortunately, I've experienced way too many instances where the data and the health information is really incomplete, disorganized, or it's sometimes not even there at all to find. So I believe there are many opportunities surrounding how the

exchange of health information between healthcare systems, providers, and payers can help improve and optimize our performance and, more importantly, improve the overall quality of care in the health of Nebraskans. I thank you for your time and consideration. I'm open to any questions.

ARCH: Thank you. Are there questions? Senator Walz.

WALZ: I just have a question. Thank you. Thanks for coming today. I'm just curious, you said the data that you needed was incomplete, disorganized, or wasn't even there. Do you have, like, any idea why that's happening?

AIMEE BLACK: I think it's, it's a little bit about what Jaime talked about as well. It's just some of the-- it's having the data governance and having the ability to-- sometimes it's there, it's just not that we're able to have access to it. So from a hospital perspective, to see sometimes that a patient was readmitted to another hospital, it's really hard to find. It's-- we don't always have that right at our fingertips to figure out, hey, they were just at the hospital down the street a couple of days ago. And so you take that patient in and you send that patient back out not addressing any of those barriers or resources that they need to be successful to stay in their own home and not have to get readmitted to the hospital. Unfortunately, you know, depending on your health condition, up to 20 percent of patients can get readmitted to the hospital. So those are your patients with chronic conditions and they have a lot of multiple things going on in their homes. And so it's, it's also working across the transitions of care to make sure that that health information is going to the home healthcare agency that might be taking care of them when they get to their home to make sure that they have the right medications. We often see up to 25 percent of the time patients have the wrong medication list when they go home. And that's often one of the things that brings them back to the hospital is because they were taking an inaccurate dose of medication because we didn't have the right information at our fingertips to provide that care safely to them.

WALZ: And you, you think it's more of a just because it takes, it takes time for the, for the provider to send on that information or--

AIMEE BLACK: Sometimes, sometimes I think it takes time. Sometimes I think it's not having access to the different networks that that information might be in. I think there's a multitude of reasons--

WALZ: OK.

AIMEE BLACK: --why that data is not there sometimes. Unfortunately, that leads to the complexity of, of it all.

WALZ: Thank you.

ARCH: Any other questions? I have one. You are appointed as a PDMP entity. Your experience with PDMP, what impact do you think that's had on the state of Nebraska?

AIMEE BLACK: I think that's had a huge impact. We did-- right when the PDMP rolled out at Methodist Health System, we had done a lot of work with our providers, specifically on opioids, to help make sure that they could see where patients were getting prescribed that so that we could decrease the opioid use in, in the health system and in the state. So I think that was one of the biggest impacts that we've seen. Unfortunately, you know, being in quality and safety, I also experienced where we had patients that came in and they were going from doctor to doctor and came in for suicide and, and other things because they were given too many of those medications. So I think that's had a huge impact in helping us to keep people safer to have that transparency.

B. HANSEN: I have a question.

ARCH: Senator Hansen.

B. HANSEN: Yeah, he made me think of something. Sorry. Because this is something I think was brought up to me earlier since we were talking of the PDMP. Have you, have you heard or any concerns from specifically law enforcement about their inability to, to access the PDMP in a timely manner or, you know, or their ability to at all? Have you heard, have you heard of anything like that?

AIMEE BLACK: I personally haven't, no.

B. HANSEN: OK, just kind of curious.

AIMEE BLACK: Yeah, I didn't, you know, being-- I wasn't specifically in the emergency room, like, that's where we would have our most encounters with law enforcement. But I didn't personally ever hear that escalate up to me.

B. HANSEN: Just curious. Just a couple concerns I've heard before. So thank you.

ARCH: Any other questions? Seeing none, thank you for being willing to serve like this.

AIMEE BLACK: Yes, thank you.

ARCH: Is there anyone that would like to speak in support of her appointment? In opposition? Or in a neutral capacity? OK, seeing none, we'll move to the next. Dr. Salzbrenner. Welcome.

