

Transcript Prepared by Clerk of the Legislature Transcribers Office
Health and Human Services Committee December 2, 2022
Rough Draft

ARCH: Well, good morning and welcome. 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 the Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: Good morning, I'm Senator Dave Murman, District 38: about eight counties in southern-- mostly the southern tier of the state.

WALZ: Good morning, everybody. My name is Lynne Walz and I represent Legislative District 15, which is Dodge County and part of Valley.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36.

M. CAVANAUGH: Machaela Cavanaugh from Legislative District 6, Douglas County.

ARCH: Also assisting the committee this morning is one of our research analysts, Lisa Johns. Serving as our committee clerk today is Noah Boger, and our committee page is Morgan Baird. A few notes about our policies and procedures. This morning we will be hearing LR368, introduced by Senator Machaela Cavanaugh. As part of this hearing, I have invited Tony Green, Director of the Division of Developmental Disabilities at the Department of Health and Human Services, to brief committee, the committee on the DD consultant and the Family Support Waiver required under LB376, which passed last session. We will then open up the hearing for anyone wishing to testify. For those of you testifying on LR376 [SIC - LR368], you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and 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-- well, I guess I'm asking you stronger than that. You'll be required to limit your testimony to five minutes. The light system will give you an indication on 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 work day before the hearing. And with that, we will begin today's hearing with Senator Cavanaugh's opening. Welcome.

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M. CAVANAUGH: Thank you. Good morning, Senator Arch and members of the Health and Human Services Committee. My name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h, and I represent District 6 in Omaha. I appreciate your office scheduling this hearing, and I'm very much looking forward to an update from Director Green and appreciate him coming here today as well. The language in this LR takes a broad approach to identifying areas where our network of services for developmentally disabled persons, particularly children, is in need of further changes. In addition to the Family Support Waiver, I'm eager to hear from organizations and individuals on how to further improve our safety net services for the families who need and use the services available, or where we need to create new ways of addressing service gaps. Of course, we'll hear a lot of workforce shortages and low pay for individuals who provide frontline services to persons with disabilities. I'm sure we will hear more about that today. I also hope to hear-- we hear more about the solutions to these issues. In particular, I hope we learn more about the challenges and benefits of allowing family members who might also be guardian to, to be considered a provider. It happens in most states, but Nebraska policies and payment structure consider this scenario too risky. I had introduced this bill this last session and it was actually heard in Judiciary, not here. So this will kind of help this committee get a better sense of what those issues are. And we didn't move it forward at all because there was too much that needed to be addressed. And it's a complicated issue. So I agree that we need to put the safety and civil rights of the disabled individual as a top priority. However, if other states pay guardians and family members, then what additional safety measures or training do we need in place to do the same? I think the department is looking at fiscal agents that could be a step toward providing further safety measures and oversight on frontline workers. I hope Director Green can touch on that effort in his remarks. When our state made the decision to deinstitutionalize decades ago, it was with the understanding that community-based services would be enhanced to provide services to our vulnerable disabled persons. Have we done that? In our continuum of services-- is our continuum of services sufficient? There are some of the questions I hope to ask and discuss today. And with that, I'll take any questions from the committee.

ARCH: Thank you, Senator Cavanaugh. Are there any questions for her at this time? Seeing none--

M. CAVANAUGH: Thank you.

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ARCH: --thank you very much. Director Green, you are welcome to come up and brief the committee.

TONY GREEN: Good morning, Chairman Arch and members of the Health and Human Services Committee. My name is Tony Green, T-o-n-y G-r-e-e-n, and I am the Director for the Division of Developmental Disabilities within the Department of Health and Human Services. And I'm here to testify on LR368, which proposes an interim study to identify deficiencies and inefficiencies in Nebraska public policy surrounding disability-related service provisions. The Developmental Disabilities provides funding and oversight for the four home and community-based waivers, which include the Aged and Disabled Waiver, the Comprehensive Developmental Disability Waiver, the Developmental Disability Adult Day Waiver, and the Traumatic Brain Injury Waiver. These waivers afford Nebraskans who are aging or experience disabilities the ability to improve their quality of life through the provision of services which promote independence and community integration. The number of community-based waivers for Nebraskans will be increased to five, with the passage of LB376 last session. The Family Support Waiver will focus on children currently on the DD Comprehensive Waiver registry or waitlist and work started immediately with the creation of a steering committee and subcommittees. This fall, the division engaged in stakeholder listening sessions, received technical assistance through the Centers for Medicare and Medicaid Services, or CMS, and is currently drafting the new waiver. Creating a new waiver also includes developing regulatory information systems and technology and staffing infrastructure. The DD advisory committee charged with overseeing and guiding implementation of this new waiver has reviewed and approved an estimated waiver implementation date of December 2023. LB376 also required the division to engage a nationally recognized consultant to provide an evaluation of the state's developmental disability system. The division posted an RFP, or request for proposal, for a consultant to complete the study, including Medicaid State Plan services, with recommendations as to how Nebraskans with developmental disabilities can better, can be better served. The RFP was awarded to CBIZ-Optimus on Thursday, September 29, 2022. CBIZ-Optimus will complete a comprehensive analysis of existing programs and service arrays available to support individuals with developmental disabilities, traumatic brain injury and children and adults with physical disabilities. Excuse me. This analysis will include a comprehensive list of all service arrays to include the 1915(c) waivers, the Medicaid State Plan Services, the Medical-- Medically Handicapped Children's Program, the Lifespan Respite Program, and other applicable

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supports to aged and disabled populations to include an emphasis on maximizing impact, effectiveness and cost efficiencies. It will also include a detailed comparison and analysis of Nebraska and comparative states' service array of Medicaid state plan services, waiver services and other mechanisms to support people with developmental disabilities. It will include a detailed comparison and analysis of Nebraska and comparative states' registry/waiting lists to include eligibility, interim services, prioritization or funding and removal to include a detailed plan for elimination, an overall set of recommendations and suggested implementation plans to bring best practice to Nebraska and maximize resources for persons with developmental disabilities and finally, any other areas that the Department would find to be beneficial to the state in the assessment of its DD waivers, services and supports. This final report is due by December 31 of 2023. I'm happy to be here today to provide updates on LB376 and I'm happy to answer any questions.

ARCH: Thank you, Director Green. Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, Director Green. Is the the time frame for establishing the, the new family support waiver, of having that in place by December 2023, a reasonable time frame, giving you the opportunity to fully research that and yet getting it out there as soon as it should be or could be?

TONY GREEN: It is an-- excuse me, it is an aggressive timeline, yes. I think until we start getting in and fully engaging in some of the technical assistance opportunities with CMS further and getting to the hard part of actually writing service definitions and provider qualifications for each of the services, it's unknown whether the months that we've estimated at this point will become reality. It kind of depends what folks are really going to want to be involved in the waiver so. The-- our, our website has the timeline kind of laid out of all the different activities of how this will take place between now and, and December. But to give you some perspective of what that looks like from the department, implementing in December of 2023 actually has us submitting that application to CMS in July of 2023. So we really only have about eight months left to get this all figured out because in order to implement in December, we would have to submit in July.

WILLIAMS: Thank you. That's helpful.

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ARCH: Other questions? Senator Walz.

WALZ: Hi, how are you?

TONY GREEN: Good morning.

WALZ: I have a couple of questions. First of all, just kind of piggybacking on Senator Williams, do we have enough funding? And do you think the funding that-- is, is it adequate to meet the--

TONY GREEN: Specific to the waiver?

WALZ: Yeah.

TONY GREEN: Well, the funding is that the slots for the waiver were limited in statute to the 850, and it does have a \$10,000 cap per child within the budget. And I believe that, that was all addressed in the fiscal note that came through. So it was appropriated to what the bill had indicated--

WALZ: Sure.

TONY GREEN: --it would support, which was a maximum of 850 slots.

WALZ: OK. The second question I have is, have we given enough, enough time-- or no, I guess that was Senator Williams. What would it take for us to allow for paid family caretakers?

