ARCH: Well, good afternoon. 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 Walz.

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

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36.

M. CAVANAUGH: Machaela Cavanaugh from Omaha, Legislative District 6.

B. HANSEN: Ben Hansen, Legislative District 16, which is Washington, Burt, Cuming, and part of Stanton Counties.

ARCH: Also assisting the committee is one of our research analysts, Lisa Johns; our committee clerk, Geri Williams; and our committee page, Logan-- is Logan back there-- there's Logan-- good timing-- Logan Brtek. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon, we'll have a briefing from the Department of Health and Human Services on the child welfare consultant and work group called for in LB1173, which we passed last session, and we'll hear two interim study resolutions. We'll be taking them in the order listed on the agenda outside the room. The hearing on LR417 is open to anyone wishing to testify. However, the hearing on LR438 is limited to invited testimony only. For those of you testifying on either resolution, 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. I'm asking that you try to limit your testimony to five minutes. The light system will give you an indication of how long you've been speaking. At four minutes, the yellow light will come on and the red light at five minutes. These are study resolutions for information-gathering purposes and not bills so there is no record of proponents and opponents. Just as with legislative bills, comments for the record may be submitted online via the Chamber Viewer page as long as comments are submitted prior to noon on the workday before the hearing. And with that, we will begin today's hearing with a briefing from DHHS. And I welcome Director Stephanie Beasley to come on up. Welcome.

STEPHANIE BEASLEY: Well, thank you.

ARCH: You can proceed.

STEPHANIE BEASLEY: OK. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Stephanie Beasley, S-t-e-p-h-a-n-i-e B-e-a-s-l-e-y, and I'm the director of the Division of Children and Family Services in the Department of Health and Human Services. I'm here to brief the committee on the child welfare consultant and work group, Eastern Service Area, and provide updates on Alternative Response. This year, LB1173 went into effect requiring the department to contract with a consultant with expertise in child welfare system transformation by December 15, 2022. DHHS completed a request for proposal that was posted on September 30, 2022, to solicit bids for a consultant to facilitate the child welfare practice model work group. The proposals were scored by a group of stakeholders selected by myself and CEO Dannette Smith. After the proposals were-- are reviewed, oral interviews will be scheduled and an intent to award will be released in November. The contract will begin by December 15, 2022, and will end on December 31, 2023. The work group will have multiple internal and external stakeholders, as outlined in the bill. Children and Family Services, also known as CFS, is working towards the goals outlined in LB1173 through the strategic transformation work group, which was created in January of '21 and continues to meet regularly. I led that work group along with a robust group of stakeholders, including individuals with lived experience. The work group identified five strategic priorities with outcome measures to improve the child welfare continuum of care and designed a set of values and principles. The outcome measures focus on reducing child maltreatment and family separation, improving child and family well-being, enhancing accessibility and belonging across the continuum of care, improving family experience within the child and family well-being system, and increasing representation in the workforce. Other examples of Nebraska's involvement in supporting the identified outcome measures are the Family First Prevention Services Act; Thriving Families, Safer Children; Alternative Response; and Plans of Safe Care, which is through the Comprehensive Addiction and Recovery Act. In addition to creating practice model work group, LB1173 eliminated the lead agency pilot from statute. In January of 2022, the Eastern Service Area, also known as ESA, case management transfer from Saint Francis Ministries to DHHS began. There were 1,568 case transfer meetings held between DHHS and Saint Francis Ministries. A total of 1,531 cases were transitioned. A small number of cases were closed during that transition period due to typical case closure reasons such as adoption, guardianship, or services no longer being necessary. The

first group of teammates were transitioned from Saint Francis Ministries on January 25, 2022, and DHHS continued to transition teams each week through May 9, 2022. A total of 109 case managers were transferred from Saint Francis Ministries to DHHS. From March to September of '22, DHHS has recruited and hired 138 new case managers in the Eastern Service Area. The contract with Saint Francis Ministries ended on June 30, 2022, and the department assumed full responsibility for case management and services statewide. Providing stability in the workforce has been a primary focus during the transition. This gives families assurance and stability in the services they receive. There have been several wins throughout this transition. However, DHHS understands it will take time to see a turnaround in performance. As of September of '22, the targeted number of case managers was 210 and there were 197 at the time. CFS is working closely with DHHS Human Resources to ensure robust recruitment efforts for these vital positions. In August of '22, nearly 40 percent of case managers had caseloads in compliance with statute, up 3 percent from the previous month. Statewide, over 70 percent of case managers have caseload and compliance as of August '22. Overall case volume varies month to month, but is increasing statewide compared to previous years. This trend is also seen in the ESA. From January to September of '21, there were 19,854 total cases compared to 22,265 during the same time frame in 2022. During the transition, several town hall meetings were held with providers and key stakeholder groups, including court-appointed special advocates, guardians ad litem, providers, probation staff, and internal teammates. The purpose of the meetings was to gather feedback on the areas needing improvement and highlight successes. In February and September of '22, town hall meetings were held to hear directly from parents, foster parents and the community. The following themes were highlighted as areas of need during the town hall meetings: provider payments, communication and training; ESA staffing structure; ESA training for service providers; process improvement for policy and guidance documents; hiring process; best practice model for family team meetings; service array for youth and families with high needs. DHHS compiled these themes from the meetings and developed action steps for these identified areas. ESA leadership will continue meetings with providers on a monthly basis and will arrange meetings as needed. Finally, I'd like to provide a brief update on Alternative Response. As a reminder, Alternative Response is an approach to case management that partners with families to safely care for children in their homes. Safety, risk, and well-being are assessed and services are provided through voluntary involvement. In 2020, LB1061 removed the

sunset date and established Alternative Response as an ongoing approach in Nebraska's response to child abuse and neglect reports. In addition to the department's hotline screening tool, a Review, Evaluate, Decision team, also known as the RED team, is utilized to determine whether certain cases will have an alternative or a traditional response. Intakes sent to the RED team are those that do not meet any one of Nebraska's 18 exclusionary criteria, but meet one or more of Nebraska's eight RED team criteria, meaning they need an extra level of review. The RED team is a rotating group of DHHS case managers, supervisors, and administrators with knowledge of Alternative Response. Statute requires a minimum of three individuals for RED team staffing. The team reviews select intakes to determine the best response and considers the following: first information from the reporting party; history of the family, including previous reports; parental cooperation and protective factors; criminal history of any household member; vulnerability of the child or children. Additional exclusionary and RED team criteria were added with the passing of LB1061. After the bill passed, there were regulation changes in both May of '21 and September. The most recent updates to regulations accomplish the following: first, removed duplication of criteria from the statute; number two, removed the randomizer from the Alternative Response pilot; and third, provided further guidance in the RED team process. Since Alternative Response transitioned from a pilot project to full implementation in 2020, usage of the program has consistently increased. In the first full year of implementation, there were 1,582 cases throughout the state, making up just over 10 percent of all the reports to the hotline. By 2021, that number increased to 4,089, representing over 22 percent of all reports to the hotline. DHHS anticipated an increase in the overall usage of Alternative Response due to the removal of the randomizer as part of the pilot project, as well as changes in regulations and statute. As of September of '22, there have been 4,061 Alternative Response cases, and that's for this year. The department remains committed to serving vulnerable children and families in Nebraska. And I want to thank you for your time. I'm happy to answer any questions you have.

ARCH: Thank you for your report. Questions? We'll open it up to the committee for questions. Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you so much for your report. And as-- well, you well know, I attended that event in September. And I appreciate the ongoing communication that you've had, and I'm really rooting for you. I want to say that before I ask my question because one of the responses I got after that public hearing in September was

people felt like I was too glowing. And I was, like, well, I know that there's problems and I know that there's going to be problems. And this is going to take some time to, to get things where they need to be. And so acknowledge-- I just wanted to acknowledge that I get that. I get that there's wins and there's, there's losses happening here. But what can we do as for-- what can DHHS do and what can the Legislature do in this next session to help improve what's going on with that transition from Saint Francis Ministries back to DHHS? I know the case management ratios are of a critical concern to a lot of the workforce. And-- but as we're thinking of legislation for next year, what should we be keeping in mind that we can do to help improve the outcomes and the workforce?

STEPHANIE BEASLEY: Thank you, Senator. We-- actually, following many of the meetings that you were in attendance at the town hall, we met with probation, guardians ad litem, CASAs. We met with our team. We met with providers. And we, we came up with what we're calling the ESA support plan, which are, are very key strategies that will improve our provider onboarding process. When we get new providers, how do we train them and support them in understanding how to bill, how to get referrals, what the expectations are? There's a, a pretty strong list of, of action steps that we have at both 30, 60, and 90 days to make sure that it's successful, that the team there continues to get the right support, that providers have clear lines of communications, and that foster parents and CASAs and others really have, you know, just a clear understanding of our policies and guidelines. I think our, you know, our monitoring of that and our work on that is really one of the many ways that we're intending to, to increase support of the ESA leadership. I think, obviously, recruitment and retention strategies are critically important. You can say in ESA, but truly all over the state we have-- our team does incredible work and they have really difficult jobs and they're-- they work very hard, so looking for opportunities to continue our retention and to continue support. We have quite a bit of work going in that area where we're looking on how to do that so I, I would say, you know, DHHS is well positioned to really monitor and we've committed to continuing to get feedback. Just one of the many ways that we've done that is we began provider councils prior to that, but we have a leadership across providers that are meeting with us and we have subcommittees that we're working with providers on, on different issues like easing billing processes or documentation, things that are, are kind of some pain points across the board. So I, I would say that DHHS is certainly very committed to making sure that all of our stakeholders are well equipped and the

kids and families are getting the right supports. And so as far as the, the Legislature, obviously, this is, I think, one opportunity, LB1173 and the work group that's coming certainly will make that report on recommendations for the practice model and the finance model moving forward.

M. CAVANAUGH: Just a follow-up, so one of the things that I think is an issue across every industry right now in Nebraska is workforce shortage but also pay. Are we able to pay a competitive amount currently or is that something that we need to be talking about before we come back in January? Is-- should we be looking at the budget and how we're actually paying our employees for this work? Are they leaving? I guess I'm asking, are they leaving-- when they leave, are they-- is there an exit interview, an exit survey so that we can get a better idea of what it is that is causing them to leave?

STEPHANIE BEASLEY: Yes, we do, Senator, an exit interview that asks, you know, why, why did you leave? We actually are also doing stay interviews routinely with our team to say, you know, how can we keep you? You're really great. How, how do we make sure that we keep you on board? And our HR department has really led that charge. And I think it's a really good process. We can get you the results of that. I do think it's so important to note that last year, CFS specialists did get a significant raise and we have heard routinely from that team how much they appreciated the increase in pay. I think it, it averaged $8,000 probably per person and so that was certainly a win for the team. I think it helps in our-- I'm going to call it sort of it's a competitive market in social services, right, and so it helped us be competitive in recruiting some very talented people.

M. CAVANAUGH: Thank you.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Director Beasley. With the-- my question deals with Alternative Response and the substantial increase in the caseloads there over this short period of time, which I think is great. But can you just help us understand, do you have adequate staffing to have that continued increase in numbers and where are the dollars coming from to pay for that staffing?

STEPHANIE BEASLEY: Thanks, Senator. So as cases increase, it will be something that we watch whether or not our staffing meets the level of need. What we're even looking at is does our, you know, level of

staffing, knowing that we have a turn-- at churns. We're looking at our projections for increase, which is sort of a crystal ball moment, right, we're just looking at where we are today. If we were to continue to see trends, we would have difficulty with caseload compliance. You know, part of I think the bigger question is we're really working to do, you know, to look at our AR, to look at our increases. We know the increases come from the release of the randomizer. With AR, we also are looking at why kids and families and, and what they need and why they're coming into interaction with the child welfare system. So I think like most of us, we suspect the difficulties from the pandemic. A lot of states are seeing the same need arise where kids and families are, are having some more behavioral health challenges or, or other things that have happened as a result of the pandemic. But we are monitoring it. If the trend would continue, that is something that we would have difficulty with compliance.

WILLIAMS: Thank you.

ARCH: Other questions? I've, I've got a couple.

STEPHANIE BEASLEY: OK.

ARCH: Your report today says that in January of '21, you created this strategic transformation work group. That was obviously before we did anything with LB1173. I-- I'm assuming you were seeing things. We were seeing things. What, what prompted you to start that work group? What, what did you want to accomplish out of that work group?

STEPHANIE BEASLEY: Actually, the conversation began for the work group with the Capacity Building Center for States in the summer of '20. I had just come and had really been-- you know, we were deep in the very beginning of the pandemic. And so there were some questions about, you know, what works and what's important to Nebraska. And so I asked a group of stakeholders to come together and just inform us, right, so that we could build this vision around how can CFS be a key part of this continuum? Because it isn't just CFS, right, the continue-- the prevention continuum starts long before, hopefully long before they come into interaction with the state. And so it was really-- I contacted the Capacity Building Center for State in Chapin Hall and said, hey, can you, can you help us facilitate a process where we are bringing people together so that we understand what does Nebraska want, you know, to look like and, and what kind of strategies could we put into place to ensure that we're doing the right thing for kids and

families? And so it was very important to us to include persons with lived experience as well. And so we have a lot of fantastic commissions and groups here in Nebraska. And so we tried to pull stakeholders from each of these and put together a team that I felt like all have a very vested, committed effort-- or, you know, interest in what's right for kids and families.

ARCH: That's-- I mean, that's great. I, you know, I look at the-- our-- from our perspective that LB1173 and the hiring of a, of a consultant not knowing the outcome, obviously, of, of what this would be but you starting this, this group in strategic transformation. So it was more than just-- I mean, you're from Indiana, correct?

STEPHANIE BEASLEY: I am.