STEPHEN SALZBRENNER: Thank you. Chairman Arch, committee members, Nebraskans, thank you, thank you very much. I, I really enjoyed listening to Miss Bland and Miss Black and echo so much of what they said. I'm Stephen Salzbrenner, S-t-e-p-h-e-n, last name is Salzbrenner, S-a-l-z-b-r-e-n-n-e-r. I'm a board certified psychiatrist. I work at the Nebraska Medical Center in the Psychiatric Emergency Service. I also see outpatients. I run an S-ketamine clinic, which is a nasally administered antidepressant, just got fast-tracked approval for depression as augmentation. I also work with health IT quite a bit. My, my big focus right now is to help improve access of medications to, to patients. I think sometimes there's excessive delay, which can cause a lot of the visits to the psych ER that I'm seeing. Also, cost is an issue. Here's a little of my history, I went to Creighton medical school and then I served in the Navy, did my residency at San Diego for internship, and then Portsmouth, Virginia for the rest of my residency. I was the psychiatrist at a combat stress company during the war during OIF just north of Baghdad in 2005, 2006, during the Saddam trial, saw a lot of psychiatric needs there. I've served as an inpatient psychiatrist, both in, in the military as well as civilian outpatient psychiatrist council liaison, which, which basically means, let's say, Senator Williams has shortness of breath, he goes to the hospital for that. And then while he's there, he starts hearing voices, you know, so then they'll call me. And that's, that's what a council liaison psychiatrist does. So I've done that in the military as well as I do that now, that's one of my other roles at the Medical Center. Lots of, you know, in the academic teaching, do a little bit of research. Well, I run the Treatment Resistant Depression Subspecialty Clinic, which I started. And essentially that's kind of what it says. Somebody just can't seem to, you know, win the battle, you know, and it's affecting their life and their, their parenting, their job, everything, and they just want to see the light again. So they've tried a lot of medicines, different procedures. So I'm kind of passionate about showing these individuals that there's a reason to have hope. So we serve those, those individuals as well. I was awarded a grant from NIH to develop a solution for something that many of you probably have no idea what it is. I know Jaime knows what it is. She sees it probably all the time. And I'm sure Aimee does, too. There's something about prior authorizations. It is-- it's a big monster. It's this process that

insurance companies developed years and years and years ago with really good intentions to make sure they were able to save costs, encourage safe prescribing by making sure that clinicians were following best practices, not jumping to the most expensive med before they tried the less expensive ones. Well, now it's gotten to the point with all the different spider web of benefits, rebates, kickbacks, that it's hard to keep track of what a formulary contains. So, for instance, if you're with NTC like Aimee, they might prefer Prozac. And I'm just using examples, everyone prefers Prozac because it's generic, but let's say someone else likes Zoloft. Well, it's hard for me as a doctor to know that, you know, this year NTC wants you to refer Zoloft and last year they wanted you to refer Prozac. So the patient goes to their Walgreens with their prescription for Prozac and then they're denied because they hadn't tried Zoloft first. So they go for a week or two without their medicine, which as you can imagine, those are important medications. The same thing happens with arthritis, ulcerative colitis, Crohn's, psoriasis, everything. So I really am passionate about making sure that when a clinician decides the patient needs treatment, there is a way for them to get that treatment to the patient as fast as they possibly can while not leaping over due diligence and making sure that the cost is taking into account, the clinical evidence is taken into account. So to sum all this up, in, in all [INAUDIBLE], I've seen how sometimes data isn't communicated to the end party the way it was meant to be communicated. And that's really, really vital to treating patients. We'll see patients that have even in the PDMP that might have filled two different doses of medicine. Well, you don't know if that means one was discontinued and the dose was changed or if they're on both medicines. It can make a big difference to a patient to double their dose of medicine when you're weren't supposed to. So this is all about making sure that the, the proper information is presented to the, to the provider at the point of care. And I think that it's-- our Health Information Exchange is wonderful. I love CyncHealth. I think Jaime's done an amazing job and I can't wait to work with her. I don't know how she does it. I am not an informatics person. I want to talk to her later at where she got her degree, because if I could be half as smart as Jaime, I'd be very happy. But that's my-- that's what I think I can offer to the board is a voice from the clinical world, you know, from the trenches who deals with this every day and who can be a voice for my peers, my colleagues, Nebraskans, patients. So I appreciate everyone's attention and I look forward to diving in and being a part of this. Thank you.

ARCH: Thank you. Questions? Any questions from the committee? Senator Day.

DAY: Thank you, Chairman Arch. And thank you, Dr. Salzbrenner, for being here today. I'm often taken aback by these appointments because people often have such impressive resumes and you are no exception to that. So thank you for your willingness to serve on the board. And you mentioned early in your testimony that you run a ketamine clinic. Is that correct? And that's a treatment for depression. Could you-- I'm just interested to hear little bit more about that.