TONY GREEN: Yeah, so paid family caregivers, it's, it's a complex issue. So let me first say, within the developmental disability waivers, we already have and do currently pay family members in, in some capacity to be caregivers. So, for example, parents of adults, 19 or over, in Nebraska are currently being paid to deliver care. We cannot currently pay somebody who is legally responsible to be the caregiver. So if they are court appointed by a district court to be the legal guardian, we are not paying them. If they are a dual role of a parent, of an adult and a legal guardian that is not currently allowed today. Parents of minor children is currently not allowed--

WALZ: OK.

TONY GREEN: --under the waivers. They are options that states can choose to put into their waivers. And then there are many requirements. If you check that box in your waiver to allow that to be a practice, there are many safeguards that have to be outlined for

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CMS. Because the fundamental issue is that CMS cannot pay for services that somebody would be legally responsible to provide anyway. So especially when you get into parents of minor children, you really have to begin to differentiate between what CMS calls "ordinary parental duties" and "extraordinary parental duties". And states have to have policies, assessments and practices in place to very clearly articulate so that you don't move into the area of paying parents to do parent functions.

WALZ: Tony, do you have any idea how many states are currently allowing for that to happen with minor-- with children who are minors?

TONY GREEN: I don't have that with me today, but I know our policy folks who have been researching this since the passage would easily have that number. And I'd be happy to get it back to you.

WALZ: All right, that's a good answer. Thank you, I appreciate that.

ARCH: Other questions? I have, I have one. One, one of the desires, as I recall, when we, when we worked on LB376 with regards to the consultant was, you know, the-- I guess the understanding that the layering of our waivers has gone on for years. And then we add a waiver and then there's another waiver. And, you know, that's just kind of been the pattern and we've done most of this work through waivers. Some states, my understanding is, maybe do a state plan amendment instead of a waiver. And that one of the things I don't see in 1 through 5 is, is the desire to make sure that we're also not only cost efficiencies, but also maximizing federal opportunities for, for reimbursement. And, and I know that would vary based upon a waiver versus a state plan amendment and the mechanism for that. Is, is that-- is your understanding that that is part of the consultant's work as well?

TONY GREEN: It is. We actually had an internal kickoff meeting with the contractor a couple of weeks ago, and in item number 1 there in my testimony, at the end, we had conversations just to that, that I believe you will get that on the maximizing impact, effectiveness and cost efficiencies.

ARCH: OK.

TONY GREEN: Because they'll be looking--

ARCH: It's in that language that--

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TONY GREEN: Yes.

ARCH: --that you pick that up.

TONY GREEN: Yes.

ARCH: OK. And, and the other, the other possibility we entertained when we were discussing LB376 was that is, is that maybe we do things differently. Other states are doing things differently. And so our current, our current waivers that we have right now, I'm assuming if at the end of '23, when that report comes out, there will be further discussion as to their recommendations or your recommendations, the department's and the Legislature. And, and then there would obviously be some need for phase-in. If, if there's a-- if we're, if we're going to change from these two waivers to a state plan amendment or something like that, this, this is not like and then January 1 we'll have a new, a new system for developmental disabilities in our state. Is that, is that your understanding of that process?

TONY GREEN: I think that's an accurate assessment. As you know, the report will come in late December. Obviously, we'll be working with the contractor between now and then and we'll have an idea of that. But until we receive kind of those final recommendations, that's really then when we can begin to have, if there's new ideas that they're bringing to Nebraska, that they're, they're thinking would work here, that we'll have to begin those collaborations with our Medicaid partners, because these are Medicaid-funded waivers. Or if there's another avenue, as you said, through Medicaid, which there are many avenues of waivers and demonstration projects, we would begin those process. So I agree that there wouldn't be a new system up and running in January.

ARCH: OK. So the consultant as well, in their work, is going to conduct a series of interviews with, with those receiving services, families and, I mean, providers and that list of, that list of those that they will need to contact has been under discussion as well.

TONY GREEN: Yes.

ARCH: Right. It's not a, it's not a matter of coming in and studying the documents. There's, there's work to be done out in the, out in the community.

TONY GREEN: Correct.

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ARCH: OK.

TONY GREEN: And, and we will post to our website very shortly, kind of the initial kickoff PowerPoint that we went through with our contractor that kind of outlines their timeline. It does include policy analysis and state analysis of documents. But you will, you-- we-- you'll begin to see the stakeholder engagement process happen after January.

ARCH: OK. All right, very good. Other questions? Well, thank you very much for your briefing.

TONY GREEN: You're very welcome.

ARCH: Thanks for the progress. It sounds like we're moving in the right direction. We'll, we'll stay tuned. All right, thank you. So I would invite testifiers to, to come forward and, and-- just, just so I have an idea as to how many would like to testify, if you could raise your hand. All right, thank you very much.

EDISON McDONALD: OK. Hello, my name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d, representing the Arc of Nebraska. We are Nebraska's largest membership organization representing people with intellectual and developmental disabilities and their families. Our DD system is failing. While the funding increases have been critical in stopping the most horrendous situations, they're still only a temporary Band-Aid. With a 1.9 percent unemployment rate and a severe shortage of staff, we have to innovate or our system will completely crash. Unless you all want to add \$2 billion to the DHHS DD budget, which I'd be OK with too. Key features of this evolution require expanding the pool of caretakers, including paid family member guardians, leveraging technology, professionalization of DSPs, and many answers we don't have yet, but we need to be ready to embrace. I've included copies of comments from a number of families on this issue to give you some context of the human impact, but as there are families here today, I will stick mostly to the systemic issues and technical details. I also have expanded written comments. As I said, our disability system is crashing. While the provider rate increase has helped to address the most significant concerns in traditional adult providers, this means there aren't as many red letters or letters that a provider can no longer safely serve an individual. As to service providers for children, there are currently very few. CRCC in Omaha is the only one that's more established, and they have a huge waiting list because of the desire for their services. There's also A Place For Us [SIC] in

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Hastings, High Hopes in Bellevue, and a new agency forming in Lincoln. While the family support waiver is still in the application process, we've begun a new task force to help with the implementation. Most of the provider needs will be things like OT, PT, speech, but where vacancies aren't as significant and we don't need traditional direct support professionals who are the main staff we are short of. However, one of the most requested services is around specialized child care. This will require increased staffing and blended funding models. So some of the solutions we need to be looking at. One, we have to make the ARPA rate increases permanent and set them to inflation without having to have us come back every single year asking for more money. Two, we need to expand the usage of abbreviated applications for providers who will be agencies but don't need to meet the same more aggressive standard for residential services. Three, we will need to break down the barrier in applications between DHHS Children and Family Services and the Developmental Disabilities Division. Four, we need to offer improved technical guidance, which the Arc has already taken some lead on and has requested that DHHS create modified trainings for. And five, we need to encourage and financially incentivize providers who better leverage technology to do more with less. And the most significant and immediate modification that needs to be made is to allow for paid family member guardian caretakers. Starting last year, there was a tremendous spike in the requests from our members for paid family caregivers as a reaction to the staffing crisis. This means that family members who have to take off work and frequently can't stay employed. Per the wonderful survey on the family support waiver that Director Green put out on the top requested service for the family support waiver with 160 of 375 participants listing it as a top need. So enabling more flexibility for independent providers is the only way to allow for more choice in the market and help to fix our system. All we need is a simple waiver amendment in section C-2 of the General Service Specification, subsection (d), (e) and (f) of the 1915(c) waiver application that is easily designed to apply for. In fact, only seven states specifically prohibit payments to spouses, parents of minor children, and people who are legally liable: Connecticut, Illinois, Indiana, Kansas, Massachusetts, Nevada and Nebraska. With such a high gap, it seems only logical that we lift this government prohibition. Despite a year of research and conversations with other states' leaders, I have found no evidence that this actually creates increased issues. However, to react to the theoretical increased risk, we have the following recommendations. One, create a fiscal intermediary, which the department is already working on and has ARPA funds to do. This has been implemented in 28

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states. Two, require mandatory training created by the MCOs or the state, as six other states require, with a maximum of 22 hours of training. And three, in addition what we already have, service coordinators who are our frontline defense, electronic visit verification that digitally tracks service providers, and we have inspections that already feel intrusive. Should other ideas to create reasonable protections are expressed, we would love to have a discussion. However, we have real people who are desperately in need now. Due to our changing workforce, this issue is only going to increase and we need to help these families now. Thank you.