ARCH: I mean, that's-- that was your, that was your last position. And seeing how Indiana does things, seeing how other states do things, how transformative are we talking about? You know, what's-- what do you-- and I don't, I don't mean to preempt the consultant and all of that, but, but how, how transformative should we be considering when we-- when the consultant comes in and are we talking about tweaking some things or are we talking about significant change?

STEPHANIE BEASLEY: You know, I, I do agree with you that it's sort of-- it's up in the air, right? There's so much to know. I think it's a great opportunity for us to look at-- I'm going to call it soup to nuts, right, from policy to training to staffing, some of our statutes like workforce, you know, our caseload. Is that still the right thing for Nebraska, the 12 and 17? And so I do think it's-- it can be groundbreaking for us. The strategic transformation group really spent a lot of time drilling into what are our values and practice principles and then what priority areas do we believe would see a most significant shift for kids and families? I think the ultimate goal for all of us is we want kids and families not to need the deep end of the system. So prevention is a key piece in that layering on this vision and the data and the outcomes that we are already committed to looking at across multiple systems, putting this consultant in, in the works and telling us really how to deepen that work most rapidly. I think it's an exciting time.

ARCH: I was, I was taking a look at your scope of work for the hiring of the consultant and it, and it's quite broad. I mean, it's, as you say, soup to nuts, including finance-- you know, development of a finance model, taking a look at the state IV-E claiming practices. So

it's not, it's not just programmatic, but it really is the, the whole comprehensive system of child welfare in the state.

STEPHANIE BEASLEY: Absolutely. We are, we're really focused on improving our penetration rate. And what strategies can we employ to do that because that leverage is more federal dollars for us. But I-- you know, we really wanted someone with subject matter expertise, national expertise to really be able to come in and facilitate what's right for Nebraska.

ARCH: Who knows other states and knows what others are doing. Good. I, I-- follow-up question to the ESA, and, and-- you know, I see that since, oh, I say from March to September, you've hired-- recruited and hired 138 new case managers. How are you-- how-- recruitment, half the equation, right? I, I know that in the transition, some people may have liked working for Saint Francis and now don't want to work for the state, whatever it may be. But now that you're beyond that, how are, how are you doing on the net recruitment versus retention?

STEPHANIE BEASLEY: We're much better than where we were in the Eastern Service Area a year ago. I think we'll continue to improve. And part of this is as caseloads start to go down, people are coming out of training. They're taking four cases, then they're taking six cases. Well, then you're going to be taking some of those cases off me, an experienced case manager. So you'll start to see stress levels decrease and stability. We've also really focused-- part of the transition was we were staffing cases. We had multiple partners at the table for the initial staffing. It happened a week before the case and the case manager would then transition over to CFS. Then we had a subsequent review from our continuous quality improvement team. So they did a full case review and they highlighted and lifted up training needs. So they gave us a report about two months later and said, drill into these areas and focus on training the staff in these areas. I think that is going to help our team quite a bit. When we had our meeting in August and September, when we were meeting with the ESA team, they were really earnestly looking for more training. There's been big change from them to go from Saint Francis Ministries processes to DHHS processes. And so it really felt like it was just such a good opportunity for us to understand and continue to support them a bit more. So I really think that that has been one big piece of it.

ARCH: Well, we know from our investigative committees and, and taking a look at Saint Francis, without a doubt, the stability of case

managers is the key to really helping the child. And, and, you know, anecdotally, we continue to hear this particular child had five case managers. And, I mean, I think that I, I, I find some reassurance from your testimony that you're focused on that, understanding it has its challenges, but you're, you're focused on that as well, because I, I think in the end, until we hit some, some greater stability and we don't have the back door swinging as fast as the front door on retention and recruitment, that, that we're, we're just going to continue to struggle. I mean, we know case managers are the key. So what-- as-- Senator Cavanaugh's comment, what can the Legislature do? We, we want to partner with you on that. And, and so if there are things that we need to do to help stabilize and, and continue to grow case managers, we, we need to have those discussions.

STEPHANIE BEASLEY: OK. Thank you, Senator.

ARCH: Other questions? Senator Walz.

WALZ: Thank you. Thanks for coming today. I want to just expand a little bit on Senator Williams' question regarding Alternative Response because it really is a significant increase from 1,582 in a year up to 4,080. And just wondering if you could help me understand how, how does that change relate to the removal of the randomizer? Like, can you explain that?

STEPHANIE BEASLEY: So when I arrived, so it was early 2020, the randomizer was still in place and I believe it was May of that year we removed it. So basically only a small portion of calls that were coming into the hotline could be considered for-- so it was randomly selected calls that were coming into the hotline to say, OK, this small portion could be considered for AR. When you remove that randomizer, it's ultimately removing a filter of cases that could be considered for Alternative Response. So ultimately, when, when hotline calls come in, you have those that go-- some, some calls get screened out because they don't meet any criteria for assessment. It's a small percentage. Then you have a percentage of that are just absolutely traditional response and they are considered an assessment the traditional way because they would meet specific criteria outlined for Alternative Response. So there are 18 exclusionary criteria that say-- that says these automatically go to a traditional assessment of abuse or neglect and then you have a, a pool. Now, nothing is filtered, right? All things that don't meet these exclusionary criteria can be considered for Alternative Response. Now there are also things within that bucket that would lift them up and say, you know, we probably

want another layer of review before we allow this to go Alternative Response. And so there's, I think eight-- I've got them in here, but I think eight criteria that you would then again look at and say mental health issues, some, some pieces, OK, we're going to go ahead and send that over to traditional response too. But when you removed the filter of what could be considered for Alternative Response, ultimately, that's why you've seen that climb, if that helps.

WALZ: Yeah. Were you surprised with the amount that it increased?

STEPHANIE BEASLEY: I think-- no, we weren't surprised. We did project that the-- once we removed the randomizer that we were going to see Alternative Response significantly increase.

ARCH: Thank you. Senator Cavanaugh.

M. CAVANAUGH: Thank you. So part of Alternative Response is voluntary involvement in services. And this is something I just remember from my first year on this committee, the Alternative Response, voluntary Alternative Response, is all the different words that kind of meant the same thing, but it didn't mean the same thing. So when we talk about these voluntary services and, and the involvement, are you seeing a high utilization of those? As we see this increase in Alternative Response, are we still seeing a utilization of the services that are voluntary now?

STEPHANIE BEASLEY: We are certainly seeing parents engage in Alternative Response. If you would like some specifics around the percentages of periods of time that, that parents are engaging, I can get that to you. I don't have that right now.

M. CAVANAUGH: Yeah, that might-- I mean, I wouldn't put it at the top of your list, but it would be nice to have. So then also, who's providing the, the services? Is that something that is provided by DHHS or are you contracting that out?

STEPHANIE BEASLEY: So the oversight of the case would be our team. Our team is holding on to that Alternative Response case. But just like multiple cases, they aren't necessarily clinicians. You know, they aren't going to be doing treatment per se, so they're just really managing the services that are being provided. So those referrals go out to our provider network--

M. CAVANAUGH: OK.

STEPHANIE BEASLEY: --and they are providing service already.

M. CAVANAUGH: OK. Does this in any way alleviate the case management ratios or is it just because they hold on to the cases regardless, it's still all part of that?

STEPHANIE BEASLEY: It's actually more intense.

M. CAVANAUGH: OK.

STEPHANIE BEASLEY: Yeah.

M. CAVANAUGH: All right.

STEPHANIE BEASLEY: You're seeing them more often.

M. CAVANAUGH: Thank you.

STEPHANIE BEASLEY: So these are intended to be shorter term, really support this family, you know, alleviate whatever the issue is and get out. So it, it actually is a, a different level of monitoring and they see them more frequently.

M. CAVANAUGH: OK. Thank you.

ARCH: Other questions? Seeing none, thank you very much--

STEPHANIE BEASLEY: Thank you, Senator.

ARCH: --for your testimony and your briefing today. Appreciate that. We'll stay in touch, I'm sure. That will conclude the briefing by DHHS on child welfare consultant and we will now open the hearing for LR417 and Senator Hansen. I would simply say as well that if you weren't here when we opened, that this particular hearing will be open for testimony if, if those of you. But be sure and fill out your green sheets and, and follow the procedures. Senator Hansen.

B. HANSEN: Good afternoon, Chairman Arch and fellow members of the Health and Human Services Committee. My name is Ben Hansen. It's B-e-n H-a-n-s-e-n, and I represent District 16 in the Nebraska Legislature. I'm here today to introduce LR417, an interim study to review the current Medicaid reimbursement rates and the processes for difficult-to-place patients in Nebraska's acute care hospitals. I brought this resolution at the request of Nebraska Hospital Association. I've asked that they provide a greater outlook of the

challenges and barriers they are facing. One of the greatest concerns is transferring patients to the appropriate level of care. Last month, last month, the NHA surveyed their members. They found that 229 patients were not at the appropriate care setting and were awaiting discharge over seven days. In an ideal situation, once acute care hospital patients improve to a certain level, they are discharged to skilled nursing facilities or long-term care in a timely manner, allowing the hospital staff to direct their energies to patients with more pressing medical needs. With the inability to transfer patients to the appropriate level of care, some patients essentially live in private hospital rooms, receiving one-on-one care and taking up precious bed capacity with no compensation provided to the hospital. Sometimes patient stays can exceed 300 or even 400 days. We are seeing these cases in every hospital across the state. As a patient, would you want to be living in a hospital setting for that length of time? It is not fair to the patient or the hospital staff to care for someone that is in the wrong care setting. The difficult-to-transfer patients may have mental health problems, physical disabilities, alcohol and drug abuse, function poorly, and have a great need for care or a combination of all of these problems. The most common barriers include, but are not limited to, pending Medicaid, lack of guardian, green card status, payer source, medically complex and having specialty equipment and transportation needs such as a tracheostomy bariatric, traumatic brain injury, dialysis or expensive medication. These patients may also have criminal histories. Another barrier is that long-term beds are hard to come by, especially for patients 55 and under, as the healthcare industry faces staffing shortages. From what I understand, the problem lies in the fact that Nebraska is limited in the amount of facilities able to take these patients. Whether it is due to regulatory burdens, the lack of funds to staff these facilities or inadequate resources to serve more clients, the long-term options we, we do have are often full or not able to provide the correct level of care necessary for these patients. I wonder if there are ways we can help these skilled nursing and long-term healthcare facilities. The possibility of promoting in-home healthcare options should also be a part of this conversation. This will provide a solution to the risk of acute care hospital beds being at full capacity, and would eliminate patients being distanced from family, an unfortunate predicament often experienced by these placed in long-term care facilities in rural districts. Our skilled nurses would be able to offer excellent care and give the one-on-one attention that some of the difficult-to-transfer patients require. Another aspect to consider is the Medicaid reimbursement rates for

patients in acute care hospitals. These rates may need to be updated to adequately allow for long-term hospital stays. Medicaid Advantage, Medicaid Advantage is denying claims at an increasing rate, which is causing further problems. Other states have addressed the additional financial strain that extends-- that extended stays create by updating the reimbursement rates and process for long-term acute care hospitals. There is no quick fix to finding a solution for difficult-to-transfer patients. Earlier this year, the Governor authorized over $7 million to construct and staff alternate care sites to transfer some patients. And those sites helped, but all those facilities have since closed as the funding ran dry. The Governor and his team have constructed a task force to examine the issue and discuss ways the state can help. The NHA also created an advisory board to examine transitions of care and some of their members are here today to discuss their problems and ways we can provide relief for hospitals and their staff, but most importantly for the patient and the patient experience. You all should have some information from the NHA transition of care advisory group, including data showing the regions where there are patients awaiting discharge, discharge and barriers for transfer. It is my hope that the committee listens closely to all those involved and the concerns for difficult-to-transfer patients in case we or the Governor need to take early action in the session. Thank you for your time today in looking to find a path forward towards solutions. While I'm happy to answer questions to the best of my ability, there are experts behind me that have in-depth knowledge of the problems hospitals are facing who will be able to offer more information. Thank you.

ARCH: Thank you. Are there any, are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Hansen.

B. HANSEN: Um-hum.

M. CAVANAUGH: I just apologize because I'm not remembering this. The $7 million that the Governor authorized, was that something that was done through the Legislature or can you tell me more about that because I--

B. HANSEN: I believe that was through ARPA funds, but I could be wrong. I believe the NHA will probably know no more about that than I would.

M. CAVANAUGH: OK.

B. HANSEN: Yeah, it's a good question.

M. CAVANAUGH: Thank you.

B. HANSEN: Thank you.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Senator Hansen. I've got a question for you, but what will be for others coming up afterwards. Are we-- it seems to me that we're looking at two things here, and I want to be sure that we focus on both of them. One is transferring patients that need a higher level of care than is being provided is one issue, but also transferring patients that need a lower level of care. And I'm hoping that we can focus on both of those with the discussion.

B. HANSEN: Yeah, and I think that's a good question. I think a lot of it has to do with acute versus chronic as well.

WILLIAMS: Yeah.

B. HANSEN: So as chronic patients, they can have higher or lower levels of care. And I think the higher levels of care are even tougher to place, like, you know, who need, you know, who might be bariatric who have a, a, a tracheotomy or they have a feeding tube, you know, that require more levels of care that are much harder to place, so yeah.

ARCH: Other questions? Seeing none, thank you.

B. HANSEN: Thank you.

ARCH: And I would ask that-- I know that-- I know some of you are here as, as members of the general public to testify. If, if I could ask that-- I'd like to hear to begin with from some of the folks from the industry, the nursing homes, the hospitals. I believe you're ready to testify as well. And-- yes--

JOEY LIGWINOWICZ: It's painful to sit in this chair. I was wondering if I, if I could speak first.

ARCH: Please, please come, come forward and speak.

JOEY LIGWINOWICZ: Thanks a lot.

ARCH: You bet. If you would-- if-- you've, you've testified previously so you know state your name and spell it.