STEPHEN SALZBRENNER: So OK, everyone-- what you just did--

DAY: Yeah.

STEPHEN SALZBRENNER: --is very common and say ketamine. And I know there's probably some pharmacy people behind me that are reacting the same way I am. So ketamine is like a-- oh, I, I, I bet anything Aimee is--so ketamine is a, is a-- like a tranquilizer that's used in animals a lot and police officers use it sometimes now to subdue. That's a whole other discussion. But, you know, it's used for that purpose, too. Well, in chemistry, a lot of the molecules that we have, they exist as mirror images of each other. So just as your hands are identical, but you cannot-- they don't match if you lay one on top the other, that's the way molecules exist, too. So ketamine is a combination of S-ketamine and R-ketamine. In Latin, S is left, R is right. And I don't-- I can't remember all the actual words, but the S-ketamine was purified and the S-ketamine is what I give. And that's given nasally for various reasons that was determined to be the way, you know, the one they want with, the S not the R. Now there are studies that show that the regular ketamine that you mentioned is even more effective, but it's, it's not FDA approved for depression, except in IV, you can give an IV. And I think part of it is because it would be really cheap and generic and no one would make money off of it so why do the studies. You know, that's kind of how a lot of things work in our field. But the S-ketamine is what I use, and so at the Buffett Center, the Cancer Center, I, I go over there and I, I basically have a bunch of a, a bunch of rooms with patients, you know, you have two hours where they have to be observed for things like blood pressure and so forth. And within sometimes a, a treatment or two, there's huge improvement in their, you know, years of suffering and then two days later they're feeling great. So it's pretty unbelievable when it works.

DAY: Interesting.

STEPHEN SALZBRENNER: Hope I answered your question.

DAY: No, you did. I was just interested to hear. Is it OK if I ask another question? Is-- and then is that an ongoing treatment or is this like a, a just an acute?

STEPHEN SALZBRENNER: I, I get asked that all the time, too. It's such-- that's such a new modality that we don't know, to be honest with you. Some people, I've, I've tapered them down. It's given twice a week, then once a week. And sometimes I've got people on every other week. I haven't had anyone stop it yet. They're afraid to stop it, to be quite honest with you, because it works so well. But a couple people have gotten so much better that I'm trying to talk them into stopping it. So I'll get back to you on that one.

DAY: OK. Thank you.

ARCH: Any other questions? Senator Hansen.

B. HANSEN: Thank you, Chairman Arch. Thank you for your willingness to serve. I'm going to beat Chairman Arch to it before he says it. And also thank you for your service in our military as well.

STEPHEN SALZBRENNER: Thank you.

B. HANSEN: Appreciate that. Just-- hope I'm not digressing too much, but you talked a little bit about the inability sometimes to get prescription medications to the places that they need to get to. And I think this relates a little bit to the HIT Board. But with your, your unique perspective, what's your thoughts about PBMs and, and, and their role that they play in the-- just generalize--

STEPHEN SALZBRENNER: That was a quick question?

B. HANSEN: --because you're, you're, you know, you're, you're, you're the one that has to deal with a lot of this kind of stuff and [INAUDIBLE], so.

STEPHEN SALZBRENNER: Well, let's bring Aimee up and get her.

B. HANSEN: And you don't have to answer if you do not like.

STEPHEN SALZBRENNER: No, here's, here's my honest thought. I think PBMs serve a vital purpose. They're a way to get a treatment through the chain to the patient. I don't think it will always be necessary, though, I think there's going to be a lot of competition. I think there's a big black box sometimes as far as where's the money going? And I've spent years trying to figure it out. And I don't think I've gotten anywhere further than I did on day one. So I think somewhere in

that box there's price inflation and I just don't know exactly where yet that's happening. I think it's very complex. But PBMs are, are, you know, are intrinsically good, in my opinion. It's just if you get the wrong motives, you can, you can go down the wrong track just like anything in life.

B. HANSEN: OK, yeah, I'm just curious because you might have a little more unique perspective there so.

STEPHEN SALZBRENNER: Oh, I could talk for a long time on this.

B. HANSEN: That's all right, so. But, yeah, I appreciate your thoughts, though, actually.

STEPHEN SALZBRENNER: Thank you.

B. HANSEN: Thank you.

WILLIAMS: [INAUDIBLE] in the Banking Committee.