ARCH: Thank you. Are there questions? Seeing none, thank you very much for your testimony. Next testifier, please.

ANDREA EVANS: Good morning. Good morning.

ARCH: Morning.

ANDREA EVANS: Excuse me. My name is Andrea Evans, A-n-d-r-e-a E-v-a-n-s. I'm a single parent of seven children. I'm here today to testify in behalf of recommending the state's implementation of LR368 and ensuring the increase in the ability of families that have children with disabilities to assess necessary disability-related services statewide and opportunities to eliminate the barriers to family member guardians as paid caretakers. What LR368 means to my family and me. One, ensuring family ties and the ability to benefit from being a paid family member as a family caregiver. Two, ensuring our family members in need of care have the opportunities to eliminate the barriers to family member guardians as paid caregivers. Three, ensuring appropriate policies and procedures that will protect the rights of individuals with disabilities who have guardians that provide care in order to minimize potential conflicts of interest without overly invasive regulation. Four, building trust that the systems have our family's best interests at heart. That was something that was big with me, I never felt that our family's best interests was ever taken to heart. The barriers my family experienced. One, worrying about outside help that may not be sympathetic or attentive in caring for my loved one. Two, being a caregiver for a family member comes at a cost. I often had to significantly reduce my number of hours working outside the home and/or leave my jobs entirely in order to provide quality care for my loved one. And that doesn't look good on your record. You know, they look at you like, oh, your family, family law really doesn't support us either. Three, I did not know my options for financial assistance while taking care of my loved one.

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That's another thing, not even knowing what's available. This lack of support and compensation for caregivers for our family in the areas I just mentioned created barriers that led to stress, trauma and lack of closure and support for my son and the family as a whole. Ensuring the elimination of barriers to family members, guardians as paid caregivers would be helpful in ensuring no stress, ensuring no trauma and the increase of support for families with children with disabilities. I recommend for the state's implementation of LR368. Now, when I do my testimonies, I always try to add something that went well and I really couldn't find anything that went well. So thank you for having us. Are there any questions?

ARCH: Are there any questions? Senator Walz.

WALZ: Thanks for coming today. I appreciate that. You mentioned that you did not feel that your family's, family's best interest was taken at heart. Can you maybe give a couple of examples so we understand what you mean by that?

ANDREA EVANS: I notice that whenever I reach out for services, and I was, I was asking in '89 for this compensation to happen for parents. And I kind of received the, the idea that-- they kind of looked at me like I was crazy, just to say. I didn't feel that we mattered as a family. The support from the state was very small. I mean, there were situations where when my child went to school, I had to be there. I had to sit there and be there from my job. And no one supported me in that. No one went in and hired someone else to even go in, you know, so I wouldn't have to miss my job being at work. If he went on field trips, I had to go too. I had to be present to go to this-- these field trips. That's a lot on a single mother with seven children. You know, I take accountability, you know, for my seven children. And I'm not crying about having seven children, but it was quite hard and I didn't feel support. No one ever came to me and said, these are some options for you and your family. You know, so that when you're missing work, because I cried about it. You know, that your job really doesn't seem to understand the need that your own child would have for you. You know what I'm saying? It would be nice if I was supported financially and even just someone telling me some resources out there so that I could get the help that I needed at the time. There's no one in any of these entities that I'm describing coming out and saying, hey, we've got this resource for you to help. So that's why I felt the way that I did. I didn't feel supported.

WALZ: Can I--

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ARCH: Yes.

WALZ: --ask another question. So and you may have already answered this question, but one of the things that I'm really concerned about is communication with families. So you said you didn't have any idea or didn't know about the financial assistance or the resources that were available. Can you maybe give us some ideas on what you think is needed to help with that communication process? Is there-- are there things that we could do that would improve that communication?

ANDREA EVANS: I'll say this, when families come to the agencies, you know, seeking things-- I mean, if there's nothing there, there's really, how can they support me? You know what I mean? I worked as a parent connector with UNL. We informed the research of empathy and vulnerability. And what we did is we helped parents to better serve their, their students that were with disabilities. And so we became a resource. We became, you know, we're the ones that would give those families those resources that they needed because we would, you know, research them. You know, we'd hunt them down and make sure that families received what I didn't receive, that support. Parent Connectors Program, we'd like to get that going back again. You know, it was just a study, it ended in 2019. And I feel that it was a great service to families between Lincoln, Omaha and Iowa. We served all of those communities.

WALZ: All right, thank you.

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

ANDREA EVANS: Thank you. Did you want a copy of this?

ARCH: You can leave it with-- yeah, the committee clerk.

DOROTHY ACKLAND: I'm sorry. I don't have any documents to give you.

ARCH: That's quite all right.

DOROTHY ACKLAND: Hi, my name is Dorothy Ackland, my spelling of my name is D-o-r-o-t-h-y A-c-k-l-a-n-d. I want to talk about choice. Choice is power, choice is dignity. There is no-- there is one choice someone should always have, that is the ability to control who touches you, your belongings, activities and choices. Taking away that is wrong. Wrong is an understatement. Taking away that choice is a power play. It says in my world, my disabled world, that you don't trust me

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or those responsible for making decisions for me. That is the great [INAUDIBLE] especially since the state and CMS both claim I have person-centered individual choice in my care. Having a disability that doesn't take this away, neither does having a guardian. I should edit that. There are human, human rights that a guardian can't take away without a good reason. Even-- it seems that there are even-- oh, wait, I just read that. It seems to me that those fundamental rights includes the right to control who is privy to personal and private information and who you hire to do your ADLs and IADLs. My biggest fear is my DSP or support worker won't see me, that they will see someone so disabled that they struggle with independent living skills. There is something profoundly undignified about needing assistance, any assistance, whether it be wiping your bottom, wiping somebody's bottom, or helping me with laundry or even making meal plans. I have to let someone-- let this person into my life. Often somebody I don't know with no choice, an undignified choice-- part is I have no choice. I need assistance, I have to work with this person. The state decided I can't use family members, not me. The choice is power and choice is dignity. Every time I choose someone to work with me is another who can abuse, neglect and exploit me. Whether I pay them, whether the state pays them or my family pays them. Some people I like may testify against this. They may think guardians or family members is more likely to get away with abuse, neglect or exploitation. I don't know why they think that a family member is statistically more likely to get away with these things because here's the truth: I'm a burnable person. The state says so. My family says so. My family may abuse me, but so may the worker who I choose to hire, who's not related to me. Teach me self-advocacy skills. Don't take away my fundamental right to choose who I spend time with. Keeping family caregivers away, I mean, keeping family caregivers from being paid takes away my self-direction and my ability to choose. If I want a family member, why shouldn't I or somebody like me be able to? Because I'm disabled? Because someone has a guardian? If I have money in my budget, why can't I spend it on who I want to? That, that's not person-centered care, that's somebody else once again making this decision for me. I'll be honest, personally, I don't want to use family members as a caregiver. This is primarily because my-- I don't want my family members to know that much about me. The pers-- the information I have to provide to my caregiver is personal and very private. Very few people are privy to that information I give my caregivers. I should have complete control over who's entitled that information. Please give us control. Thank you for this, your time and for listening. Are there any questions?

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ARCH: Are there any questions from the committee? Seeing none, thank you very much for coming and testifying.

DOROTHY ACKLAND: Would you like me to give this to you?

ARCH: You can give that to the committee clerk. Next testifier. Next testifier.