JOEY LITWINOWICZ: Yeah. I don't know if I can spell it. I was 25 before I could do that. My, my name is Joey Litwinowicz, J-o-e-y L-i-t-w-i-n-o-w-i-c-z. Now you can see why. I, I came here today, I'm totally in support of this bill. And not only that, because of catastrophe, this is a perfect example of why we need provider rate increases probably across the board. So I recently lost one of my health aides just because she couldn't do anything and she did a lot of my hours and I couldn't-- I still can't get one. And the owner came today-- I mean, I have some from the other-- you know, about half my hours I can do. And so the owner is frequently coming out because he can't hire anybody. And, and it's, it's such a disaster because what spurred me to come on in the morning-- or right now is that I was a-- my health aide-- well, anyway, I was having-- I barely got on the-- anyway, I had an accident, you know, in the bathroom. And so I pulled my pants up too tight. I got, I had to get out of here, though, and, and, and come tell you guys this because it's, it's, it's a disaster. I mean, it's just-- there's other stuff I can talk-- I just-- escapes me at the moment, but just thanks for hearing me out.

ARCH: Thank you. Are there any questions? Seeing none, thank you for your--

JOEY LITWINOWICZ: I just wanted to-- I got to go and, and thanks.

ARCH: Sure. Thank you. Thank you for your testimony. Next testifier on LR417. Welcome.

ANDREA LONOWSKI: Thank you.

ARCH: You may proceed.

ANDREA LONOWSKI: Thank you. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. Thank you for holding this hearing today. And thank you, Senator Hansen, for introducing LR417. I'm Andrea Lonowski, A-n-d-r-e-a L-o-n-o-w-s-k-i. I'm the care continuum director for Nebraska Medicine, which is a nonprofit, integrated healthcare system affiliated with the University of Nebraska Medical Center. Our health network includes two hospitals, Nebraska Medical Center and Bellevue Medical Center, and nearly 70 specialties and primary healthcare centers in the Omaha area and

beyond. Over the past week, we have had an average of 85 patients in our hospitals that are medically stable and ready for discharge, but unable to access appropriate post-acute placement for a variety of reasons. This is equivalent to an entire hospital similar to the size of our own Bellevue Medical Center or Methodist Fremont or Kearney Regional, full of patients who no longer require acute inpatient level of care. As you can see on the attached slide two, this high number of patients waiting for discharge have become the new normal for us. This throughput issue creates challenges not just for individual hospitals, but for our entire healthcare ecosystem. Inefficient care transitions hinder-- transitions hinder patient outcomes, add uncompensated care cost to the system and limit patient choice and access to the right type of healthcare at the right time. Every day that a medically stable, ready-to-discharge patient remains in our hospital, it's called an avoidable day. Our health system absorbs the cost of avoidable days, as we are generally reimbursed a set amount on a diagnosis and complexity, not based on a length of stay. Our health system experiences an estimated 27,000 avoidable days at a cost of about $24 million per year, as detailed in slide three, and a number of our avoidable days are rising. Every hospital bed being used by patient ready-- by a patient ready and waiting to discharge is a bed that we cannot provide to someone else in need. Annual avoidable days equate to approximately 3,900-plus patients who care-- whose care is delayed or denied because of the barriers to efficient post-acute transitions. We are seeing a backup in our emergency department with patients waiting significantly longer to be admitted to the inpatient beds. Our stretched capacity also limits the number of transfers from across the state to our-- across the state that our healthcare system can accept. As, as the state's tertiary academic medical center, there are some services that Nebraska Medicine uniquely is suited for to provide, including treating certain kinds of emergencies, cancer care, and organ transplants. If our beds are full of patients who no longer need our level of care, we cannot take care of those who do. The largest system barriers to post-acute placement that our hospital system face are complex discharge patients, payer barriers, and guardianship challenges. Today, the remainder of my comments will focus on complex discharge patient barriers, while other testifiers will provide greater detail on the other challenges. Complex discharge patients often have multiple barriers that result in extended lengths of stay. The average length of stay at Nebraska Medicine for complex discharged patients over the past two years have been 112 days, although we actually had a case of one that stayed for 706 days. Many of our complex discharged patients have multiple health needs that

require post-acute facilities to have specific types of expertise and specialty equipment. For example, to accept a bariatric patient, post-acute facilities require expensive bariatric equipment, such as an oversized bed, oversized chair, wheelchair and walker. The room often needs to be a private room for a Hoyer lift, and the staff need supportive services and education to ensure appropriate handling of the patient to avoid patient and staff injury. Often these patients have multiple other needs, such as special diets, diabetes management and wound care. In addition to the bariatric patients, we often struggle with placement of patients who have behavioral health conditions that do not fit the criteria for an inpatient psychiatric program. Patients diagnosed with dementia, Alzheimer's, or even those that experience a traumatic brain injury can be difficult for us to create a safe discharge plan because the long-term care facilities must be prepared to devote extra time to these individuals. Extra time and education mean extra cost. Safety concerns must also be considered for the wandering patient or the individual with unpredicted outbursts that could harm those vulnerable residents. To help our healthcare ecosystem provide appropriate post-acute care opportunities for patients with complex needs, we recommend that this committee consider implementing specific supports to post-acute facilities to provide care for patients with complex needs. Although I have only addressed complex patient care challenges in detail, we support the range of solutions that will be proposed by our other hospital system colleagues and Nebraska Hospital Association, including increasing capacity of the Office of Public Guardian and Medicaid program and payment enhancements. We look forward to working with this committee and to maximize, maximize access to appropriate care, treat patients in the right care setting at the right time, and get the most out of the healthcare dollars. Thank you for your consideration, and I'm happy to answer any questions that you may have.

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

WILLIAMS: Thank you, Chairman Arch, and thank you for being here. Of the 85 patients that you're talking about at, at any point in time, how many of those are Medicaid patients that you're looking for Medicaid reimbursement on versus private pay?

ANDREA LONOWSKI: My apologies. I do not have those numbers with me. I can get those sent to you, though. I do not have those written down right now.

WILLIAMS: OK. I, I think that would be helpful for us to understand that difference because we deal oftentimes specifically with Medicaid--

ANDREA LONOWSKI: With Medicaid.

WILLIAMS: --reimbursement--

ANDREA LONOWSKI: Yes. Yes.

WILLIAMS: --issues.

ANDREA LONOWSKI: And I think someone is talking about the Medicaid so they might be able to give you a better idea with the, with the data that we put in for the Nebraska Hospital Association.

WILLIAMS: OK. Thank you.

ANDREA LONOWSKI: Uh-huh.

ARCH: Other questions? I have one.

ANDREA LONOWSKI: Uh-huh.

ARCH: So for the patients that are currently waiting placement to another-- are these, are these all going to be-- I mean, obviously, you're at an acute care level--

ANDREA LONOWSKI: We are.

ARCH: --in the hospital.

ANDREA LONOWSKI: We are.

ARCH: Will this-- will all of these be a step down?

ANDREA LONOWSKI: Well, to us, how I interpret this is this is going to the next level of care. So most of these are going to the next lower level of care--

ARCH: Right.

ANDREA LONOWSKI: --such as skilled nursing homes and long-term care. Some are going to the next level of care, which we call long-term acute care.

ARCH: OK.

ANDREA LONOWSKI: And so-- and/or acute rehab, where they get more extensive rehabilitation or they're going to have longer stays because of their complicated problems, like in the long-term acute care where they're having "trachs" and it's going to take a longer rehab. I hope that makes sense.

ARCH: Yes, it does.

ANDREA LONOWSKI: OK.

ARCH: It does.

ANDREA LONOWSKI: OK.

ARCH: Yeah, so it could be long-term acute care that they would go to.

ANDREA LONOWSKI: Yes, they could, sir.

ARCH: Not a hospital, but they're-- they'll be cared for at a--

ANDREA LONOWSKI: It's a different level.

ARCH: --at a very high level of care.

ANDREA LONOWSKI: Um-hum.

ARCH: Yeah, OK. Any other questions? Seeing none, thank you very much for testifying.

ANDREA LONOWSKI: Thank you.

ADRIENNE OLSON: Hi.

ARCH: Welcome.

ADRIENNE OLSON: Thank you. Do you want me to go ahead and get started?

ARCH: Please.

ADRIENNE OLSON: OK, great. Well, good afternoon, I am-- Senator Arch and members of the Health and Human Services Committee. My name is Adrienne Olson, A-d-r-i-e-n-n-e O-l-s-o-n. I have been a registered nurse in the state of Nebraska for over 15 years, working in both rural and urban settings. I currently serve as the chief nursing

officer and vice president of patient care services at Bryan Medical Center here in Lincoln, Nebraska. I come to you today on behalf of Bryan Health and the communities we serve to describe the challenges we experience when we cannot-- when patients cannot access the correct level of care. When a patient no longer requires care in an acute care facility, there are a variety of options. They could be discharged home independently or another post-acute level of care may be required. The process for securing post-acute placement is multifactorial and highly complex. Bryan Medical Center has anywhere from 20 to 40 patients at any given time that cannot access the correct level of post-acute care. Barriers to appropriate placement typically include securing guardianship, bariatric body habitus, sex offender status, or payer source. Each week, the care transitions team at Bryan Medical Center meets to discuss patients who have a significant barrier to post-acute care placement. These patients are considered long-stay patients that no longer need our acute hospital care and are not appropriate to return home even if they had health home-- home health services. Last week there were 22 patients on this list. Guardianship is the key barrier for six of those patients. Three of those patients who are waiting to have a guardian assigned to them from the Office of Public Guardianship now have hospital lengths of stay of 350, 142, and 113 days. The average length of stay at a-- at-- for a patient at Bryan Medical Center is approximately five days. If each of those patients had been appropriately discharged to a post-acute setting, 118 additional patients who did require acute care could have been cared for in those beds, those three beds alone. Stated another way, we have had an average of 389 avoidable patient days each month this year. The unnecessary occupancy of acute care beds leads to dangerous ramifications. Hospitals are consistently over capacity. As we enter into what is to be a predicted-- predicted to be a harsh flu season, and what we are already seeing with RSV numbers and other pediatric respiratory illnesses on top of the lingering effects from the pandemic, there's urgency to free up our acute care resources so that every patient has access to the level of care that they need. Our team is committed to providing safe discharge plans for our patients and securing placement that accommodates the appropriate level of care is vital. We need action by the state to focus in the areas of guardianship, Medicaid reimbursement rates for hospitals and nursing facilities, and support for nursing facilities to make capital improvements to accommodate patients with expanded medical needs. Above all, we ask the state to make the same commitment to the Nebraskans that we mutually serve to have access to the level of care they need. I am grateful for the opportunity to share the challenges

that our patients and colleagues face, not only at Bryan Medical Center, but in each hospital throughout the state. We ask that you be moved to take action in the upcoming legislative session for the health and well-being of Nebraskans and our state's healthcare delivery system. Thank you for your time, and I would welcome any questions that you have.

ARCH: Thank you for your testimony.

ADRIENNE OLSON: Yes.

ARCH: Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you for being here. The-- you stated hospitals are consistently over capacity. Is that overcapacity due to staffing shortages?

ADRIENNE OLSON: I would say-- so in general, I think that absolutely plays a part in it. At Bryan Medical Center specifically, we haven't closed beds. We're actually opening more units to allow for overflow. So, for example, yesterday for pediatric space specifically, we were at 147 percent occupancy. And that has to do with boarding patients in the ER. A lot of that is because, like was described earlier, you can't free up the bed on the floor, then you're holding people in the ER until you can get them where they need to go. I have heard of other facilities in the state, though, that it would be largely that they're decreasing the capacity because of staffing, so.

WILLIAMS: Yeah. You mentioned you have experience in the rural side along with here in Lincoln--

ADRIENNE OLSON: Yes.

WILLIAMS: --at Bryan. And, and my constituency base is rural with rural critical access hospitals.

ADRIENNE OLSON: Um-hum.

WILLIAMS: And I'm aware of several situations there where it's the reverse of what you're talking about here.

ADRIENNE OLSON: Exactly.

WILLIAMS: It's they need to move a patient to a hospital that can provide a higher level of care.

ADRIENNE OLSON: Um-hum.

WILLIAMS: For instance, a patient that has sores that need certain kinds of surgery that they can't do in a hospital in Cozad, but UNMC can.

ADRIENNE OLSON: Right.

WILLIAMS: Do you have any comments about that direction too?

ADRIENNE OLSON: Yeah, I would love to comment on that. I'm very happy that you asked that question. I was the CNO at Kearney Regional Medical Center for about nine years, a little over, right before I moved here in July to join Bryan Medical Center. And I will say that that situation for not just critical access hospitals but other acute care facilities that don't have the expanded range of services, it's terrifying because-- so in our instance, we would potentially need to send a patient from Kearney to here in Lincoln or to Omaha to Nebraska Medicine. And when you have to sit on that patient because there isn't a bed available where they can actually be cared for, it's terrifying. It really is. And when you have staff that are overstretched anyway, so they're taking more patients than they would normally take, plus these patients become more and more acute, it's, it's a really-- a rough situation. And not just the nursing staff, the physicians and providers that, you know, they're used to seeing these patients, stabilizing them, and then shipping them out and that it's just you're lucky if you can get a bed where those people need to go. So it's, it's scary.

WILLIAMS: It's a completely different issue of, of lifesaving or not. If you're transferring a patient to a lower level of care, they're already in a higher level of care--

ADRIENNE OLSON: Yeah.

WILLIAMS: --they're safe. They're cared for.

ADRIENNE OLSON: Sure.

WILLIAMS: You may not have the availability of the beds--

ADRIENNE OLSON: Yeah.

WILLIAMS: --but the other direction is, is--

ADRIENNE OLSON: Right.

WILLIAMS: --life threatening to that patient.

ADRIENNE OLSON: Right, and the other-- so it's like the, the first direction that you described is the thing that's preventing the lifesaving measure direction, you know, so it just is a kind of a vicious circle.