ARCH: Yeah, right. This is not Insurance and Banking Committee, but good question. Any other questions? I have, I have one other. I've been told by clinicians that one of the challenges with psychotropic meds is that perhaps you would see a family practice doctor, and then you may see a psychiatrist, and then you may-- you know, that multiple physicians involved in prescribing over the years where some of these meds tend to layer on top of each other, having a PDMP, having knowledge of, of what, of what that patient is actually taking, do you think that that helps with that issue? Is that-- are we far enough into the PDMP that, that all the physicians are looking at it and we're seeing that, we're seeing that multiple medication issue--

STEPHEN SALZBRENNER: Well, I wouldn't say all the physicians.

ARCH: --inappropriate, inappropriate? But anyway.

STEPHEN SALZBRENNER: I appreciate the question. Sorry for the interruption.

ARCH: No.

STEPHEN SALZBRENNER: Yes, I used it this week many times. Think about my field, they come in, they're psychotic, disorganized, you don't know what medicines they're on. The only thing you have is the health record. And often in a health record, you'll see all kinds of duplicates. Because what happens often is-- let's just-- I'm going to say Senator Arch's Walgreens, Senator Williams' CVS, and there's, you

know, Hy-Vee pharmacies. The lawyer here. Just put your name there. So, so Walgreens-- so I-- I'm the family practitioner. I prescribe Prozac to Walgreens. OK, so there's 30 pills. All right. Now even if the, the family petitioner discontinues the Prozac, that message doesn't always get to the pharmacy. So now in our-- in the health record, I will see the active Prozac prescription, even though it's been stopped at the point of care. And now you start Zoloft, and I see Prozac, sorry, Prozac and Zoloft. Well, I want to get a psychiatrist now because my family practitioner isn't doing the trick. So now I'm going to go to, to-- and I move, so now I'm using CVS. So now on according to what I'm seeing as a clinician in my point of care, I've got a patient on both Prozac and Zoloft. Now let's say this psychiatrist stops the Zoloft and their system doesn't yet have the capability because it's, you know, features. You got to pay a little bit more money for these-- all these different features. So they don't have the feature yet where the discontinuation message goes, goes to the pharmacy. And let's say now you start, I don't know, some other medicine. Say it's Effexor. So now I've got this patient on, on Prozac, Zoloft, and Effexor, even though they're really only taking the Effexor because that's all that was prescribed. But in my record, I don't see all that necessarily. So now the patient is found unconscious in-- I don't know, on 42nd & Farnam where I'm-- my, my hood. So they, they come into the ER and now a doctor looks at the record and says, oh wow, they're on high dose. They're on Zoloft, Prozac, and Effexor. Let's start them all right now because, you know, they must be pretty depressed to be on all that. Well, now they, now they give them even worse problems by starting three medicines. So it's not a perfect system, as I just illustrated, but I use it all the time. And Jaime has done phenomenal and I don't know how these guys do it, but it's really good. And I, I-- it is vital. A lot of doctors are using it. I don't know if all of them are because kind of like what Aimee said, there's still some-- or not Aimee-- veterinarian, there are still not some providers who just are scared of technology. They just don't want, they don't want to deal with it. They're close to retirement. And so they'd rather just have paper and pen to be honest with you, they don't like to the HRs, so you're going to have those people. But it's definitely brought us a long way.

ARCH: Great. All right. Any other questions? Well, thank you. I'll say again, thank you--

STEPHEN SALZBRENNER: Thank you.

ARCH: --for being willing to serve in this capacity.

STEPHEN SALZBRENNER: I appreciate it. Thank you, sir.

ARCH: Is there anyone that would like to speak in support? Opposition? Or neutral? Seeing none, thank you. Next appointment. Michael Aerni. Aerni.

MICHAEL AERNI: Either way is OK.

ARCH: I apologize.

MICHAEL AERNI: Before my ancestors came to America, it was Aerni, and then they changed it to Aerni because it was much easier to pronounce.

ARCH: OK.

MICHAEL AERNI: I'm Michael Aerni from Fremont, Nebraska, M-i-c-h-a-e-l A-e-r-n-i. I've been a resident of Fremont for 39 years. I'm a retired educator and principal. I worked with Senator Walz for two years if you need any inside information.

ARCH: We do. We do.

MICHAEL AERNI: She was a wonderful person to work with.

ARCH: Oh, OK.