BRAD MEURRENS: Hold on. Good morning, Chairman Arch, members of the committee. For the record, my name is Brad, B-r-a-d, Meurrens, M-e-u-r-r-e-n-s, and I am the public policy director with Disability Rights Nebraska. We are the designated protection and advocacy organization for persons with disabilities in Nebraska, and I'm here today to clarify our position and raise issues surrounding the family guardian payment issue described in the resolution. We recognize the significant unmet service needs of families of children with disabilities and families caring for elders. Our agency has, for many years, advocated for eliminating the Development Disability Registry or the waiting list, calling out the impact on families who lack services. As the protection and advocacy organization, we are charged with protecting and advocating for the legal rights of persons with disabilities. As an agency that is involved in addressing issues regarding guardianships for people with disabilities, we have a particular and additional interest in this LR and I will tailor my comments to that. Nebraska has some of the strongest protections for persons under guardianship in the country, and the state should be highly reluctant to throw open the doors to edit them. As we know, there is no guarantee that editing won't spill over into other areas of statute, which could cause unintended harm for persons with disabilities and their families. Paying family guardians sets up another financial incentive for persons to become guardians. Families need services and if they can get paid for caregiving as a family guardian, why wouldn't they jump at it? Since guardianship is a serious restriction on an individual's liberty and rights, and since many guardians in the state of Nebraska are full or plenary, which encompasses essentially the totality of all the ward's choices, Nebraska should be very wary of establishing routes to increase guardianship. Paying family guardians involves clear and inherent conflicts of interest. Our concern here is not unfounded. In 2006, North Carolina ended paying family guardians for adult wards because of high costs and the inherent risk of conflict. Quote, A disabled adult's legal guardian must help develop and approve an annual care plan. It would be a conflict of interest for guardians to approve the plans and also get paid for implementing them. Paying guardians to

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care for relatives is a sensitive issue, said Dave Richard, executive director of the Arc of North Carolina. But Richard said the new policy is basically a good one. The potential for conflicts of interest is significant if the person on the front lines making sure that proper care is provided is also the one doing the work, end quote. Among other protections, if Nebraska would want to move toward this direction, they would have to determine, quote, things like how the provision of care by the family caregiver is in the best interest of the child, that the use of the family member does not create a conflict of interest, especially around finances and service planning, monitoring service plans for community integration requirements, determining payment is made only for services rendered and put in place safeguards for abuse, neglect and exploitation. Paying family caregivers can already be done within Nebraska's existing HCBS waivers. A family caregiver that is not a legally responsible person or a family guardian can be paid for care-- caregiving services. There are additional waivers under federal Medicaid that could be used to alleviate the burden on families that Nebraska has not chosen to adopt. For example: the Community First Choice Waiver 1915(k) self-directed personal assistance services state plan option; the 1915(j) waiver; and HCBS's State Plan option 1915(i) waiver. These options, we would argue, should be explored and utilized before opening up the guardianship statutes. Perhaps educating families about the existing opportunities for family caregivers to be paid in the status quo would be a better, quicker and more direct option. Paying family caregivers was proposed by Senator Krist in 2016 in LB674. The Disabled Family Support Program [SIC] is another avenue that could help defray some of the costs of caregiving. That's already existing. The state could invest more money now that we have flush coffers into programs like that. And our concern here is amplified given that the, the root cause of the service crisis seems to be state funding, as well as the low wages paid to human service staff, both of which drive the significant service agency understaffing and turnover. Nebraska should invest more in the human service systems in light of the current flush coffers and consider the wider systemic impact when making investments in disability services and systems. We're not convinced that paying the slice of folks that are guard-- family guardians would alleviate the scope of the, of the problem in total. That, that concludes my testimony. I'd be happy to answer any questions.

ARCH: Thank you. Are there any questions? Seeing none, appreciate you coming today and testifying.

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BRAD MEURENS: Thank you.

ARCH: Next testifier.

CHRISTINA EVANS: Hello. My name is Christina Evans, C-h-r-i-s-t-i-n-a E-v-a-n-s. My husband, Andrew, and I have three boys ages thirt-- 15, 13 and 5. Both our 13-year-old son and our 5-year-old son have been diagnosed with moderate to severe autism. Our 13-year-old has received waiver services since August of 2016 when he received priority one funding for the DD waiver. Our five-year-old son has been approved for the same waiver and has been on the waitlist for services since 2020 when he was diagnosed. Because of the extra support my children need and the lack of childcare for children with special needs, I am a stay-at-home mother. We have worked with two agencies in the past for providers for my 13-year-old. Having two children who need constant supervision and assistance with daily activities, even with staff in the home for our 13-year-old, I am also needed to be home for our other children. We have not had providers in our home for three years because of inconsistent staffing and too many people that do not stick around for long. We recently moved out to southeast of Lincoln in rural Lancaster County, so finding staff is even more difficult for us now. With paid family caregivers, our children and our family as a whole would benefit tremendously. I am prepared and willing to take the necessary training and classes to be able to provide the same services to our children I do now on my own. I know my children best and have been their number one provider for 13 years. I plan to be their caregiver as long as I possibly can. Allowing for parents to be paid providers would help address the staffing shortage and help families like mine be able to provide for their families. Thank you. That's all.

ARCH: Does that conclude your testimony?

CHRISTINA EVANS: Yep.

ARCH: Are there questions? Seeing none, thank you for coming today.

CHRISTINA EVANS: Thank you.

ARCH: Next testifier.

ANDRIA COGLEY: Hi. My name is-- I'm sorry. I may get emotional. My name is Andria Cogley, A-n-d-r-i-a C-o-g-l-e-y. My daughter is 21 and has something-- a rare chromosome disorder called Phelan-McDermid syndrome. She will never outgrow this. She's cognitively about three

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or four. She is nonverbal and unable to care for herself. She's a joy. My husband submitted his testimony so I hope that that will be read. But I'm here to tell you about my personal experience as her caregiver and her favorite person in the whole world. The care that children need begins long before they become adults and residential services are available. I had a successful graphic designer career when my daughter was born. We were blessed to find a wonderful in-home daycare for her when she was a baby. But as she aged, she became much older than the other children, became harder to care for her within that daycare and provide the needs of the other children. So we were faced with the question, what do we do? Our child is now not becoming more independent and able to care for herself. How are we going to provide care for her before and after school, through the summer when there is no school? So we made the difficult decision for me to quit my professional career and be home with her to be available for her. I was able to continue to do some freelance and currently have a painting business but it in no way provides a salary for our family. We've since added two boys to our family and staying home has been a blessing to care for all three of them, but our boys are getting older and more independent. But Adeline [PHONETIC] is not and she will not. It was a no-brainer when guardianship came up when she was 19. There's no way we would allow her to become a ward of the state. Not that the state doesn't provide adequate services for those who need it, but in our case, we wanted to be in control of how she was cared for. And she would want us to be in control of that as well. Then her residential services became available through DHHS. And yes, becoming a shared living provider is available for parents, but you have to remove your guardianship to do so. I can't tell you how horrible that was to remove my legal guardianship from my daughter. To the state, I am nothing to her, but I do everything for her and I'm an expert in her care. Everyone calls me to know how to care for her. I went through 50 hours of training to become a shared living provider for my daughter, yet I still have to call someone who's never met her in order to give her a TUMS for a tummy ache because I'm only a shared living provider, I am no longer her guardian. I can't tell you what that feels like, being the expert of my child and not being able to have both titles. My husband is her guardian, her legal guardian still, and thankfully able to make those decisions for her, but it has been a difficult and trying journey. However, we feel we had no choice. Thank you for your time. Do you have any questions?

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

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WILLIAMS: Thank you, Chairman Arch, and thank you for being here and sharing your story. I'm slightly confused--

ANDRIA COGLEY: Yes.

WILLIAMS: --about the guardianship with your daughter. As you mentioned, you had to be-- if I understood your testimony, you had to be removed as guardian.

ANDRIA COGLEY: Yes. You cannot be a legal guardian and a shared living provider right now.

WILLIAMS: But your husband is the guardian then?

ANDRIA COGLEY: My husband is able to remain her guardian.

WILLIAMS: Is there-- are there additional guardians besides your husband or is he the sole guardian?

ANDRIA COGLEY: Not currently. He is the sole guardian. We have no family available to help care for her or to, to hold that title or, or that responsibility. That's, you know, a big reason why it would be huge if I could also retain--

WILLIAMS: [INAUDIBLE] this question. Do you and your husband live in the same household?