WILLIAMS: Thank you.

ADRIENNE OLSON: Yes.

ARCH: Other questions? I have one.

ADRIENNE OLSON: Yeah.

ARCH: Help us understand guardianship a little bit better. You mentioned, you mentioned some of them are waiting for guardianship.

ADRIENNE OLSON: Um-hum.

ARCH: If, if you're waiting for guardianship, how is the hospital handling the care of that adult? Who's making the decisions on the medical care?

ADRIENNE OLSON: So I would-- I do not know the ins and outs because I'm not actually a caseworker and I haven't done that work. But what I understand is that it is extremely complex and it's different in every situation. And I think that it leaves the care of the patient kind of in question sometimes, which is another problem. It's a completely separate thing, but it, it's from what I understand, there's an entire team working on figuring out options for that, but there just aren't enough and it takes too long. And yeah, there's question on how to care for the patient in the meantime.

ARCH: Right, because guardianship implies that the patient is not able to make those decisions themselves.

ADRIENNE OLSON: Exactly.

ARCH: So, OK.

ADRIENNE OLSON: Yeah.

ARCH: Perhaps somebody else could answer that--

ADRIENNE OLSON: Yeah, probably.

ARCH: --that comes up.

ADRIENNE OLSON: Yes.

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

ADRIENNE OLSON: Thank you.

ARCH: --testimony. Next testifier. You may proceed.

HENRY SAKOWSKI: Thank you, Chairman Arch and the members of the Health and Human Services Committee for this-- for listening to us today. My name is Dr. Henry Sakowski. That's spelled H-e-n-r-y S-a-k-o-w-s-k-i. I'm the medical director for CHI Health Partners, which is part of the CHI Health Midwest regional health network, consisting of 11 hospitals in Nebraska, as well as 17 in Iowa, Minnesota and North Dakota. CHI Health Partners provides primary care for over 60,000 Medicaid beneficiaries in Nebraska. One particular challenge that Medicaid beneficiaries face is post-acute placement, as you've heard, following an inpatient stay at one of our hospitals. Patients with baseline complex medical and behavioral issues that require inpatient care for an acute medical condition frequently require ongoing skilled nursing care or rehabilitation after the acute illness has been treated. Skilled nursing facilities, however, are often unable or ill-equipped to safely manage these patients with complex conditions, and their previous caregivers are not able to provide the skilled care or rehabilitation that they now require. These patients are resigned to remain in the acute care hospitals, which are not staffed nor equipped to provide rehabilitative services to these patients, thus delaying their recovery. Post-acute placement delays are deeply problematic for three reasons, three main reasons: For patients in need of rehabilitation for ongoing long-term care, recovery and health outcomes may be negatively impacted by the lack of timely access to appropriate services. The acute care setting is often not the best place for these patients to encourage their long-term recovery. And when a patient cannot be placed in an appropriate post-acute setting in our community, it is not uncommon for acute care management staff to look outside the community and even outside the state for facilities to care for these patients. This places additional burden on, on the patient's loved ones who may be needed to fill in as caregivers. Number two is patients who no longer require acute care services but remain hospitalized may restrict access to acute care for

patients who desperately need it, as you've heard. This exact situation occurred within the past year with the pandemic and associated workforce staffing shortages wherein staff beds were filled and unavailable and requests for transfers into our health systems were at times denied. This results in dangerous care delays for patients requiring acute care and the need to receive-- for them to search for care outside our community, which again places patients away from their loved ones and caregivers. Delays in the discharge of Medicaid patients results in additional uncompensated care for already financially strained hospitals struggling to recover from the COVID-19 pandemic and, and rising labor and supply costs. In the past years-- in the past year, our CHI Health Nebraska hospitals recorded over 29,000 hospital days that were attributed to avoidable delays. Of those, just over half of all avoidable delays were due to insufficient post-acute placement options to meet the patient's ongoing needs. This is significant because Medicaid reimburses a fixed amount based on the diagnosis and medical necessity, not length of stay. So if acute care is no longer deemed necessary, but we are unable to secure post-acute placement, we are left in a precarious financial situation. Delays in insurance approvals for transitions of care also impair the hospital's ability to efficiently discharge patients and open access to acute care for those who truly need it. Want to share an example of a patient that we continue to care for in our hospitals long beyond their treatment for acute care-- for their acute illness. This patient was admitted to one of our hospitals for a total of 785 days, spanning over two and a half years that was split between two separate hospital stays. The patient required one-on-one supervision for much of their hospital stay because of significant cognitive and behavioral issues and, and violence stemming from frustration in their needing to stay in the hospital. During his first day, which totaled 563 days, the hospital recouped 17 percent of the charges from Medicaid for his care. During his second 222-day stay, Medicaid covered only eight days, meaning that 214 days or 96 percent of the hospital stay resulted in uncompensated care. CHI Health support solutions for this patient and others being offered by the Nebraska Health Associ-- Nebraska Hospital Association and our fellow member hospitals including: administrative, administrative fees for nonmedical stays equivalent to appropriate post-acute care setting. Number two, incentives for swing beds in, in nursing homes to accept complex patients. Number three is increased payment for post-acute settings accepting Level II PASRR patients. And number four, alternative community-based, post-acute care models. I want to thank you, the Health and Human Services Committee, for your support of strengthening

the continuum of healthcare services for Nebraskans on Medicaid and easing the financial pressures for healthcare systems providing the best possible care. And I'd be pleased to answer any questions.

ARCH: Thank you. Are there any questions?

WILLIAMS: I'm sorry, I keep asking questions.

ARCH: No, it's all right. Senator Williams. It's why we're here.

WILLIAMS: Thank you, Chairman Arch. And thank you, Doctor, for being here. I want to go back to a question I asked earlier about those, those patients that are in the situation that are Medicaid patients and those that are private pay. And you've done a good job of describing the situation with Medicaid. What happens with a, a patient that would be private pay in, in that? Are insurance companies then declining to make payments on those extra days?

HENRY SAKOWSKI: I guess I need a definition of private pay. Private pay, we usually-- I equate to somebody who does not have insurance so they're paying, they're paying out of pocket.

WILLIAMS: OK, let's say it's someone that has--

ARCH: Commercial.

WILLIAMS: --commercial insurance.

HENRY SAKOWSKI: Yeah, it's, it's similar.

WILLIAMS: So they are-- if-- same kind of thing that you have with Medicaid.

HENRY SAKOWSKI: Right.

WILLIAMS: If they're not improving--

HENRY SAKOWSKI: Yeah.

WILLIAMS: --you'd lose coverage there too.

HENRY SAKOWSKI: Yeah, but because commercial insurers reimburse at a higher rate for their-- for post-acute care, it's not quite as difficult to get them placed.

WILLIAMS: OK.

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

HENRY SAKOWSKI: Thank you.

ARCH: --testimony. Good to see you again, Dr. Sakowski.

JEREMY NORDQUIST: Good afternoon--

ARCH: Good afternoon.

JEREMY NORDQUIST: --Chairman Arch, members of the Health and Human Services Committee. I'm Jeremy Nordquist, J-e-r-e-m-y N-o-r-d-q-u-i-s-t, president of the Nebraska Hospital Association. First of all, I want to thank Senator Hansen for working with us and introducing this and for your attention and taking time to hold a hearing on this important topic today. Certainly, if you talk to hospital leaders around Nebraska, you know, workforce would be priority one. But the growing financial pressures and, and then post-acute placement are right up there in terms of the challenges they're facing. And I think Andrea, Adrienne, and Henry did a good job laying out the challenges that we're seeing. I do want to point out the handout we just gave out. This is about a week old, hot off the press. We started serving our members fully in September. We did a, a snapshot way back in March, but we're going to be doing an ongoing monthly report with our membership on this issue, and we'll make sure to provide this to you as we go forward. Senator Williams, to your question, there is a payer breakdown. You know, Medicaid is, is probably about a third. So it isn't, it isn't the whole enchilada here. And this is a growing topic of conversation at the federal level among hospital leadership to our members of Congress when it comes to Medicare payment. You know, I think, I think we hit on the, the impacts here. Obviously, there's impacts to patient care, both for the individual who can't get transferred to the right level of care. If you're not in the right setting, your recovery isn't going to be as good as it could be if you were in the right setting. That means, that even means moving from an acute care hospital bed to a rehab. You may consider that a lower level of care, but it's the right level of care for you, and you're going to get the right rehabilitation supports there to, to have the best recovery. Certainly, you know, no one, no one would benefit from unnecessarily being in a hospital bed for six months or 300 or 400 days, as we've heard in some situations. So it really, first and foremost, is a patient care issue. It's a workforce issue. We actually just had a call yesterday of a new workforce collaborative we set up with higher education and a, a number of

healthcare groups and talking to representatives of our nurses. These more challenging patients unnecessarily being in the hospital, being in the wrong setting adds another layer of taxing work to our hospital staffs that are already stretched and stressed. Having a behavioral health patient in a non-inpatient behavioral health bed and just a general acute care bed, it's more work and it's more challenging. We got to get those patients in the right level of care. Obviously, capacity-- it's a capacity challenge. The Governor, since day one of COVID, has made, you know, hospital capacity the guiding light of decisions. And we did a good job the best we could, I think, through COVID. But right now, you know, we know we have no open hospital beds. And, and just this morning, we had a call with DHHS, Children's Hospital, Boys Town, and the systems to talk about this pediatric surge that we're seeing. And when, when pediatric beds are filled, then the next flow is nonpediatric inpatient beds. But because of this being part of the issue, we don't have any of those excess beds sitting around. So what used to be a relief valve when there was a pediatric surge really isn't in there. And then, you know, the financial pressures that are growing on our hospitals with inflation, with the costs of labor supplies, medicines not being able to be reimbursed for this care as these patients sit there and then not, not being able to do procedures that would then generate some revenue to benefit the bottom line, all of that makes the financial pressures worse. So we, we came today with another sheet here with a hand-- a few suggested policy changes. We worked on this with our transitions of care counsel, with hospital members. We've also engaged with our allies in-- with the nursing home-- the Healthcare Association and nursing homes and really laid out five buckets that we think we can make progress on. Again, all of these are probably a little longer-term solution than, than we wish they were. The short-term solution, what the Governor helped us with, with the alternative care site, additional support for staffing right now if we need it. That, that's about the best short-term solution we're going to get. But in terms of longer term, looking at specialized care units. It's challenging to send one behavioral health patient to a nursing home that isn't staffed to handle behavioral health patients. But could we create reimbursement model that would allow for specialized units for behavioral health or bariatric patients, helping our nursing homes get some grant funding to procure the equipment to handle, you know, the lifts for bariatric patients and maybe some renovation that's needed to be able to care for those patients? Those would-- that would be one-time expenditures. Growing our guardianship capacity in the states, obviously we have a waitlist. Last year, I think it was 68

percent of the guardian cases went-- for hospitals went to the waitlist. So that's a backlog we have to address. I'll go through real quickly for the next two. Reimbursements for-- reimbursement for hospitals, basically some sort of per diem. Several states have moved forward with a, a reimbursement beyond the DRG for, for patients sitting in hospitals without any payment mechanism. There's actually going to be a push in Congress also to talk about this for Medicare. And then finally, the long-term acute care hospitals, I think there's 24 states that have a long-term acute care hospital, we're one of those, 17 of those 24 have Medicaid reimbursement. Right now, if a patient comes into our hospital and needs long-term acute care, so that's, that's beyond our average length of stay of five or six days. It's 25 days is the average length of stay for a long-term acute care hospital. They're with us. We get the DRG. We're trying to do the best in our hospitals with them. But it's not the right level of care. If they're in a long-term acute care hospital, they're going to get probably more rehabilitation, the right level of rehabilitation and have better outcomes. But we don't have that reimbursement mechanism. So if they're a Medicare patient, they get it. If they're a Medicaid patient, they stay with us and can't go to that, that level of care. Sorry for going over time.

ARCH: Questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Senator Nordquist, for being here. We've talked a lot about the patients needing to be transferred. We have not talked much about what I consider to be an even larger issue than that. And that is simply the level of Medicaid reimbursement that is both going to our hospitals and to our long-term care facilities, situation that some of us talked about at your association meetings last week that we were fortunate that I think we increased those reimbursements a little bit last year, maybe around 2 percent. At the same time, you're experiencing and we're all experiencing 8.5 percent inflation rates with the things that you mentioned early in your testimony. Opening that up as an issue, are there any comments that you would like to make on that general business model where if I'm understanding it right, many of your facilities are relying on somewhere between 60, maybe even up to 70 percent of their reimbursement is either from Medicaid or Medicare so--

JEREMY NORDQUIST: Yeah, you know the numbers well.

WILLIAMS: --and the clock is not running, so you can answer my question.

JEREMY NORDQUIST: Yeah, you're, you're right. It, it can be as, as high as, as 80 percent payer mix from government payers; 60, 70 is probably the typical range. And what we've seen, you know, from the state, it was 2 percent a year the last two years in the budget. Medicare I think last year was 2.3. They're proposing for Nebraska's rate collectively is I think 3.2 or 3.5 for the, for the coming year. All while in the last two years, our collective costs have gone up about 28.1 percent. Labor being a big driver, that supplies are both-- those are around 20 percent, food and utilities, 15 percent or so. But then medications are up about 30 to 40 percent. So combined 20 percent over two years. So if a hospital, you know, that's why we're starting to see across the country now, 50 percent of hospitals are running negative margins. And what that means is pulling back-- we can't turn anyone away, but pulling back on services that, that some may deem optional are essential for trying to-- you know, I'm not, not saying any hospitals are in particular cutting, you know, things yet. Some have closed their-- one in Geneva closed their geriatric psych unit. We've seen hospitals that own nursing homes that don't generate a profit. A few have pulled back and closed those over the last six months. But, but ultimately, hospitals are, you know, they're, they're nonprofit entities, but they can't survive forever on negative margins. So we've got to make sure that our reimbursement rates are, are keeping up with the cost of providing care. Again, Medicaid, we all know, only typically covers 50, 60 percent of the cost of, of the care and for hospital-based care. But we can't let that slip much further than that or the ability to, to provide care will be impacted.