MICHAEL AERNI: I don't have any, any mud. It's been an honor for me to be here today. I have been retired since 2012 as an elementary principal, 37 years as an educator principal. How I became involved with Foster Care Review Board the very first time, I happened to be at Ace Hardware in Fremont, and a fellow educator who is retired spotted me around one of the aisles and said, Mike, I've got something I want you to consider. We need a board member for the Foster Care Review Board in Fremont. You'd be perfect for that. Went home and I said, I'll think about it. I started that December and I've been on that review board now about ten years. And it's just a, a real pleasure to do that. We read about four to five cases every month as a committee. What we do is we have a lead case that we are the lead questioner on, the lead reader. We take charge, you know, charge of that, but we are required to read every case, you know, top to bottom. So over the years of ten years or so, it's been about 400 cases to 450 cases that we've read each and each individual. And some of those have been repeats, which we really don't like to have because we like to try to help the child that's in foster care. I'm currently in my second term on the Foster Care Review Advisory Board. I started four and a half years ago this past March, and been a pleasure for me to serve with many of them that started at the same time. A couple of them will be here speaking to you in just a little while. We've been involved as a

group in the last year and a half. We started with a new executive director, Monika Gross, and she's done a marvelous job. And under her leadership, I think we're going to go a long way. And my role on the board currently is the chair. But we're all leaders on the, on the crew. Do you have any questions for me?

ARCH: Are there questions? Senator Walz.

WALZ: I'll take a question. I'm so glad to see you, first of all. And I'm so glad that you're doing this work.

MICHAEL AERNI: Oh, thank you.

WALZ: What have been, like, the biggest challenges that you've seen over the years when it comes to foster care, foster care placement?

MICHAEL AERNI: The biggest challenge is as we see as board members at the local level. And, and I don't want to bring up the Saint Francis thing other than the fact we read in the paper that they have way too many cases, their case loads are heavy. And our part of that, we're on a, a local board member, we still have problems with-- we have lots of different caseworkers per case, per child. There's so much turnover. And one of my beliefs has always been in order for you to get part of this of a child, you've got to get all of this first. And you can't get all of this if you have five or six caseworkers, they have to start learning about your habits as an adult. And do I trust you? What are you going to do to me? So I think the biggest problem is that we have caseloads that are-- caseworkers that are overloaded. I also think that, you know, sometimes parents who are recommended by the courts to go through diversion programs, parenting counseling, family therapy, they're not willing to do that. And I think part of that might be we have to get this from them first because we need, you know, to get this. A lot of parents anymore they really do try to be the best mom and dad they can. But I'm not real sure that the resources available to them when they get started with that are available. And I think some of them are doing it by, and I don't mean to be derogatory, some of it's by trial and error, you know, some of it happens because of, you know, not planning ahead. But the biggest problem would be caseload. Caseworkers are overloaded. That also backlogs the courts, you know, and sometimes when you have to go through so many different reviews, the saddest thing for me as a local board member is when you have a repeat case and by, you know, you have to review them by every six months if, you know, especially if it's court ordered. There's a lot of repeats and we're not doing the best service we can, if not everybody's on the same page. Did that answer your question?

WALZ: Yes, thank you very much.

MICHAEL AERNI: Caseloads are extremely high for those with Saint Francis. And if you look at our quarterly report, one of the things that we've identified in our annual report from FCRO, the changeover in caseworkers is one of the biggest factors to success of that. So we're working as hard as we can. The one thing that Monika has been able to do is, you know, we're, we're looking at the folks that work in the FCR Office, and rather than as a management team, they're becoming a leadership team. And I think when you have more leaders, you can get farther down the road. And she's doing wonderful things with strategic planning, which we had in July. She's got a leadership training coming up for her, her group at the office. So I think we're going to get some places, but we really need to help those children that are in foster care. Any more questions?

ARCH: Good.

WALZ: Can I just--

ARCH: Other questions?

WALZ: One more.

ARCH: Sure. Certainly.

MICHAEL AERNI: Sure.

WALZ: Just a follow-up on that. So-- and this may be a stupid question, but so after you meet and let's say that you know that there's an overload of case-- of caseloads that, that they're overloaded, are those-- do you make recommendations then to the state regarding-- do you make any recommendations as part of the board?