ANDRIA COGLEY: We do current-- yes, we do.

WILLIAMS: OK.

ANDREA EVANS: Yes.

WILLIAMS: So he has the responsibility of making the guardian-type decisions.

ANDRIA COGLEY: Yes.

WILLIAMS: OK. Now I understand. Thank you.

ANDRIA COGLEY: Yes. Any other questions?

ARCH: And that enable-- and that enables you to be paid--

ANDRIA COGLEY: That enables me to be paid.

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ARCH: --as a shared living provider.

ANDRIA COGLEY: Yes, correct. And so she is 21. I have not been able to have a salary or a full-time job since she was eight, which means I have not been able to provide for my family. I mean, I have worked from home. I-- trust me. I have done everything in my power to help support my family, but now we are actually able to provide for our future, which we have not been able to do until now.

ARCH: How long ago did this change happen for your family?

ANDRIA COGLEY: Just in September, her residential services became available.

ARCH: Oh, with the waiver.

ANDRIA COGLEY: Yes, the waiver became available.

ARCH: Yeah.

ANDRIA COGLEY: However, it took-- I just began actually serve-- like, providing services as of November 15. It took that long to do training and it's extensive training that you have to go through to become a shared living provider.

ARCH: Thank you. Senator Murman.

MURMAN: So thanks for testifying, first of all. But so since you're a couple, you can-- you have worked around the, I guess, the regulations from the state to take care of your child or your adult child now, but.

ANDRIA COGLEY: In a way.

MURMAN: But if you were a single parent--

ANDRIA COGLEY: Um-hum.

MURMAN: --I, I don't see how that--

ANDRIA COGLEY: Yeah.

MURMAN: --you'd have to hire someone outside the--

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ANDRIA COGLEY: You would absolutely have to. And I have been a single parent. She was from a previous relationship. If we were-- if I was still in that situation, I would have no choice.

MURMAN: Yeah, that would even be more difficult.

ANDRIA COGLEY: Absolutely.

MURMAN: Thank you.

ANDRIA COGLEY: Thank you.

ARCH: Thank you for your testimony. Next testifier.

CATHY MARTINEZ: Good morning. My name is Cathy Martinez, C-a-t-h-y M-a-r-t-i-n-e-z. Senator Arch and members of the committee, I am the mother of a 19-year-old named Jake who is profoundly affected by autism. He is non-verbal and has an IQ of 44. He relies on assistance for most of his activities of daily living. He can be aggressive at times and my husband and I know proper techniques to calm and restrain him during these types of situations. He was born a healthy baby in June of 2003. In July of 2005, he was diagnosed with severe autism spectrum disorder. We enrolled him in speech and occupational therapy, which we paid for mostly out of pocket because our insurance at the time didn't cover that. That cost our family thousands of dollars each year. Then we enrolled him in ABA therapy, which cost our family over \$60,000 annually for three years. Eventually, that caused our family to file bankruptcy in 2010, as a result for paying all of that out of pocket. We waited-- he waited on the DD waiver registry for eight years until there was funding available for services. We were fortunate that I work from home because we couldn't afford to pay for any service providers for before and after school for him at that time until we received DD funding. He received special education services through LPS from 2005 to 2022. He is currently enrolled in the Independence Academy, receiving job coaching and life skills training. Having a child with disabilities can cause great financial hardship for families. As mentioned earlier, these therapies are often not covered by insurance. We've needed to hire an attorney to advocate for him when there was an error made on his needs assessment with DHHS two years ago, costing our family \$4,100 in legal fees. We needed to hire a lawyer to create our special needs trust and update our will to account for Jake's special needs once we are no longer here. That cost us \$2,500. We had to again pay for an attorney, approximately \$2,000 this year, to gain guardianship over him on his 19th birthday so we

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could communicate with his doctors and his school. With that being said, our family is fortunate in the fact that we could pay for these services at this time. Many families can't. Our plan is to have Jake remain at home to live with us as long as we are able. We are the best choice to be his caregivers. We know him, we love him and he is most comfortable with his family in the only home he has ever known. We know his medical record better than anyone else. We know his likes and dislikes. We know his triggers. We know his sleep patterns, these things people often don't realize all of the different things that we have to keep track of. He will seek-- we will seek to be his extended family home once he turns 21 and no longer receiving educational services. At that time, we will need to change our guardianship once again according to current state policy. We will incur yet another legal bill in our ongoing journey of caring for our child. Raising a child with special needs has taken a toll on us, not just emotionally and financially, but physically as well. We make sacrifices every single day to give him the best care; sacrifices in our careers, our social lives, and the obvious, a financial sacrifice. Any parent of a child with special needs can attest to what burdens exist as a caregiver. Other states allow guardians to be paid providers. It just makes sense for us to do it as well and it prevents further financial burden being placed on caregivers. Since Jake was diagnosed, we've been jumping through hoops to provide the best for him; the DD waiver, SSI, guardianship, Special Needs Trust, IEPs, special education. The list goes on. I knew the moment he was diagnosed it would change the course of our lives. We will be caring for him until we're physically unable to do so. We will never retire like normal couples do. Raising a child with significant impairments has been challenging at times, but we, like many, decided our child would never be institutionalized. He would remain in our-- with our family who know him and love him and can provide him with the best care. Creating legislation to address these issues gives you the opportunity to lighten our load just a little bit. Taking care of Jake is a full-time job. Very often, parents of children with disabilities must quit their jobs to take care of their children, causing loss of household income. Lack of trained and willing-- I'm sorry, lack of trained and willing providers is another issue that compounds the challenge of finding adequate assistance and care. Appropriate legislation could provide these parents with a chance to still earn an income while fulfilling the job of caring for their disabled loved one. It's a win-win for Nebraska. Parents get to provide the best care for their child. The affected individuals get to receive consistency of care in their family home with people who love them. The state addresses an issue of lack of

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qualified providers. Please address these issues for Nebraska special needs families by make-- this just makes sense and please do what's right for the disability community.

ARCH: Thank you for your testimony. Are there any questions from the committee?

WALZ: I have a--

ARCH: Senator Walz.

WALZ: --question. Thanks. First of all, did you say \$60,000 annually?

CATHY MARTINEZ: It was. ABA costs \$60,000 annually for the 40-hour intensive treatment that's recommended for severely autistic individuals. That was addressed in 2014 with LB254 that was introduced by Senator Coash and that service is currently being paid for in the state of Nebraska.

WALZ: OK, good. And then if, if you had been able to take advantage of paid family care-- the paid family caretaker system, would you have still had to fight the legal battles that you fought? Or would some of those legal battles been--

CATHY MARTINEZ: I assume that we would still have to--

WALZ: OK.

CATHY MARTINEZ: --fight those legal battles--

WALZ: OK.

CATHY MARTINEZ: --that we've already fought.

WALZ: All right. Thank you.

CATHY MARTINEZ: Um-hum.