WILLIAMS: Thank you.

JEREMY NORDQUIST: Yeah.

ARCH: Other questions? It's hard, it's hard to judge the financial impact, isn't it?

JEREMY NORDQUIST: Yeah.

ARCH: I was going to ask if there's a study been done of, obviously, it's expensive to stay, but not if nobody's paying.

JEREMY NORDQUIST: Yeah.

ARCH: Right? And so I-- you know, I won't, I won't ask the question, but, but obviously, it is expensive for patients to stay in the hospital when they don't need to be in the hospital.

JEREMY NORDQUIST: That's right. That's right. We've had--

ARCH: I mean, it's expensive to the system--

JEREMY NORDQUIST: Yeah.

ARCH: --the healthcare system.

JEREMY NORDQUIST: That's right. That's right. It's-- yeah, you know, the hospitals, if they were in a, a maybe a better financial time could weather some of this in their own bottom line. But I think because of the inflationary issues and, and, and workforce costs and rates not keeping up there, if the margin goes down, it's tough to offset these other losses that, that, that continue on. But, you know, we also don't want-- you know, it isn't just a financial thing, it's--

ARCH: Sure.

JEREMY NORDQUIST: --obviously about those patients getting the right care at the right time.

ARCH: Right. All right. Other questions? Seeing none--

JEREMY NORDQUIST: Thank you.

ARCH: --thank you very much.

JALENE CARPENTER: Good afternoon.

ARCH: Welcome.

JALENE CARPENTER: Good afternoon, Chairman Arch and members of Health and Human Services Committee. My name is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r. I'm the President and CEO of Nebraska Health Care Association. I am here today to testify on LR417 on behalf of our 185 nonprofit proprietary skilled nursing facility members and our 233 nonprofit proprietary assisted living communities who currently serve roughly 20,000 Nebraskans. We appreciate Senator Hansen bringing the issue, this very difficult issue of difficult-to-place hospital patients to light. The need for Nebraskans to provide necessary resources for certain types of individuals have been a problem for

decades. Difficult-to-place patients is not a new problem, it's definitely been exacerbated and heightened with the pandemic. In working with the NHA, we've been able to identify several barriers that prevent hospital patients from being discharged. The hospital association provides you with a lot of great data illustrating the issues and the challenges on discharging those patients. So we're hoping to bring you the perspective from long-term care on why long-term care facilities are not accepting those patients. So we surveyed our members. Roughly 50 percent of our members responded, and they identified their primary reasons for not accepting patients, these difficult-to-place patients. So their number one reason was behaviors, which encompasses the following issues: violent, aggressive or sexually aggressive behavior requiring one-to-one supervision, active substance abuse, and other mental illnesses. The second primary issue was no active payor source or no decision maker, which in this example is a guardian. The third is clinical needs exceed the facility's current capabilities as identified from the hospital's trachs, dialysis patients, bariatric patients. And finally, just staffing challenges to meet clinical needs. We're also continuing to face COVID regulations and admitting COVID positive patients, having to shut down, you know, a room and not being able to admit a second person to that room due to COVID positivity, etcetera. I'd like to articulate that nursing facilities can only continue to operate if they admit new residents. So we are in the business of admitting patients. The staffing challenges did prevent facilities from admitting patients during the height of the pandemic. Wings were closed and they had bans on admission for a period of time. Today, our Nebraska nursing facilities are still experiencing a roughly 12 percent decrease in workforce from February of 2020. That equates to roughly 2,000 team members below where they were pre-pandemic. However, we are seeing recovery in new admissions, so nursing facilities are within 1 percent of caring for the number of people they did pre-pandemic. So to state that, again, nursing facilities are caring for close to the same number of patients they were pre-pandemic while continuing to face those staffing challenges. Closures have impacted our overall number of beds and those closures are creating barriers of access specifically in rural communities. I would like to note, as the hospital mentioned, facilities that did close did serve these particular type of patients and that is also exacerbating this problem. In many cases, our data overlapped with the hospital association data. I want to make sure that the-- they did a great job articulating it. Sometimes the problem is identified as, how do we get this person to a nursing home? And, you know, these difficult-to-place

patients are being referred to a nursing home oftentimes because it's the only level of care option, not that it's the right particular care setting. Definitely they need a lower level of care, but it may not be a nursing facility that's appropriate. We continue to work with solutions on these barriers with the NHA. Number one obviously, increasing the number of staffing is always going to help facilities ability to admit. Second would be increased caseload for guardians. Third, we do have an active workgroup with DHHS accelerating that Medicaid application process. There was the conversation and the idea of the utilization of specialty care units for specific clinical needs, for example, a bariatric facility. That does come with additional conversation of specific regulations, proper licensure and liability insurance coverage that can come into play with those specialty units. Overall in partnership with NHA and obviously DHHS, we're committed to finding solutions and I would be happy to answer any questions.

ARCH: Thank you for your testimony. Questions? Yeah, this is a, this is a thorny problem on all, on all levels and it's, it's multifaceted. I think just so people understand, we, we met this summer and with, with provide-- with hospitals and specifically regarding difficult-to-place psychiatric patients, adult, adult patients. And, and the regulations on the nursing homes, the regulations on the hospitals that, that plays a large factor. Can you-- could you speak for a second about those CMS regulations and how that also plays a factor in, in preventing you from accepting some patients or not preventing? It's, it is a, it is a barrier.

JALENE CARPENTER: It is a large barrier that funding, even if funded to cost, would still be a barrier because of the regulations. That's why I would call out if we're evaluating specialty units, the licensure category of a skilled nursing facility may not be the most appropriate because when you're licensed that way, you are regulated by CMS. So there's particular regulations when it comes-- two big barriers. One is when a patient is taking a psychotropic medication. There are disincentive-- there's, there's a disincentive for nursing facilities to take multiple types of those patients because there's a heavy regulatory burden when it comes to managing that patient. They're also required to decrease an antipsychotic or a psychotropic medication that, like, they're-- without a really strong intervention from a psychiatrist that is frequently on site, those facilities are mandated to reduce psychotropic medication. So they may be stable in the hospital. Their medication is great. They're going to come to that nursing home and within the first 90 days, they're going to reduce

those medications, which frequently kind of just catapults the problem because then they end up back in the hospital. The-- a really sticky one when it comes to those behaviors which people identified, whether that's wandering, sexually aggressive, violent, all of those things, is nursing facilities have a regulatory burden of protecting each individual resident's rights. What that translates to is, I cannot infringe upon a potentially sexually aggressive or violent resident's right. I can't isolate them to their room. I have to honor their rights as much as I do another, another resident's right who might want to be not near that particular resident. That comes-- there is a lot of survey burden and there's a lot of regulatory burden when it comes to reporting incidents and so those get reported and investigated frequently. It is not uncommon for APS or DHHS surveyors to be in a facility investigating allegations of abuse, meaning the facility self-reported that. So that ten, there has been recent cases where facilities have been heavily cited of causing immediate jeopardy or causing actual harm because one resident has acted against another resident. That's why you see facilities not willing to accept this particular type of patient because there's just heavy regulation and quite frankly, costly, legal ramifications and as well as CMP fines. Does that answer your question? It's very long, I'm sorry.

ARCH: It does and I-- and then if you put those two together where you're, where you're bringing someone down off of psychotropic meds, and at that point then the patient may become aggressive and assaultive, you've, you've-- yeah, that's a combination that makes a skilled nursing facility reluctant to accept.

JALENE CARPENTER: There is another example of taking Level ll PASRRs, or those diagnosed with a serious mental illness. There is licensure capacity. There's some very old regulations out there saying that you have to-- you can only admit so many of that particular type of diagnosis so that also limits that specialty unit category. You can't fill up an entire facility full of that one diagnosis.

ARCH: All right. Thank you. Any other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Ms. Carpenter. We've talked a lot about the challenging business model that your membership is, is faced with during not just COVID, but during normal times and again from in particular, some of the rural areas of having a higher percentage of Medicaid patients in your facilities and that. I think Senator Nordquist testified, if I remember right, that approximately the Medicaid reimbursement that they are receiving is

about 50 percent of the cost. What would that number be for, for the nursing home, the skilled nursing home facilities?

JALENE CARPENTER: So we did receive a generous increase in the last legislative session that made up a big gap. It was-- we were, it was roughly, we were losing-- we, we look at it a little different than percentage. It's roughly $40 per resident per day. We made up a little over half of that. Now, that was so hard because, you know, that happened in last spring. And then now we are where we are today and we're seeing that wage inflation continue. We're seeing other inflationary costs go up, but we're still just below $20 per resident per day below the cost of care. What is interesting from a skilled nursing facilities perspective, specifically in the rural areas, Jeremy mentioned in hospitals, it's only about a third of their population, so their system is able to absorb that loss. Our rural facilities see anywhere from 60 to 80 percent of their residents being on Medicaid, and so there's nothing else to absorb that loss.

WILLIAMS: So it is, it's clear that the Medicaid reimbursement is falling significantly below the cost of providing service.

JALENE CARPENTER: It is still below, I won't say significantly based upon the increase that we did.

WILLIAMS: Well, I gave you the opportunity.

JALENE CARPENTER: I know you did. [LAUGHTER] I don't want Senator Stinner to read the tape because I, I'll be--

WILLIAMS: He won't be here either. He's, he's going to the same place I am.

JALENE CARPENTER: We, we took a big step in the right direction.

WILLIAMS: Yeah.

JALENE CARPENTER: But we are not covering the cost of care.

WILLIAMS: Thank you.

ARCH: You need to run for office sometime. With, with an answer like that, that's, that's pretty good. All right. Any other questions? Seeing none, thank you for your testimony.

JALENE CARPENTER: Thank you.

ARCH: Other testifiers? All right. Seeing none, Senator Hansen, would you like to close? Senator Hansen waives close. So we will move on to our last LR of the day, and I will introduce this. If Senator Williams--

WILLIAMS: You bet.

ARCH: --you'll take it?

WILLIAMS: All righty. We will open the hearing on LR438 introduced by Chairman Arch. Chairman Arch.

ARCH: All right. Good afternoon, Senator Williams, members of the Health and Human Services Committee. For the record, my name is John Arch, J-o-h-n A-r-c-h. I represent the 14th Legislative District in Sarpy County. I'm here today to introduce LR438. LR438 is an interim study resolution introduced by this committee to identify potential policy changes to improve communication and sharing of case-specific information among state and local agencies responsible for the care, custody, treatment of systems-involved youth with the goal of improving efficiency in treating youth who transition from the care of one agency to another. Over the interim, we convened a group of stakeholders and held a series of roundtable discussions to identify barriers to communication and information sharing with respect to this group of youth. Our group included Senator Walz and myself, Education Commissioner Matt Blomstedt, representatives of the Department of Education, DHHS CEO Danette Smith, and representatives from that agency and State Court Administrator Corey Steel, and representatives from the courts and probation. First, when we talk about system-involved youth, we had to define exactly which youth we were talking about. System-involved turns out to be pretty broad. We decided to start with looking at the care of court-involved youth and this would include those in foster care and those in our, in our YRTC system. We divided the study into two components, education and clinical. This is the information sharing of education, information and clinical information. And in prevent-- and in presenting this interim study, I'm going to do it a little bit differently. I'll introduce the education component first and then I'm going to come back up, take my seat, have the invited testifiers with respect to that component come up, and then I'll come back and introduce the clinical component and follow with those testifiers. First of all, with respect to education, we started with four key questions. What information is already being shared? What opportunities do we have to improve the education of these youth? And third, what barriers exist

to improve communication and coordination of this piece of youths' care? And with that, I will stop and let Commissioner Blomstedt come up and further outline the issues regarding educational barriers. We'll have three testifiers to this, to this piece, the education barriers. It'll be Commissioner Matt Blomstedt, Larry Kahl from the Department of Health and Human Services and LaDonna Jones-Dunlap, who will explain a program that's currently in place. Thank you.

WILLIAMS: Thank you, Chairman Arch. Commissioner Blomstedt, the stage is yours.