MICHAEL AERNI: Yes, we do. Yes, we do, as a local board. OK. The recommendation that we make through FCRO, we meet quarterly with Monika and the Advisory Committee. And then she, of course, then makes reports to the Legislature, those kind of things. What we do is we have a system oversight specialist at the local board level, and ours is Jodi Borer from Columbus and she has several other boards. And when we review cases, we talk about different things that need to be implemented or need to be successful. And then her report goes directly to the judge. And so whatever recommendations we may have as a committee, as review members, we all are in on it together and we agree with what we're going to say through her to the judges of the courts. So we do think we have a voice.

WALZ: Thank you.

ARCH: Good. Other questions?

MICHAEL AERNI: Anybody else?

ARCH: Seeing none, thank you very much.

MICHAEL AERNI: Thank you. Been an honor to be here.

ARCH: Thank you for being willing to serve--

MICHAEL AERNI: Thank you.

ARCH: --and be reappointed. Yes. Is there anybody that would like to speak in support of this appointment? Opposition? Or neutral? Seeing none, we'll move to the next. Noelle Petersen. Welcome.

NOELLE PETERSEN: Thank you. Good afternoon, Senator, members of the committee, my name is Noelle Petersen, N-o-e-l-l-e, and Petersen is P-e-t-e-r-s-e-n. I'm honored to serve on the Foster Care Review Office Advisory Committee with Mike. We came on at the same time. So this will be my reappointment to a second term as well. A little bit of history. A long time ago I worked here in the State Capitol. I worked for a state senator as an administrative aide, and my first exposure to the Foster Care Review Board was through a constituent. So there was a situation that a constituent called us about. They were very upset because there was a threat of their foster kids being removed from them and they plan to adopt. And the long and the short of it was I ended up attending a team meeting on behalf of our constituents to advocate for what we believe was best for the kids. And at that meeting, there was a Foster Care Review Board representative as well. And after the meeting, she approached me and said, you seem really passionate about this. Would you be interested in volunteering? And I said, I guess so. Tell me more. So because of my work here at the Capitol, I was exposed to and became really interested in issues surrounding child welfare. And that has remained true. That was about 11 years ago. So I did join a board a few months after that. I served on a local board and still do and then I applied to the Advisory Committee when there were some spots that opened up. And because I had been on a local board for a while, there were some issues that I felt really passionate about and I felt like I wanted to do more. We-- my husband and I adopted our daughter privately in 2016 and then we adopted our son. We will finalize his adoption in just a couple of months. So I continue to be passionate about adoption and adoption-related issues. And this is just one way for me to serve and

advocate on behalf of kids in foster care. I would echo what Mike said. My two top concerns about the system at large would be the caseworker turnover rates. And not only is it a disservice to people that want to do social work and serve children, it really does ultimately harm the children, which is what we're concerned most about, vulnerable kids who really are in the system most of the time through no fault of their own in circumstances beyond their control. And we have had some really dedicated, impressive caseworkers participate in our meetings. Those people exist. We want those people to stay in the field. So, you know, our interest is in taking care of kids, but also making sure that quality people that really want to do social work can stay in social work because the conditions permit them to thrive in that environment. And my second biggest concern is voluntary cases for what we understand to be kids that are not necessarily counted in our data about children in out-of-home care, but children that are at risk of being in out-of-home care. Currently, there's no oversight for us to use to understand what happens in those cases or to make sure that issues that put those children at risk are really being-- services are being provided and things are being done so that those kids don't have to be removed at all. And I think if there's one thing, I know Monika is passionate about that as well, and that's something the Advisory Committee continues to discuss, is the future of that issue and how we can continue to make sure there are eyes on children in every component of issues at home, you know, the department is involved to children have to be removed because if we can prevent some of those removals, of course, we want to do that. But we also want to make sure that it's being done safely and appropriately and the issues that would cause that removal are really being addressed. So thank you for your time and I would answer any questions.

ARCH: Thank you. Questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you so much for the service that you've already provided in this arena. I really just was distracted by the beautiful kids in the back.

NOELLE PETERSEN: Thank you.

M. CAVANAUGH: And I was, I was curious, what, what are their names?

NOELLE PETERSEN: My daughter's Anila [PHONETIC] and my son is Jamison [PHONETIC]. They're very active, as you can tell. So thank you for bearing with them. They really wanted to come, so.

M. CAVANAUGH: I love it. I love it a lot. So thank you. I just-- and I appreciate your, your note on that and raising the voluntary cases and the oversight. I think that's something that we certainly need to be paying attention to. So thank you for raising that.