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

WADE JOHNSON: My name is Wade Johnson, W-a-d-e J-o-h-n-s-o-n, and I am thankful for the opportunity to speak to you this morning. Most parents simply do not have the ability, the resources to come to Lincoln and speak. I am the father of an adoptive 16-year-old daughter, Zoe, who has a big smile and feels the emotions of life

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deeply and is developmentally disabled. My wife Adeline and I started Our Place After School Care four years ago to serve developmentally disabled 13- to 21-year-olds. We wanted a safe and enriching place for her and others to go after school and in the summer while we finished our work day. In addition to our full-time jobs, my wife Addie, an elementary school teacher, and I serve as the director of Christian education at Faith Lutheran Church. My wife serves as executive director of Our Place After School Care and I serve as a board member of the program without pay. Countless hours have been spent learning about administration, marketing, fundraising, grant writing, educating staff and volunteer management, all to make our program a success. When we first started, workers from DHS [SIC] informed us that it could not be done. Yet four years later, we are still here, stronger than ever. We are, we are one of just four programs in the state of Nebraska. Outside of Lincoln and Omaha, we are the only one to serve this population. For the first four years, we ran out of three classrooms in the basement of our church, rent free. We have now moved into our own space and have added retail space in which we will train our clients in marketing items for sale and working in some of the store with, with the public. With the help of many volunteer and staff, our store and our consignments from local artists and craftsmen will help support the program. We wanted our program to open-- be opened up to anyone who needed it for the parents to have the opportunity to finish their workday. So far, with many generous donors, we have offered a sliding pay scale and offered above-average pay scale to our dedicated workers who serve faithfully. Students dropped off from the school on the bus stay until five-- after five until their parents can come pick them up after work. We offer programming in math, science, social studies, gardening, community science, cooking, cleaning, life skills and more. In the summer, we run from 8 a.m. to 5:15 p.m.. Adult DD programs only operate till 3 p.m., which does not allow caregivers the opportunity to work a full-time job. Other providers have not served this population because they could not see how to fund it. I would put our program up against any other serving this population at any age. No good deed goes unpunished. This past summer, our daughter has been approved for the DD waiver after eight years. We cannot receive funds from the state because my wife serves as the executive director of the program and I served on the board without pay. The program receives Zoe's DD funding. If the program receives Zoe's DD funding, we would remain unpaid. We started it because no one else offers this service and only caring, loving, crazy parents would take on such a venture. Other parents in our program are thankful for our service. In addition to

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our sliding scale, our level of care, we are much more reliable than independent providers in our community that they have had before. I get it. You do not want to make the most vulnerable population receive-- receiving good care-- you want them to receive good care. Truthfully, this population has fallen through the 13- to 21-year-old hole. Families are facing impossible decisions to care for the youth and provide for their families. We have demonstrated that we can reliably care for our kids while employing caring and dedicated providers and giving safe, enriching activities. I ask you to open up this legislation to creative solutions like ours. State funding could be opened up our program to serve youth and families of more profound developmental and behavioral needs. Please help us to prove that it is possible to open up programs like ours in other communities in the state. Thank you.

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

MURMAN: Yeah, thank you for your service for the community of Hastings area.

WADE JOHNSON: Thank you.

MURMAN: Do you-- about-- I've got to ask a question. So about what is the ratio? How many caregivers do you have?

WADE JOHNSON: Currently, we have two to four.

MURMAN: OK. Thank you very much. Thanks for what you do.

WADE JOHNSON: Um-hum.

ARCH: Wait just a second.

WADE JOHNSON: Yeah.

ARCH: There may be other questions. I just want to make sure.

WALZ: I did have a question. You-- and I'm sorry, I was trying to follow along, but this may be silly. You said that you were not able to get paid. Can you tell me why again?

WADE JOHNSON: Because it prohibits the services being paid to a organization that we run.

WALZ: OK, even though you were providing services to other--

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WADE JOHNSON: Even though we're providing services to other children.

WALZ: OK.

ARCH: Other questions?

WADE JOHNSON: We'd like to correct that in the state mandate.

ARCH: Seeing none, thank you for your testimony.

WADE JOHNSON: Thank you.

ARCH: Next testifier.

RIC NELSON: Thank you, Chairman-- Senator Arch and committee members. My name is Ric Nelson, R-i-c N-e-l-s-o-n. I am the vice president of operations for Mosaic of Nebraska. I'd like to thank you for the opportunity to speak today. Mosaic is a nonprofit healthcare organization serving 4,900 people across 13 states and more than 700 communities. We help and empower people with disabilities, mental health needs and autism, as well as aging individuals to serve and live their best life. We primarily serve people in home- and community-based services. In Nebraska, we support, support over 600 people in service and nearly 800 members of our workforce. As we reflect on ways to enhance services for people with intellectual and developmental disabilities in Nebraska, the number-one roadblock to the provision and stability of services is the workforce crisis. The provision of high-quality services and support requires maintaining a highly skilled, professional workforce. Our industry has historic turnover rates in the last several years. For Mosaic, our direct support turnover rate is 89 percent, with a 30 percent vacancy rate. Our industry has lost the ability to compete for a highly skilled workforce and our direct service employees have seen the competitive value of their important work erode. Historic investments have been made to close the gap between direct support professionals and other professionals in a similar level of accountability and responsibility. We are very grateful for the investment. However, the work is not done yet. The gap continues to grow with time and now faces a new challenge. History-- pardon me-- historically, direct support professionals have not equated to minimum-wage jobs given the skills required of the position. To maintain stability of services, the total impact of increasing the state minimum wage on the direct care for, for-- workforce must be assessed and addressed. We must look for adjustments to long-term funding frameworks that proactively adjust to

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compression of minimum-wage adjustments and inflation to ensure we do not lose any gains we have made in the support for people with disabilities. As we look forward to the future of services for people with intellectual and developmental disabilities, we envision services that meet the needs of the persons served in the right setting and at the right time, maximizing community involvement with high quality outcomes. Mosaic supports people in a variety of settings, including the personalized setting of shared living. It is Mosaic's firm belief that providing personalized services such as shared living to those who support their quality-- to those we support enhances their quality of life. We support further enhancement and expansion of shared living as a personalized service to include the use of family members as providers. Any enhancements must and need to ensure they break down barriers of accessing, accessing services and not necessarily create them. We support implementation of agency standards without regulatory burden and that do not create unfunded mandates or divergence of resources from direct service provision, standards that offer agencies the flexibility to determine the individual level of support providers may require and to provide those high-quality shared living services. Most-- Mosaic is very thankful for the recent rate increases to disability services, yet by no means solves our staffing issues, our revenue shortage long term or the stability of services. Thank you very much for letting me share Mosaic's elevated vision for services with you today. And we look forward to partnering with the committee, along with the department, to serve people in the state of Nebraska with intellectual, intellectual and developmental disabilities. Thank you.

ARCH: Thank you for your testimony. Questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Mr. Nelson, for being here. You, you have touched on a subject that hits a lot of areas: workforce shortage, workforce crisis, medical profession, teaching profession and a lot of others. I want to explore a little more in depth so I understand that when you use the term that your industry has lost, the ability to compete, I think, were the words that you used in your testimony. Can you explain how you go from-- evidently, when you say lost the ability to compete, you were able to compete. What has changed that now has you in a position where you're not able to compete?

RIC NELSON: I'll try to answer that question without getting too--

WILLIAMS: Too far--

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RIC NELSON: --too into the weeds. That's a big question to answer. I'll use an example. I'll use my example. When I started the direct service profession, I started as a direct support professional back in my day. I had the lucky, the luck-- the opportunity and the great fortune to move up at-- in, in the industry. When I started in the industry, I was making \$11 an hour. That was not yesterday. That was 25 years ago. Our funding and our mechanisms to compensate direct support professionals have been stagnant and they have, pretty much since the mid 2000s have really stagnated. States have to increase minimum wage. That has also put compression and that was-- in my testimony, I mentioned that really the, the competitive advantage is that we are now competing with minimum-wage positions that we never had to before because of the inability to keep up or keep that gap. Nebraska is fortunate that that gap right now is roughly around 67 percent between minimum wage and the average wage for a direct support professional. We want to make sure that we maintain that. The increase in the minimum wage that is currently moving forward, that gap will significantly close, if not almost disappear.

WILLIAMS: Gotcha. This, this is, is troubling for, again, I think for a lot of things, not just your industry. Childcare, early childhood learning, all of these are sitting there. When I drive by a McDonald's in Gothenburg, Nebraska, and the sign is there, apply now, \$15 an hour, you know, for a starting job, but that's where we are economically. Thank you for your testimony.

RIC NELSON: Thank you.

ARCH: Other questions? Senator Murman.

MURMAN: Thank you for what you do caring for disabled individuals. From your testimony, I was trying to determine, would you favor family caregivers being paid to take care of family members?

RIC NELSON: Senator, yes. Mosaic is a, is a multi-state provider and we actually provide a service in Maine that actually allows quite a few parents that provide services. So in our experience, family members can and have successfully provided, provided shared living services.

MURMAN: OK, so you don't see that as competition at all?

RIC NELSON: No.

MURMAN: Thank you.

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RIC NELSON: We actually are a shared living provider agency, so-- that does the quality oversight.