MATT BLOMSTEDT: Well, good afternoon, everyone. It's really nice outside when I walked in earlier, so I'll go through my testimony and I appreciate the-- my chance. So I'm Matt Blomstedt. My last name is B-l-o-m-s-t-e-d-t, and I am the Commissioner of Education and I submit the following. I have given you a written copy of and I don't normally read testimony, so we'll see how I do today as I go through this. So first, I would like to express my appreciation to Senator Arch for his commitment to the efforts on this study, as he has sought to convene positive conversations among multiple partners in this important topic and has remained dedicated to the efforts that I hope to highlight here. I also thank Senator Walz for her commitment to the education issues, ultimately that parallel the effort to improve intergovernmental data sharing that ultimately will improve educational outcomes for students who are in the care of the state and who we share a mutual responsibility for in the state education system. Second, I want to thank the leadership of the staff, the Nebraska state probation offices under the Nebraska judicial branch and the staff of the Department of Health and Human Services who have been involved in this effort and continue to build partnerships with the Nebraska Department of Education. I want to remind those in this body and otherwise that the important partnerships between and among state and local agencies is crucial to addressing the challenges of today and tomorrow. Today's hearing is only one example of hundreds of efforts underway to collectively serve our students, families and communities. I will soon complete my ninth and final year as Commissioner of Education. I smiled a bit on that, by the way. I have been party and witness to many conversations, efforts and improvements over the years that have been championed by a number of different people. I appreciate all those efforts from the leadership of the Chief Justice, who has been a consistent leader in convening state agencies with responsibilities for these children to the regular engagement of legislators and to a broader engagement with various commissions and efforts led by very many. I admittedly still, still

feel like I'm learning. Over the years, I had the opportunity to tour the state's YRT-- YRTC system and throw-- though generally impressed by the efforts of those staff on the ground, with each visit, I saw that there were signs of issues with the system writ large. Primarily and obvious to me was the lack of sufficient staff, resources, facilities and supports obvious in my visits there, but also obvious in my visits to schools across the state is schools expressed concerns for supports for students who are system-- systems-involved. As I developed a better understanding of the system impacting these students, in addition to the lack of proper investment, I also noted a lack of system coordination. As situations came to my attention, I volunteered the Department of Education to be part of the solution where we could. I think or hope that this will be a legacy of my time at NDE but I also know the efforts that we have accomplished so far are only the beginning of a necessary foundation of efforts to improve. There are several systems improvements that have developed over the last nine years that include student-level data system improvements, but generally-- excuse me, student-level system data improvements generally, but specifically include foundational efforts, including the Education Court report led by the Supreme Court Commission on Children in the Courts, the improvements in communication to superintendents through the DHHS superintendent letter that notifies schools when students who become state wards or if change in wards status, as well as the recent work to engage and assist in the development and improvement of educational opportunities for students in the YRTC settings. Over the last three years, I've been involved with the initial concerns about education after the closure of the Geneva site. Worked with, with this committee under the leadership of then-Chair Senator Howard, and now to completing the cycle of contracting and consulting with DHHS to provide a superintendent to the current staff-- to the current status where the NDE and DHHS can continue to build on those efforts after seeing DHHS hire the statutorily required superintendent role. With the advent of additional federal funds in the midst of the pandemic, the NDE has invested funds in further improving and enhancing supports for system-involved youth. And I believe that through certain data enhancements, or excuse me, that those certain data enhancements are needed. The follow-up provided by knowledgeable and trained staff to further support students is still necessary. You will have a good example of that work, I think, in the testimony that will follow with from LaDonna Jones-Dunlap. My testimony will focus on the work identified by the efforts so far under LR438. I am pleased to outline briefly all of these important next steps to build on this history and

continue improvements necessary to improve educational outcomes for students under our collective care. The first issue that we identified is an issue of data sharing. It's a challenge for agencies and local school districts as well. There are many barriers to data sharing that include the legal responsibilities, practical application of data sharing, and in many ways, the cost of implementing different systems. During the LR438 convenings and with several other conversations about data sharing, it is clear each entity is willing and eager to engage, but there is a need to dedicate time and resources to the conversation and propose that a consultant is needed to shepherd the various entities through the effort and propose an appropriate method for education data sharing. So the first possible recommendation is that we would introduce legislation to require interagency data sharing among entities responsible for education, treatment and rehabilitation of youth and include an appropriate and include-- I should have said an appropriation-- I see I missed the typo there-- for the hiring of a consultant to develop methods of education data and record sharing among all necessary entities, including but not limited to DHHS, NDE, the courts and such entities serving systems for court-involved youth. There are examples of this approach working to share data among such entities, including the work that advanced education and workforce data sharing over the past several years. Issue two: students who are system-involved have many dis-- disruptions in their educational opportunities and a common challenge is that there is not a uniform approach or an appropriate means to address the transfer of incomplete educational credits. This results in a high level of frustration for students, as well as a high level of frustration for schools as they seek to ensure that students have the opportunity to learn key content. There are multiple examples across multiple systems. The LR438 efforts and conversations highlighted several examples that might assist, including the concepts of shared data system, shared approaches to credit recovery, and the possibility of forming a student registrar position at NDE to help manage educational records for students who are court-involved and moving between school systems. So a possible recommendation in this particular case is to actually embed some of this particular work in, in the efforts with the consultant underneath recommended, recommendation one. We did talk-- and I'll go off script a little bit. We did talk a lot about the responsibilities that we kind of share in that process. Certainly from an educational standpoint, I often hear and I've had stories where I could go to YRTC and the frustration levels that you see with students is, is palatable, right, that it's frustrating for them to have to start a class and restart the same class and restart the same class

over and over again. And so I think again, all of the partners that were in these discussions felt that was a really key issue and I think could be addressed with some of that thoughtful process in, in possibly looking at the data sharing and, and the possible consultation that we might have with, with a-- kind of an outside partner. Issue three: once students become court-involved or state wards, the funding for various services and for general education become complex. And in this particular case, I've shared before the notion that students are treated a little bit differently underneath the school finance formula, depending on where they are in their current status within court involvement and otherwise. And I think it's really important that we continue to look at ways that we would address that, that school finance function. It does create an issue for school districts as well when they're being placed in different settings that ultimately schools don't have the funding that is right there attached to a given student. And I think it gives us a chance to look at that a little bit different. Senator Walz, sorry, but we kind of punted on this one and said perhaps the Education Committee can look at this a little bit, a little bit differently. And I wrote in here that we would defer that issue. And I know it's something you and I have chatted about before, but I do think there's an opportunity to look at the funding of systems-involved youth a little bit different than we have in the past and I think some opportunities could come out of that. I don't think we wrote-- I wrote into here that might be kind of a future interim study or in the, in some of the current work that's going on could be-- it could be better addressed through that, through that data sharing review process as well. Issue four: there's a level uncertainty about educational rights for students. I will claim some ignorance as we, as we, we're diving into this. It's very seldom that educational rights are removed from parents or guardians within those particular processes, but often that's not shared necessarily with school districts. And folks don't necessarily know who ultimately has educational rights. And so as, as the, that becomes unclear for folks, you get a lot of kind of questions, especially when students are moving often. And one of the things that we've discussed and potentially that having some folks that would help navigate that, if the courts are going to leave that in the parental as a-- educational decision rights with a parent, there might be some assistance that could be provided to parents as well. And so poss-- one of the possible recommendations was perhaps working with the Supreme Court Commission on Children in the Courts. We've had some conversations between the Department of Education and, and various subcommittees there. Continue that work, but it might be helpful to

have an interim study next year on, on that particular topic. Finally, YRTCs is issue five. YRTCs are not legally defined as a school district or local education agency for state or federal purposes, which leaves unclear the educational responsibilities of the state. And any educational responsibilities ultimately remain with local school districts regarding special education and things along those-- in that line and it becomes challenging when you look at the transfer of students between such entities. However, I really do appreciate the efforts of this committee and the Legislature overall to establish the superintendent of institutional schools under statute, as well as the requirements that are set forth in Rule 10 for accreditation. We're looking forward to that particular work. DHHS, and I know Larry will follow up at some-- maybe right after me, but I think it's been really important to be able to have a superintendent hired and in place. And really the recommendation that I leave you with here is let that process work. Let's see how that kind of goes. Let the accreditation process work, as, as that-- Scott English, who's the superintendent there now, brings that and works, continues to work with the Department of Education to, I think, implement that particular legislation and implement that intent. So I end on that particular front and I told you I couldn't read all the way through that without just going, going off the top of my head, so thanks.

ARCH: Thank you. Let me also just offer my thanks to you for your leadership with our workgroup this summer. We certainly could not have gotten here without somebody with your background to tell us, you know, here's, here's the problem and here's some possible, some possible solutions. And I think as the committee sees this, there's, there's obvious overlap between our committee and the Education Committee as, as well as there's a number of issues here that don't require legislative action necessarily, but more study. There's, there's more, more consideration for some of these. But every one of these, I think, would make a big difference in the life of a child and the ability to share that information. I think as we met this summer, you and I had a number of conversations about-- and the group-- about how in the past there has been a willingness, but sometimes there's been technological barriers. And now I think given where we are in technology, we can match up willingness with technology and come to some solution. So I appreciate, appreciate your work and appreciate your testimony. Questions from the committee? Well, you were a thorough presenter.

MATT BLOMSTEDT: I was thorough, I tried anyway.

ARCH: You were a thorough presenter.

MATT BLOMSTEDT: I will just say really-- and I know I read it, but I really mean it, that the work of the partners in state government on this particular front is, is real. And I think sometimes folks don't get to see the work that takes place and so the partnerships of really probably, I don't know who all is left in the room, but there's a lot of important partners for this work and I have appreciated very much their efforts, not just in my time, but generally for the services seen, so.

ARCH: Yeah, me as well. I mean to have, to have the Legislature, Department of Education, Department of Health and Human Services and the court system in the room talking about how to improve the-- our care for these court-involved youth, that's, that, that's how we get things done.

MATT BLOMSTEDT: Yeah. So thank you, Senator.

ARCH: So appreciate that and thank you, thank you for your testimony. Next testifier, Larry Kahl. Good afternoon.

LARRY KAHL: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Larry Kahl, L-a-r-r-y K-a-h-l, and I am the chief operating officer for the Department of Health and Human Services. Thank you for introducing this resolution, for the opportunity to be a part of the workgroup this summer and the invitation to testify today. Commissioner Blomstedt did an excellent job outlining the issues that the LR438 workgroup identified as they relate to the education of court-involved youth. I'm here today to highlight some of the educational enhancements that have been made at the Youth Rehabilitation and Treatment Centers, the YRTCs, and further elaborate on the educational issues that continue to exist. Those issues will be an important part of the consultant agreement and potential interim studies moving forward. So first, I'd like to share some of the YRTC success stories. YRTC changed from the basic education to a teaching curriculum. The narrative around the state was youth from the YRTCs were not getting instruction in the core subject areas. Therefore, credits did not typically transfer credit for credit, subject matter for subject matter. For example, districts would not honor an algebra credit from packet work. I think makeup work. You know, you missed class, here's, here's a packet. Do the packet to make up your assignment. YRTCs have not done packet work nor basic education since 2018. The math department has adopted materials

and training is in progress. Our system-wide curriculum instruction and assessment plan is in its final stages of implementation. And we've had a, we've had a combined percentage of 95.1 percent of youth attain academic credit for the summer term this year, for example, most recently. Another noteworthy success is the Omaha Public Schools workgroup. This pilot project was developed after a couple of meetings with LaDonna Jones-Dunlap, who I believe you'll be hearing from next. Its focus was to make sure youth were being placed in schools in a timely manner. Previously, there was very limited communication between the YRTC and OPS, the Omaha Public Schools. This has been a success because the YRTC guidance counselor, educational liaison and "voc" rehab/transition specialists have all established relationships with the probation office and pertinent staff at OPS. The youth's documents are sent to OPS placement staff and followed with communication between the YRTC counselor and OPS placement. While these successes are a great step in the right direction and the pilot project will help to develop best practices for implementation statewide, there is still more work to be done. Two of the specific issues that Commissioner Blomstedt touched on that relate specifically to the YRTCs are as follows. First, there remains a lack of consistent education data regarding students coming into the YRTC school from their previous districts and issues when they return to their home district. The proposed consultant that you've heard about in the previous testimony today would be tasked with developing a method of education data sharing to assist with this process. One potential gap in the existing process that is specific to the YRTCs is having a dedicated registrar to help with the managing education data. There have been some initial steps taken to help facilitate this data exchange. For example, both a student information system and a grading system have been implemented. However, the LR438 workgroup still identified a dedicated registrar as a possible next step. DHHS looks forward to hearing what advice the consultant may have to further enhance those efforts. Ultimately, the primary need for this data sharing is to support youth and to better facilitate their education path towards graduation. It is imperative that the youth are being placed in the proper courses and that their education progress be available as they move into and out of the YRTC school system and schools back in their communities. For example, the courses that they have completed must be helping them to meet their graduation requirements, in particular, core curriculum requirements as opposed to electives. However, students often move during the semester and the assignments that they've completed at one school should have a means to apply to the same course at another school in a manner that keeps

them progressing to graduation. It's no secret that graduating high school is essential to their future success and the more consistency that can be provided to make sure their educational efforts are leading towards graduation, the more likely they will be to actually meet this important milestone. Secondly, there's not a legal definition of the YRTC schools as a school district nor local education agency, an LEA, for state or federal purposes. This leaves uncertainty on educational responsibilities between school districts, the state and the YRTC school. Some specific areas of uncertainty are responsibilities for special ed, educational data, credit transfers and funding. DHHS supports the further exploration of this issue to determine the best course of action moving forward, acknowledging that there are pros and cons to being identified as either a school district or LEA. This could be a good topic for an intern-- interim study next year, but may also benefit from being added to the scope of the work of the consultant. In summary, the goal of DHHS and the YRTC schools is to best serve the youth and their educational needs. Processes that can be developed by a consultant or to better accomplish that goal will be welcomed. DHHS stands ready to partner with the Nebraska Department of Education and the courts to continue this important work. And I'd really like to thank you this afternoon for the invitation and opportunity to testify and I'd be happy to answer any questions.

ARCH: Thank you. Are there questions from the committee? I guess I don't have a question, but I would make a comment. We've come a long ways with the YRTC. You have come a long ways with the YRTC, the department. And at one point, I know that when, when we started down this road, education was, was, was not seen as, as-- I don't know how to say it, but it was, it was, it was secondary to the behavior and to the, and to the treatment of the, of the youth there. Now, it has been elevated, obviously. And again, with the consultation of the Department of Education, within, within that framework, the hiring of a superintendent now and, and all of that, it, it's, it has, it has come a long ways. And I, I would just like to continue to see that and your, your reference to the LEA possibility or, or that, I think the department is, is committed to that as well. And that's-- there's a question mark on the end of that. Is that your, is that your intention?