NOELLE PETERSEN: Thank you. Yeah, it's a huge-- I think that's the next big thing that we have to address, definitely.

ARCH: Other questions? I guess I would just have a comment, I think you're the third of our appointees who have gone from the Foster Care Review Board to the Advisory Committee. Is that, is that helpful to start at that Foster Care Review Board level and, and before moving to the Advisory Committee?

NOELLE PETERSEN: I believe so. The other part of that is the way the Advisory Committee is made up. It's required that I think at least two, two or three of the members have to be local board members. So there's also that qualification. But, yeah, I really do believe that you-- because I served on a board for so many years-- well, several different boards, it really, as Mike said, you start to see patterns, you see patterns in how cases are managed and how bio parents challenges are being dealt with. You see certain kinds of kids that linger in care. And I mean, I think when you're exposed to that month after month, you develop a passion for, you know, seeing the issue. And this-- these patterns of things going wrong and saying, like, this is about kids and, of course, we want to do better for them. So, yeah, I definitely think serving on a local board is a great place to start and it's a very reasonable time commitment. So I think the other thing that we need to do as a board that we've discussed is a more aggressive recruitment in younger age groups as well, because that's the future of this advocacy work as well.

ARCH: Yeah. Very good. Thank you. Any other questions? Seeing none, thank you very much.

NOELLE PETERSEN: Thank you.

ARCH: Thanks for your willingness to serve again. Anybody that would like to speak in support? Anybody in opposition? Anybody in a neutral capacity? OK. We have two appointees that will be calling in. The first, I believe, is Dr. Marsh. Is that correct? Good afternoon, Dr. Marsh.

MICHELE MARSH: Hi there. Dr. Marsh.

ARCH: Yes, thank you. Thank you for calling in. We have the HHS committee here and we would like to maybe give you an opportunity. I know this is, this is a reappointment for the Foster Care Advisory Committee for you.

MICHELE MARSH: Correct.

ARCH: And but tell us a little bit about your background and experience and why you're willing to be reappointed.

MICHELE MARSH: Oh, certainly. So my name is Michele Marsh. I'm a child and adolescent psychiatrist and I've been a member of the review organization since 2017. And it's really been just an honor to be on this committee. And that is what led me to reapply. So I have been practicing in Nebraska after completing medical school at the University of Nebraska Medical Center and then residency at Creighton University and my Child and Adolescent Fellowship at Creighton University. So initially I was in private practice, but in 2009 I made a big change and came over to Immanuel Hospital, where I'm currently the medical director for a child and adolescent psychiatric services. And on a daily basis, I run a partial care program here where the children come daily from nine to three. It's very, very intense program. They come nine to three, five days a week. So it's not as intense as an inpatient unit, but fairly intense. The difference is they're safe enough to go home at night. So I was initially born in Brooklyn, New York, and graduated from college in New York. But then I joined the Volunteer In-Service to America program, which is the domestic Peace Corps. And I don't think it's really running right now. I think it's now it's more referred to as Teach for America. So the program that I was assigned to was here in Nebraska. So I actually lived for two years on the Santee Sioux Indian Reservation. And my role there was to write grants for funding of treatment and prevention of substance use. So I did that for two years and then I moved to Omaha having, I think, fallen in love with Nebraska did not want to go back to New York. And then I started medical school here. So that is, you know, some of my background. The one thing I think that's helped me also, as I've participated in the Foster Care Review organization, is that over the past year I have been consulting at Douglas County Youth Center a morning every week and evaluating some of the youth there who have potential psychiatric illness or require treatment. So, I mean, I guess I'm just-- feel as if the, you know, there's more to do for these kids. And I'm just hoping that, you know, we can figure out a way to lighten the stress that they all experience after being removed from their homes and figure out a way to just provide more stability in terms of their relationships, their normal childhood

development. Education is a big factor. And so but I feel like this is, is a foster care review organization is really helpful in moving that process forward.

ARCH: Great. Thank you. Thank you for that background. That's very helpful. Questions for Dr. Marsh? I, I have one, Dr. Marsh. I, I, I am sure that in your, in your practice, both on the psychiatric residential treatment facility as well as the inpatient, you see a number of, of youth who have either-- they're either in, in the foster care system or have been in the foster care system in the past. What, what, what percent of, of the population do you think would, would have, would have been in the system at some point in their life?