MURMAN: Thank you.

ARCH: Senator Walz.

WALZ: So I-- can I-- I just want to clarify. That was a good question. Thank you. I was going to ask that. But I just want to clarify so a shared living or a family would still be working underneath maybe a provider such as Mosaic. They would still have to have that connection with a provider?

RIC NELSON: Currently, that's the way the--

WALZ: OK.

RIC NELSON: --system is set up.

WALZ: All right. Thanks. I just wanted to clarify that.

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

RIC NELSON: Thank you.

ARCH: Next testifier.

JOE VALENTI: Chairperson Arch and the committee, my name is Joe Valenti, J-o-e V-a-l-- V-a-l-e-n-t-i. Let me start by saying the current system to care for this population is not working as designed or as you, parents, guardians and others would hope it would work. As much as I support the system of parent caregivers getting paid, I do not believe this is the long-term solution to staffing crisis we have in our state and across the nation. The staffing challenges continues to be one which is not being met with-- even with additional funding, which was provided in the last, last Legislature session. By current statistics, Nebraska is the seventh-highest paying state for DSPs, with one of the highest turnovers of DSPs. I won't go into all my thinking on that right now unless you have questions. The concern I have with additional funding, with the additional funding, did it get to the DSP level? I do think the department is working to implement quality and accountability measures which will help to understand the operation of the providers. One of the, one of the significant challenges is the middle-management area providers. I know you're not here to discuss that today, but if we keep avoiding really what I

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think and what others think is the crux of the problem with, with providers, I think we're missing just continuing to increase DSP wages. So one of the highest turnovers also is in the middle-management ranks of DS-- of providers. And this is causing then inconsistencies within the DSP level with the, with the, with the-- providing the care that the individuals need following their programs, etcetera. I believe we all need to explore other ideas and options for how we serve this population. The system of individual homes spread across a geographical area, community is not the answer. Considering the shortage of workers, which is not going to go away, the time has come to explore other options. Consolidation of providers, back-room services, specialized services and other ideas need to be explored. It has been mentioned on several occasions the shortage we have in behavioral health; psychiatrists, nursing, other professional areas that are in dire need of additional staff. I understand none of this is going to be easy and I know you've heard this term before. The definition of insanity is doing the same thing over and over again and expecting different results. I conclude my testimony. Thank you.

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

JOE VALENTI: Thank you.

ARCH: Next testifier. Is there anyone else who would wish to testify?

JENNIFER STUHMER: Good morning.

ARCH: Good morning.

JENNIFER STUHMER: I'm Jennifer Stuhmer, J-e-n-n-i-f-e-r S-t-u-h-m-e-r. I am a mom. I am living this. I am learning this as a mom of an individual with disabilities. My son is 18 right now and he was born with a very rare chromosome syndrome, deletion, a very rare syndrome. This impacted his intellectual, his physical, and his medical, his medical development. After birth, Damon [PHONETIC] was in the NICU for seven months and then another seven months he spent at the Ambassador in Omaha, which had, like, ten beds for pediatrics at the time. We had to do this to learn how to take care of our son before we could even bring him help. We had to learn how to do trach cares, handle a ventilator. He still sleeps on a ventilator to this day. He requires 24/7 nursing at home and that means someone needs to know what to do if he needs it. And that means we have had intensive training on how to care for his trach, his G-button and all medical cares, all right?

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I'm mainly focused on the medical piece, but that's just a part of my son. All of this was due to a medical fragile state and the only way that I could bring him some-- my son back was to learn these things. And then we had private-duty nursing in the home. Private-duty nursing was great as long as there were nurses, right? Then the nursing shortage came. Present day, times have changed. The nurse shortage was worse than ever. Damon still requires nursing and someone specifically trained to care for him and his cares. So he still uses the ventilator to sleep and he's "trached" G-button fed, low muscle tone, wheelchair dependent, prone to seizures and illnesses and on many medications around the clock. I now have to utilize two different nursing agencies, agencies so that my son has enough coverage to go to school and so that I can work and so that we can also sleep at night so that my husband can go to work. In the past 18 years, it's been a struggle to find a job that will support our family financially and understand my son's medical issues and needs. I've lost jobs due to my son's needs and having to miss work due to nurses not showing up, not scheduled, not being there. Damon is a nursing level of care individual requiring 24/7 care. There are three people outside of the nurses that care for my son that are able to take care of him; that's myself, my husband, and my mother. My mom's getting old. Damon is getting bigger so that really just leaves my husband and myself to care for my son if a paid nursing person cannot be there. If we were able to be paid to care for Damon when the nursing agencies can't fill his shift, that would help offset some of that financial burden that we've incurred over 18 years of time. And this, it's the same trickle-down effect. If you can't work, you can't make money. If you can't make money, you can't pay the bills. It just would be nice to have-- if we're, if we're working to keep our son alive, that we could pay our bills. LR368 is an important part of what the state needs right now. With the current times of nursing shortage, unemployment and families needing more medical-based care for their children, this bill will answer the needs of many families living with these tough decisions of what to do when there is only one person to care for their child. And I have a-- I skipped-- when there's only one-- me to care for my child and I have to work and pay the bills and stay home-- make that choice of stay home or to keep my child alive. LR368 has been necessary for years and now it's time to make it happen. Thank you.

ARCH: Thank you.

JENNIFER STUHMER: Questions?

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

JENNIFER STUHMER: Sorry, I got very nervous today.

ARCH: No, that's--

JENNIFER STUHMER: I can talk for hours and I would love to visit sometime. This just feels very intimidating. Thank you so much.

ARCH: Glad you came.

_____ : You did great.

JENNIFER MEINTS: Good morning.

ARCH: Good morning.

JENNIFER MEINTS: So my name is Jennifer Meints. I am a wife. I'm a parent. I'm very emotional as well, so--

ARCH: Could you--

JENNIFER MEINTS: --I will try to keep it together.

ARCH: Could you please spell--

JENNIFER MEINTS: Oh, I'm sorry. Yes, Jennifer Meints, J-e-n-n-i-f-e-r M-e-i-n-t-s. So, again, I am a wife, a parent, an advocate, and a professional in the community. I work in this field. I love it. It's my life. It has been for the last almost 20 years. When I-- when you are a parent and you-- or choose to be a parent, you, you're excited, you know? You go to your, your ultrasounds. You are excited to bring this baby home. When I was 25 weeks pregnant with my middle child, I was told there was something wrong with her brain and that she would not sustain life. I was told when my daughter was 25 weeks pregnant [SIC] to terminate my pregnancy. That would be the best option for her because she would never be able to have quality of life at all. I am happy to say that my daughter will be 20 years old this month and she is one of the most passionate, caring, lovely young ladies I've ever met in my entire life. During her first year of life, we had 23 specialists that we saw. She was born with a syndrome that only about 500 kids in the entire world have. So as parents, we were learning. Our other child that we had previous to, to Grace was a healthy, young, young girl. So learning how to navigate medical systems,

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learning to-- therapies, Medicaid. You know, our daughter was in the hospital for several weeks. We brought her home. We had no idea what was wrong with her at that point because nobody had ever seen this. It was, it was still very, very rare when she was born almost 20 years ago. So we were navigating talking to people all around the country, trying to figure out the best way to care for our child. We could not both work during that time. We have traveled to over seven states to try to find specialists that can help us with the areas of need for our child. We had to decide who was going to work full time, who was going to work part time. What, what were we going to do to, to help our family? We have struggled at times. My husband currently works for the school system. It gives him the opportunity to do what he loves and to be with kids and make a difference in these kids' lives. It also allows him to be with our children-- or our daughter when she's not in school and to be able to care for her, take her to therapy, take her to all of her appointments and everything that she needs to, to go to. We wouldn't change any of this for anything in the world. It has been hard. It has been a struggle, but it has also been fabulous in the same, same way. We have been able to teach people things. We have learned, we have learned, grown up together and, and learned how to get through these, these tough systems. I will say my-- working with the DHHS system has been difficult at times, just not knowing exactly what was out there, what could we do, what was, what was available to families. What does the A&D waiver mean? What does the DD waiver mean? What, what is right for my child? When does this one end? When does this one begin? We-- she is on-- currently on the A&D waiver and it has, it has served the purpose that we have needed until now. We are currently on the waitlist for the DD waiver, which will be more beneficial to our daughter as she grows and, and as she has learned how to navigate life. It is hard to find care for anybody on the A&D waiver. There are no-- there are not any agencies currently, as you've heard from other parents, that provide care for A&D waiver recipients such as DD. You know, there's DD providers all over the state. Hundred-- or there's probably 40 in Lincoln, Nebraska. There is not one A&D-specific provider or somebody, an agency. So my mom, myself and my husband are the only caregivers for my daughter because everybody else is nervous. What if she has a seizure? What if her shot malfunctions? What if, what if something happens and we don't know what to do? It's hard. So if we want to go out to dinner, if we want to go somewhere, that can't really happen because we don't have anybody that, that can take care of our daughter. If you want to get somebody, a provider-- a care provider for your children, it can take, you know, up to three months for them to go through their background