LARRY KAHL: It would be. I mean, to your point, Senator Arch, historically we were juvenile justice. We were a adolescent correctional facility. As one of our consultants that we worked with in doing some of the initial design recommendations per your earlier I

think last, last session request or maybe even the session before, in terms of the request for us to look at some of the specialty needs of the kids in terms of the housing at the facility, the architect clearly pointed out to me in his presentation, treatment is in your name because you're supposed to be a treatment center. You're not just supposed to be corrections. And so while we haven't moved completely away from that, from a juvenile justice mindset, all of our referrals come from the courts. We are a treatment center that tips its hat to the juvenile justice system because it's unavoidable. We have a connectivity, but it's a light touch. If you remember, I had spoken about the three-legged school approach to how we would treat things in the facilities. I think the new three-legged stool is tip of our hat to juvenile justice, education and treatment, and it seems to be working. We've had some great success, tremendous outcomes in the reduction of confinement. Where we used to look at and measure in terms of 24-hour increments for confinement time frames, we're down to looking at minutes or hour, an hour or two hours of confinement. And the majority of the time today, that confinement is requested by the youth. These guys are bugging me. Can I, can I get some downtime here? Can I get away for a little bit? Youth on staff, youth on youth, the number of incidences has declined dramatically. It really is an entirely different world than what it was just a few years ago. So I think that the movement forward with embracing education and that educational structure is a key component to us-- to our continued success.

ARCH: Thank you.

LARRY KAHL: Thank you, sir.

ARCH: You mentioned facilities. Since you brought it up and you're sitting there--

LARRY KAHL: Yes.

ARCH: --can you help us understand where you are in the, in the construction process of some new facilities at Kearney?

LARRY KAHL: Yes. The timeline, we submitted an RFP for our architectural firms. Architectural firms responded. We interviewed, selected. We've begun. I think we're, we're just about to have our third design meeting. So we're in the design phase now that lasts approximately until April, at which point we hope to have an approved design process and to be able to go out to bid for contractors.

Looking at the possibility of beginning as early as June and breaking ground and then moving that construction progress-- process forward approximately 18 months. I think we would be able to see perhaps a ribbon-cutting in January of '25.

ARCH: OK.

LARRY KAHL: Yeah, excited about it. We're on target. We continue to move forward.

ARCH: That's helpful. Again, facilities are necessary and vital part of, of the treatment model.

LARRY KAHL: Agreed. Thank you.

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

LARRY KAHL: Thank you, sir.

ARCH: Next testifier, LaDonna Jones-Dunlap.

LaDONNA JONES-DUNLAP: Good afternoon. My name is LaDonna Jones-Dunlap, L-a-D-o-n-n-a J-o-n-e-s-D-u-n-l-a-p, and I'm the systems-involved youth specialist, the shared position with the Nebraska Department of Education and the Nebraska Children and Families Foundation. Some of my role entails communicating between various offices at the Nebraska Department of Education and communicating with Rule 18 and special purpose school principals and LEA teachers as it relates to reentry, transitions, superintendent letters and responsible school districts of youth to transfer into a different school district outside of their district of origin. Due to the complexities of court-involved or systems-involved youth and their high mobility, disruptions to their education occur, which leads to delayed education paperwork transfer, duplicated coursework and/or undocumented coursework due to various transitions of in and out of various out-of-home placements in-state and sometimes out-of-state. Unfortunately, many court-involved, systems-involved youth who enter the child welfare and our juvenile justice system have education deficits and delayed paperwork, duplicated course and/or undocumented coursework may aggravate such deficits and have or leave a systems-involved person feeling frustrated and helpless. In talking with education staff specifically at the YRTC Kearney, I was curious to know the process in which they ascertained a historical snapshot of a young person's education journey through the child welfare and/or juvenile justice system. The

following four scenarios were shared. Scenario one: a student arrives at the YRTC Kearney with no transcripts. During the intake, the student report his out-of-home placements he can remember. Such placements are contacted to ascertain education records. Placement one reports they've already sent the records to the home school and will not send to the YRTC. Placement two reports he wasn't there long enough to earn any credits. Placement three report, reports he has credits, but they've already been sent to the home school. Transcripts are requested from the home school and is told they don't have the transcripts because the student wasn't there long enough. Weeks are spent attempting to locate transcripts and meanwhile the student is complaining, quote, I already took these classes, I don't need them again, end quote. If and when the transcripts are received from the home school, it's discovered the student was right. And due to the delay and weeks into the term, it's too late to switch his schedule, which subsequently results in duplicate credits. Scenario two: a student arrives at the YRTC Kearney with no transcripts. During the intake interview, the student reports the out-of-home placements he can remember. Such placements are contacted for record. Placement one is out of state and the curriculum is different. Placement two is in Nebraska, but they are unsure if the student earned any credits. Placement three sends a transcript with numerous credits listed as transfer credits, but the credits do not appear on other transcripts received and placement is not listed on the transcript. Placement four is the home school and the credits listed do not match the credit, does not match the credits on the other transcripts received and many of the courses are listed as transfer electives with no course title. Scenario number three: a student arrives at the YRTC Kearney with no transcripts. During the intake interview, the student reports the out-of-home placements he can remember. In this scenario, a placement history is provided by probation and it's noticed there were several placements not mentioned by the student. In the interim, a student is developed-- a student schedule is developed and pending education paperwork from the previous placement. The student is informed of a possible schedule change. The student becomes a discipline problem, interrupting the learning of others. If and when student's transcripts arrive, there are no, there are no course codes listed. Scenario number four: a student arrives at YRTC Kearney and within a couple of days, transcripts are received but there are several duplicated credits, 20 credits of Algebra 1, 20 credits of English. It appears the prior placements did not review the transcripts or may not have requested them. Therefore, the student has repeated courses previously passed. Because the student only needs ten credits for Algebra and ten

credits for English, he now has a surplus of 20 credits that cannot be applied to core coursework but may be applied to elective credits. Due to the duplicated credits, the student becomes upset and disruptive. In these four scenarios, the facility oftentimes relies on the student and the students as, as the historian of their coursework, which could span over a nine-month to a year time span. Moving into reentry. Around or about March of 2022, I gathered a group together, YRTC education staff, probation reentry team and Omaha Public Schools placement administrator, to develop a communication process between the YRTC Kearney facility and Omaha Public Schools to assist the reentry of youth transferring out of the YRTC Kearney and transferring into the Omaha Public Schools District. As you see in the handout that I will briefly go through, when a youth is committed to the YRTC Kearney, probation reentry team initiates a preadmission conversation with the YRTC Kearney education staff. The youth, the youth arrives at the YRTC Kearney and the education liaison begins working with the students. When the 60-day reentry court hearing notification is received by probation, reentry notifies the Omaha Public School administrator. The Omaha Public Schools administrator receives a 60-day notice and is invited to attend the family team meeting where an individualized reentry plan is discussed along with the probation reentry team, the assigned probation officer and the family. During this meeting, the OPS placement administrator may or may not attend. A second notice is initiated by the probation reentry team to the Omaha Public School administrator 30 days prior to the youth reentering. Once that OPS administrator receives the 30-day notice, the OPS administrator and the YRTC education staff begin to discuss grades in progress. OK. And then basically the youth reenters the community and then intensive supervised probation begins. In conclusion, thank you, Senator Arch, for your unwavering commitment to improving the educational outcomes of systems-involved youth and this legislative body for the opportunity to present today. Does anyone have questions?

ARCH: Thank you. Is your, is your present work exclusively with OPS?

LaDONNA JONES-DUNLAP: Currently, yes.

ARCH: Currently. Do you see a, do you see a role like this for other school systems? Is this-- I mean where-- you're focusing on OPS because there's a large number of students that transition back to OPS, is that, is that why?

LaDONNA JONES-DUNLAP: That-- yes, that's correct.

ARCH: Is there-- would there be-- I mean, what, what do you see as some of the challenges to extending your kind of a, of a program to schools across the state?

LaDONNA JONES-DUNLAP: I'm glad you asked that question because I'm actually meeting with Lincoln Public Schools next week to talk to them about this communication process and see if they would be on board to do something like this because it's my understanding that there's been an uptick in kids out of Lancaster being committed to the YRTC Kearney.

ARCH: OK. Very good. Other questions? All right. Seeing none, thank you very much for your testimony.

LaDONNA JONES-DUNLAP: Thank you.

WILLIAMS: We'll move back to Chairman Arch and doing the second part of the LR.

ARCH: As you can see with the testimony that we've heard today, there's, there are great ideas for how to improve this education, the flow of information, great ideas and more work to be done on that, but I think that there's a lot of effort. I think, I think the bottom line is to the degree that we can establish a system and not and, and not see if we can hire another 20 LaDonnas to, to, to do this work, if there's a system that would, that would support individuals involved in this, in this process, all the better. And so I think that that's going to be the goal and obviously, there's more work of the committee to be done and, and, and, and education-- the Education Committee to be done in the future to make some of these ideas realized. So with that, we'll end the education piece of it and I want to turn for a second at the very end here to the clinical component. Well, if education is complicated, clinical is twice as complicated so we'll, we'll talk a little bit about that. But with the clinical component, we asked the same four questions. What information is already being shared? What opportunities do we have to improve the health of state wards? What barriers exist to improve, improving communication and coordination of this piece of youths' care? Clinical proved to be much more challenging to narrow down and pinpoint the barriers. When we are talking about the health of court-involved youth, we're talking about a particular group of children that may have both physical and mental health issues. When a youth is newly placed with an agency or at a YRTC, there are immediate medical health questions that need to be answered. Is the child diabetic? Do they have specific allergies? What

medications might they be taking? And we found that there's no clear-cut way this information is obtained by any agency when that youth first comes into their care. There are also questions about who can legally access that medical information. Do they have to be a licensed physician or nurse? How do you share pertinent information without violating HIPAA? Then, of course, there is the mental health component and the ability to share that information is even more elusive. So I'm going to first invite Jeanne Brandner, deputy administrator for the Office of Probation Administration, to testify as to how the courts obtain and share clinical information once a youth comes into the system and the challenges faced at that stage.

JEANNE BRANDNER: All right. Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. My name is Jeanne Brandner, J-e-a-n-n-e B-r-a-n-d-n-e-r. I'm employed by the Nebraska Supreme Court's Administrative Office of the Courts and Probation as the deputy administrator overseeing juvenile probation. I first want to echo my thanks to Senator Arch for introducing the legislative resolution, also Senator Walz from the Education Committee and Senator Lathrop from the Judiciary Committee because, as has been mentioned, these items intersect all of those committees. I have been asked to provide testimony today regarding Probation's process for gathering medical and mental health information. I do want to first clarify, as Senator Arch early stated-- stated earlier, that this is regarding court-involved youth. And I want to clarify that youth who are placed on probation in Nebraska are under community supervision. And this does not equate to probation having a legal custody in care of youth. A couple of scenarios I wanted to provide to you. When a youth comes to the attention of probation to be screened for detention, intake is gathered from law enforcement, parent or guardian and youth. Questions that are standard include, typically of the law enforcement officer, is the youth fit for confinement? Does the youth have any physical or mental health concerns? That's typically asked of the parent and/or the child. Has the youth ever participated in therapy or evaluation? Again, parent or child. And is the youth currently prescribed medications and what are the current medical concerns? And some of these, as Senator Arch had mentioned, diabetes, allergies, asthma, pregnancy, some of kind of the more prevalent concerns that a facility would need to be aware of right away. As you can imagine, this scenario may occur at any time of the day or night so information is accessed via self-report, but not typically verified by another source in that given moment. The information is then provided to the facility or placement upon that intake. It's my understanding that juvenile

detention facilities and residential child caring or placing agencies also have their own intake or medical screening process that may be directed or informed either by jail standards or licensing regulations. Another scenario is once a youth is adjudicated or found responsible for the offense that brought them to the attention of the court, the court may order a predisposition investigation. When this occurs, probation has the youth and parents sign releases in order to obtain collateral, collateral information for active or historical behavioral health relationships or-- and/or medical. The family is also provided a questionnaire that covers a broad spectrum related to physical status, hospitalizations, mental and emotional status as well. When the youth and family present for the formal investigation interview, probation staff review, verify and ask additional questions as it relates to the completed questionnaire. Again, this information includes such things as youth current health and behavioral health status, diagnosis, any treatment, medications, treatment providers, hospitalization, youth past behavioral health, youth significant past health issues, and the parent and guardian current health and behavioral health status as well as any past behavioral health history of the parents. In addition to reviewing the collateral information gathered from the behavioral health providers, probation also administers a behavioral health screen to assess the need for further evaluation. It is rare that physical health information is verified. Upon order of the court, the completed investigation is shared with potential providers during service referral or placement intake. In closing, the Administrative Office of the Courts and Probation is committed as a collaborative partner with the Health and Human Services Committee, Education Committee and other system partners who continue to explore a better system for gathering, storing and sharing critical education, education, medical and behavioral health information. Thank you for your time, and I'm happy to answer any questions that you might have.

ARCH: Thank you. Are there questions? I have a few.

JEANNE BRANDNER: OK.

ARCH: So I want to go back to the one, the-- your first scenario where, where a youth shows up in the middle of the night or doesn't even have to be middle of the night. How, how-- I mean, if somebody asked me what-- you tell me about your medications and tell me your dosage. You know, what, what-- is it, 50 or is it 100 or-- I don't, I don't know that I could tell them, I mean. And so what do you, what do

you do practically in a situation like that where, where it's self-report of, of a minor? How do you handle that?

JEANNE BRANDNER: Yeah, it's an investigative process, Senator, and I think it's a very relevant question. Probation, we aren't super users. We don't have a secret access to medical or behavioral health information, and we don't have access to a single source of truth. And so it is through-- and again, it may vary if it's 3:00 in the morning, who we do or don't have access to. If the child was historically with us, we may have more information than if they're brand new to us. If the child was previously a state ward, we may be able to get-- or currently a state ward-- we may be able to get information from a caseworker, but otherwise it is ascertaining that from the youth themselves. The parents sometimes, sometimes I say, may have better information, but they may or may not know the, the details of the dosage or the history or especially as it relates to prescription medication. So it is an investigative process to be able to determine that. And if, if possible, again, if we have waivers and things, getting information directly from physicians or doctor's offices, but in the moment, it's not something that happens rather quickly, unfortunately.