MICHELE MARSH: Oh, you mean overall. I would just, you know, I'm not sure I know the, the bigger answer to that, but I would just say on a, on a smaller level, I would-- I think about maybe 20 percent of the kids that come through our program and to the inpatient unit approximately, are, you know, currently either, you know, wards of the state or have been removed from their home and returned home.

ARCH: OK, thank you. And this is a, this is a reappointment to the Advisory Committee. Is that correct?

MICHELE MARSH: Yes, that is correct.

ARCH: OK, well, again, we want to thank you for your willingness to continue and to, and to serve in that capacity.

MICHELE MARSH: Well, thank you so much. Really been a pleasure.

ARCH: Any other questions? Seeing, seeing none, thank you very much, Dr. Marsh. And--

MICHELE MARSH: Thank you.

ARCH: --we will-- we'll-- we're going to move this pretty quickly. And, and we want to get this to the, to the floor to get these appointments done. So thank you for your willingness to serve again.

MICHELE MARSH: OK, thank you so much.

ARCH: Thank you. Have a good day.

MICHELE MARSH: Bye-bye.

ARCH: I guess I don't need to ask about in support or opposition or neutral. I don't think there's anybody, I don't think there's anybody--

WILLIAMS: Anybody's here.

ARCH: So we have one more. And Dr. Nelson, is he going to, is he going to call in?

_____: I just texted Mr. Nelson and he should be calling in.

ARCH: OK. Dr. Nelson?

PAUL NELSON: Yes, yes, thank you.

ARCH: Thank you for calling in. The, the Health and Human Services Committee, this is Senator Arch. The Health and Human Services Committee are here. And if, if you could tell us a little bit about your background. I understand that you are, are being appointed as a reappointment to the Child Abuse Prevention Fund Board. And tell us a little bit about your background and your willingness to serve in that capacity.

PAUL NELSON: Yes, I graduated from medical school at the University of Nebraska in 1969 and, and subsequent to the experience in both internal medicine and pediatrics for four years. And then in 1973, '75 completed a two-year military obligation as a physician and then started private practice in Omaha in 1975. And during my career, the first ten years, I was the pediatric consultant to Child Protective Services in Omaha. At the time, Child Protective Services were still under county authority and eventually came under statewide authority. So that, that was between 1975, 1985. And toward the end of my career, acquired an interest in dimensions of our nation's population health and its healthcare, which as everyone has probably come to understand, is pretty complicated and is associated with all kinds of difficult to understand problems in our health of our country and its survival. So anyway, I've been on the, the committee for now three or four years and are up for approval for to finish another final year of the appointment. And it's been my privilege to be on that board for which we have authorized a, a, a variety of community-- basically, centered initiatives, particularly in the eastern part of the state, the more populous part of the state and statewide to implement known and validated community-based projects to prevent child abuse and its associated child neglect. So it's been an honor to serve on that committee, and I, I would be interested in finishing up my second

term, sincerely. And one of the things that I, I will all take a personal interest in the coming year is to increase the committee to possibly establish a, a recurring analysis of with, with the appropriate elements of our social structure with throughout the state to develop maybe a triannual report regarding the status of child abuse and neglect in the state as a future reference for all of the various programs which are going across the state, and I might add, are increasingly based on promoting community-based, improved attention to the, the occurrence of child abuse and its factors as well as its associated child neglect. So I'm, I'm representing the committee. I can say that there are a wide variety of programs, particularly one in Omaha, and as a result of by the Governor's Office in this regard. So I, I would be privileged to serve again to finish out my term.

ARCH: Thank you. Thank you. Any questions for Dr. Nelson? Well, Dr. Nelson, I think we, we certainly understand your background and, and, and so appreciate your willingness to serve in this way and, and provide your expertise. We as a HHS committee wrestle with a lot of large issues regarding child abuse. And, and we, we appreciate people such as you that have volunteered to, to help us in making this a better state. So thank you. Thank you very much. We are going to move the appointees pretty quickly. And so you'll-- you should be hearing shortly regarding your appointment. But I, but I, again, really appreciate your willingness to serve.

PAUL NELSON: Yeah, and, and thank you for [INAUDIBLE].

ARCH: All right. Thank you for calling in and have a nice day.

PAUL NELSON: Yeah, yeah, you bet. Thank you.

ARCH: Thank you.

PAUL NELSON: Bye-bye.

ARCH: Bye. That will end the appointees and end the gubernatorial appointment hearing for the day.