ARCH: So an improvement to that process would be welcome. Obviously, if, if, if we can figure out how to handle the authority to access information and all of those, all the legal issues as well, having that information earlier would, would provide better care in your-- in detention?

JEANNE BRANDNER: Yeah, absolutely, especially for-- you know, just because they come to the detention doesn't mean they will go to detention. But for those youth that do have to go to facility placement, whether it be detention or a shelter or a foster home or whatever those options are, that information is critical for the caretakers to be able to know and understand what's happening. And similar to the testimony earlier today with hospitals, when you're talking especially individuals that might be on psychotropic medications, then that, that absence of that dosage or those medications can result in other difficulties that may perpetuate that youth to, to have other episodes or be perceived as aggressive or uncooperative when it may just be a medical or behavioral health issue that they're experiencing.

ARCH: Right. Right. Very good. Other questions?

WALZ: I just want to follow up on that--

ARCH: Yes, Senator Walz.

WALZ: --because we talked about this in the last meeting that we had and I think it's important for the record. How long does it take to get through that investigative process? What's-- and I know that varies, but can you kind of give an example or give us an average of how long does it take for you to get the information that you need?

JEANNE BRANDNER: Yeah, that's a great question, Senator Walz, and unfortunately, the answer is it depends. When we're talking about detention intake, if a youth is brought to our attention via law enforcement, typically the intake process can range anywhere from an hour or two to sometimes seven hours. The longer periods of time are usually a transportation-related issue. And so a lot of times, we may forgo information or say we don't have that information. But when we get further into the court process and if you're talking about the predisposition investigations, when those are ordered, those typically take about-- there's some statutory guidelines around that, but if a youth is in detention 21 days, if a youth is in the community 30 days. And so we have about a, you know, about a month's window to be able to gather information again and a lot of that is dependent upon what we get back. So even if we call a provider or fax something over, say we want some history or documents, it's dependent upon whether that comes back. You know, we may have to check back in and, and if the parent is or not available for signatures as well. So we've had occasions and the court has certainly supported and been able to order some access to information if, let's say a parent is maybe in jail and another parent may have gone to treatment and just really unavailable at the moment. Those are always-- if there's not an HHS worker, that those are always situations that while not frequent, that they do occur. So it does depend. And again, as Senator Arch pointed out, depending on how-- and I don't even want to say cooperative because sometimes it's not a matter of cooperation, sometimes it's just a matter of what your knowledge and skill level is around or your investment or involvement in your behavioral or mental health history. Some kids don't know that information. Other kids know it in depth. And so it just really depends. And then again, once we get that, is that really the true source of information or is there maybe, as LaDonna pointed out, maybe there was a memory issue or I didn't, you know, remember that I had that medication because I haven't been taking it or those types of things. So there are certainly scenarios that, that we, we try to figure out the best we can. And as I said, the facility also then has

a medical staff that would come in and have a subsequent process to say, OK, let's dig deeper, let's see it. And, and they may have, as you mentioned, Senator Arch, given their medical credentials, have-- be able to get access to information a little bit easier than we can. But again, I don't know that to be 100 percent true because I still think it's a barrier.

WALZ: Thank you.

JEANNE BRANDNER: Great question.

ARCH: Great. Any other questions? Thank you. Thanks for your testimony today.

JEANNE BRANDNER: Thank you.

ARCH: So we've talked-- Jaime Bland, if you could come forward. We, we've talked a little bit about, about the issues of access and who has, who has the right to see some of this information. And that was part of our discussion within our, within our working group as well. What, what our, what do our statutes say and I say that's, that's work yet to be done. But, but the question I've asked, I've asked Jaime Bland to come, who is the CEO of CyncHealth-- the question of, of even the question of availability. Is the, is the information even available if we were to solve some of the access problems? So I would turn it over to you for your testimony. Thank you.

JAIME BLAND: Thank you. Good afternoon, committee members. My name is Jaime Bland, J-a-i-m-e B-l-a-n-d, and I'm president and CEO of CyncHealth, Nebraska and Iowa's Statewide Health Information Exchange, or HIE. In Nebraska, CyncHealth is connected to all hospitals, 991 pharmacies, which includes brick-and-mortar pharmacies, as well as mail-order pharmacies, 86 different ambulatory clinics, 60 skilled nursing facilities, 13 ambulatory surgical centers, and 441 community organizations across the state. The facilities are connected to our healthcare delivery sites. Our healthcare delivery sites and community organizations that deliver care for Nebraskans and share data with us as a statewide HIE to ensure continuity of care, care coordination and optimal outcomes for Nebraska patients. CyncHealth has a variety of connection points. We connect to all pharmacies through the PDMP to traditional brick-and-mortar healthcare delivery sites like hospitals and clinics through the HIE, to the community-based organizations like food banks and housing referrals through the Community Information Exchange, which is a network that supports social needs referral

system with the community. Each of these different types of connections contributes to unique sets of data, which then combine together to provide comprehensive health information and history for Nebraskans' longitudinal health records. The data available in the Health Information Exchange is similar to what you find in electronic health record in a hospital. For example, a history of encounters with providers, conditions and diagnoses, medication history and information regarding a clinical stay at a hospital. Because of this data that is being used to make healthcare decisions, CyncHealth's top focus is on data quality, making sure that the data being put into the HIE follows a standard that providers can rely on. The national standard for health data sharing is called the U.S. Core Data for Interoperability, or USCDI, and there is a handout in your packet that details the data elements there. The pharmacy data including in the HIE is a comprehensive list of all dispensed medications from the pharmacy systems across Nebraska. CyncHealth also partners with community organizations for sharing of information related to social determinants of health, which are social factors that can affect the health and ability to get care. These partners are community organizations that assist with housing, transportation, food and other social needs. Healthcare providers make referrals to these community organizations to help person navigate social aspects of life that happen outside of the healthcare delivery system, but play an important part in the patient's health outcomes. These factors outside of the traditional healthcare delivery system are important in the care coordination and case management. In recent years, federal agencies have expanded their focus to include these additional social factors to improve health outcomes and support value-based care. So with that kind of data available within the HIE, there is no more complete source of health information than CyncHealth. I know the focus has been on youth and those in our state system, so I'll turn now to our understanding of access to this information. Any state entity can connect with CyncHealth as long as the proper data privacy protections are in place and the utilization of sharing of the data within CyncHealth is for treatment, payment and operations or purposes allowed under any applicable laws like HIPAA. Access of information through CyncHealth is role dependent and follows the, the TPO purposes components of HIPAA. This means that depending upon the role, certain members of the care team may access a record using minimum necessary standards under HIPAA. For example, a pharmacist or social worker may be part of a care team that is managing a medically complex child who sees specialty care providers across the system and who has family issues like housing instability or for-- food insecurity. Information

can be accessed within CyncHealth that would assist both the pharmacist and social worker in care management and care coordination to not only treat the child's clinical health concerns, but also support the child's ability to even access needed care and participate fully in their own treatment. Care coordination and case management activities are an important part of modern healthcare and federal health data sharing regulations such as HIPAA and Part 2 Substance Use Disorder Confidentiality Regulations [SIC] are expanding and updating to allow for care to happen across teams more easily than ever. Federal policy, which has pushed the healthcare industry to define access and sharing parameters, has ushered in these updates as a means to balance necessary information sharing with patient confident, confidentiality and privacy protections. CyncHealth's health information network is a comprehensive care and case management tool that when leveraged by care teams, is the most comprehensive repository of information available. The technology that supports this work is secure and modernized to meet the latest standards of sharing of information that are detailed in federal policy. CyncHealth are experts in linking data across multiple systems, matching information to individuals, securing technical and data systems, and ensuring that information is shared only when the legal parameters are met through governance oversight at multiple toll gates. The organization has internal data governance to comprehensive root-- comprehensively review data requests and access. All data and access requests are subject to internal data governance process and entities that include three independent boards of CyncHealth, the Nebraska Health Care Collaborative and our foundation that reviews use cases and works with academic institutional review boards. Safeguarding this information is our organizational expertise and our top priority. Additionally, information is reviewed by the State HIT Board, where we work closely with the department on any data involving PDMP. This comprehensive governance is robust, transparent and has been highlighted as a best-in-class process among comparable peer organizations. CyncHealth could be a secure and reliable tool for facilities, DHHS and the providers who are caring for Nebraska's youth. I'm happy to answer any questions.

ARCH: Thank you. Questions? Well, again, I have a couple.

JAIME BLAND: Yes.

ARCH: So you have-- there is a lot of information in the HIE.

JAIME BLAND: Correct.

ARCH: Some of it is complete. Some of it is incomplete. Not everybody participates in the HIE, so you could have an individual physician solo practice in, in a community that, that is not participating and so that information wouldn't be in. But, but with regards to the PDMP, all of that information is in.

JAIME BLAND: That's correct.

ARCH: Am I correct? So pharmacists are inputting it all. Prescribers are inputting it all. That's all required.

JAIME BLAND: Yes.

ARCH: So as it relates to medications that youth may be on, that's, that's a fairly 100 percent information system for that--

JAIME BLAND: That's correct.

ARCH: --that issue?

JAIME BLAND: So any, any medication prescribed by a physician would be transmitted to the pharmacy and once it's dispensed and collected, it would be in the PDMP system.

ARCH: So there-- if access is granted, there an individual could look up, see dosage, could see frequency, could see medication, all of that without depending upon self-report from the youth.

JAIME BLAND: That's correct.

ARCH: Within the PDMP, what, what other information is in there? Are there allergies?

JAIME BLAND: There's not in the PDMP.

ARCH: Not in the PDMP.

JAIME BLAND: So there's two access points for PDMP. One is for the HIE which is medication history, which that would have the contextual information on, like, allergies, encounters, that kind of thing. So if at any point the person that you're looking at, the medication history, has been in a hospital system, we would likely have the allergies then. If they've only sought care through an ambulatory care center, then there's-- or a clinic or, you know, somebody that using paper records, we may not have that information, but it is likely that

it is documented somewhere between the PDMP or there, the medication history component.

ARCH: And you make the statement in here that it is, it is the most complete.

JAIME BLAND: It--

ARCH: Right? I mean, that's, that's worded correctly.

JAIME BLAND: Yes.

ARCH: It's not 100 percent complete. It is, it is the most complete source for, for the, for the health information--

JAIME BLAND: Yeah. I mean--

ARCH: --of an individual.

JAIME BLAND: Correct. I mean, that's-- we are the most, if not, if not the most robust in the top three of the most robust clinical data repositories in the country.

ARCH: In the country.

JAIME BLAND: Correct.

ARCH: OK. All right. So, so if we were to, if we were to resolve the issue of access and still more research needs to be done on that, if we, if we could resolve the issue of access to the satisfaction of, of providers, the state, Legislature, everyone involved, that access to that would, would go a long ways to solving the issue that we've been discussing and that is when a, when a youth appears at an agency for placement or enters into the court system, if those-- if that can be accessed at that point, there's a lot of information. While maybe not 100 percent on every youth, there would be, there would be a lot of information available to the, to those individuals.

JAIME BLAND: Yeah. At a minimum, the medication history would be comprehensive.

ARCH: Right.

JAIME BLAND: And then the other information would be complementary to that.

ARCH: Right. Right. OK. All right. Any other questions? Well, seeing none, thank you very much for coming in today.

JAIME BLAND: Yeah. There--

ARCH: Anything else you want to talk about?

JAIME BLAND: Yeah, I'll just say that--

ARCH: Please.

JAIME BLAND: --so the, the access-- and we, we do have a number of corrections facilities that do access and the TPO purposes cover care coordination, care management, which if we look at that definition, you know, as a child is moving, the care coordination component does allow for those use cases. So we've, we've worked with a number of different corrections agencies and different kinds of organizations. You wouldn't typically fill our healthcare delivery organizations. So I think there's-- and we've gone all the way to the Office of Civil Rights to ask for clarification.

ARCH: Are you, are you saying that's, that's been done in the state of Nebraska or elsewhere?

JAIME BLAND: We've done it in both Nebraska and Iowa, yeah.

ARCH: OK.

JAIME BLAND: Yeah. And I'm not-- like, there's different county jurisdictions, different jurisdictions that we've, we've worked with, but we've comprehensively connected in Iowa to corrections and then a few county jurisdictions in Nebraska.

ARCH: OK.

JAIME BLAND: Yeah.

ARCH: All right. Thank you. Senator Williams.

WILLIAMS: Yes, thank you, Chairman Arch. Are those that you are doing, are any of those with minors?

JAIME BLAND: Yes.

WILLIAMS: OK, so those--

JAIME BLAND: I mean, any minors--

WILLIAMS: --are with minors?

JAIME BLAND: Yeah. It does include that.

WILLIAMS: So is it with parental consent, then, of some kind?

JAIME BLAND: Guardian or parental consent.

WILLIAMS: OK, gotcha.

JAIME BLAND: So minors, depending upon the jurisdiction, some can self-- like, at 14, right? They can say that I'm-- I can access information or I want to access my information.

WILLIAMS: OK.

JAIME BLAND: The diff-- there's different ages, but yeah.

ARCH: All right. Any other questions? Well, seeing none, thank you very much for your testimony. I would say that we had, we had a provider scheduled to come and talk to us again today. And yesterday, the provider needed provisions. She became sick and so she was not able to come today. So with that, I would say that with, with regards to both of these issues, the education as well as the clinical side, there is more work to be done and some, we're a little bit further along on the education side than we are on the clinical side. But I'm hopeful that, that, that this committee and the Education Committee can pick this up and take it forward and, and come to some very concrete steps that will improve the sharing of communication of-- between-- on the education as well as the clinical for our court-involved youth. So with that, we will, we will conclude today's hearing and LR438, and we will conclude the hearings for the day. Thank you for coming.