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check and to go through all of the, the paperwork that you need to complete to become a caregiver. So it's been difficult. I will say the department has been fabulous. DHHS, the DD division, listening, trying to, to come together to work with families, to work with entities to try to make systems better. And I'm very grateful for the leadership that has been open minded. Talking about being paid as a caregiver, like I said, I-- one of us has worked full time, one of us has worked part time our whole lives. Retirement, not a whole lot there. There-- it's, it's hard. But even when my daughter is 21 and could move out of the house, where does her choice come in? You know, we talk about choice. We talk about person-centered planning. My daughter deserves a choice and if she, if she wants to live with her family, she should be able to live with her family. And it is extra--

ARCH: Excuse me.

JENNIFER MEINTS: Yes.

ARCH: The red light has come on.

JENNIFER MEINTS: OK.

ARCH: And so I would ask that you, that you conclude your remarks, wrap--

JENNIFER MEINTS: OK.

ARCH: --wrap it up.

JENNIFER MEINTS: Yes.

ARCH: Thank you.

JENNIFER MEINTS: OK. All I want to say is taking care of a child when they're older, still taking them to therapy, taking them to appointments, they can't go to social events on their own. So we are caring for our child more than anybody-- you know, more than a parent would when their child does turn 21. Yes, I will conclude at that time. Sorry, I could go forever, so.

ARCH: Thank you. Questions? Are there any questions? See--

JENNIFER MEINTS: Sorry I rambled.

ARCH: That's-- no. Thank you for your testimony--

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JENNIFER MEINTS: Thank you.

ARCH: --very much.

_____ : You did a great job.

SHANNON BUTALLA: Hi. I'm Shannon Butalla. That's spelled S-h-a-n-n-o-n. My last name, B-u-t-a-l-l-a. I'm here today because I'm an advocate, I'm a mother and I'm a guardian of a young man named Sam. And he is, he is a-- he has a rare degenerative disease that's caused deafness, blindness, global developmental delay and it's a neurodegenerative disease so eventually death. My mom always says, squeeze your butt cheeks together when you want to talk. [LAUGHTER] No, so with that enlightening thing, it's, like, do that and just carry on. This is an emotional thing. We've cared for this young man for 20 years and he's going to be 21 in July. And I've been a fierce advocate for him his entire life and last year, we had to decide between guardianship and being an SLP. My husband is a colonel in the Kansas Army National Guard. He also works a full-time job. I'm a realtor with Nebraska Realty. I manage about 40-plus transactions a year, but I wasn't able to do this until Sam was 15 because in addition to his rare disease, he also had leukemia when he was six. And so it, it causes a lot of stress and-- but we did what we could to financially pull together and do what we needed to do to best care for him. I have parents who are 81 and 82 years old and they've been my lifeline. But last year, my mom had an accident that has caused her to lose her mobility as well. So I have a 120-pound child. He finishes school this May and I have nowhere for him to go in terms of an agency-level care that can provide him the same type of love and support and community outreach that we do as a family. So we're going to be faced with hard decisions. We made those for the first 15 years of life when I was a stay-at-home mom. The last seven years, we decided for me to add into the, to the financial health and wealth of our family so that we could build an accessible home. So we have a beautiful home to care for our child, to make sure that he has meaningful, loving days every single day. We travel with him. We take him out in the community. He has a very loving, supporting, wonderful life that only we can provide. My caregivers have diminished down one person, his bus driver. Now imagine that the only time I can get his bus driver to work is when she's not driving a bus. So it's very limited for us in terms of his care level because everyone else has fallen off. My parents are too old. His other caregivers have gotten married or had their own children or have other, you know, needs to take care of and we don't have anyone. And not only that, the agencies

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supporting-- even people that are very, very honest say, like, your child doesn't fit in our box. He doesn't fit in any box. So we need to take care of people like Sam. I don't mean to be emotional over this, but this is a very emotional thing for so many families and we have sacrificed so much for the love and care for our children. The last time I was in this room, I was speaking on behalf of a bill for rare diseases to add to the newborn screening and I, I spoke on behalf of those rare diseases. My son has that rare disease, one of the rare disease that was, that was advocated and passed so that we take care of our children. Most of us that choose to be guardians have gone through rigorous background checks, have gone through so many, you know, so many avenues for people to uncover if we're good humans. And we're good humans. I mean, I had a lawyer come and visit us at home and says, like, I don't need to look any further, the love and care of this home. It's pretty evident when you go into a guardian's home. And I don't think my husband and I should have to choose between being Sam's guardian and being his caregiver. Now, I learned today through this testimony that I-- in fact, we could split this up because we had been told before that that was not an option for us. We could choose care, we could be an SLP or we could be guardians. And I learned something new today as a result of that so I'm grateful for coming to that, to find that out. But the thing is I don't think we should have to make that decision. I don't think that Rich and I should have to decide either he is going to be his guardian or I should be his guardian. I think that we should both be able to retain guardianship and still be able to care for Sam. If I don't want to do 40 transactions anymore in real estate because I want to live out my son's best days before he dies of this fatal disease, I should be able to do that as his mom and not have someone who provides him substandard care that knows nothing about him medically, physically, emotionally, and puts him at risk to care for my child. And he is-- even though he's turning 21, he is still my child. And I've done this for 21 years and whether or not you tell me that I'm going to be paid for it, I'm still going to do it. But the fact of the matter is, is there's no one out there that can provide as good of care for him as me. So I would like you to take a long look at, at the way that we provide. I don't think that all parents should be in positions of guardians. I do believe that there should be safeguards to take care of our most vulnerable individuals. But I, but I best believe that I think that with care and concern, that parents should be allowed to make those choices to help make those family plans. Just as I did with my college daughter who's serving in the U.S. Army and helping her with her college plan, I should be able to help with the college-- or

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with the life plans of my adult son who can't have-- do those things on his own. That's all I have.

ARCH: Thank you for your testimony.

SHANNON BUTALLA: Any questions?

ARCH: Are there, are there questions from the committee? Seeing none, appreciate you coming today very much.

LISA O'CONNELL: Hello. I'm Lisa O'Connell, L-i-s-a O'-C-o-n-n-e-l-l. I'm a mom and a guardian of two boys; one is 24 and one is 26. And I am also guardian of my nephew and my mother and I share guardianship with my younger son and my nephew. And so I've got the same situation as everybody else here with the care and stuff, but, like, my youngest one, he has type one diabetes and that's a full-time job of keeping that under control. I mean, numbers go up to 300-plus, boom into the hospital, adjustments on insulin, you name it. And they both got the capacity, all three of them, about 3 to 15 years old. And now my oldest one, he's been into this very sneaky, defiant type of behavior and getting himself into all situations that actually with guardianship rules, it's like you, you-- you're stuck, you know, on certain things. And he's actually went to Marshalltown, Iowa, when he met somebody off the Internet. And he-- I tried to get him back. I could, but it was just such a long, long process. And I will say that I took the four hours to go there all the time to see if he's OK. I even called the officers to do well checks on him to see if he's OK. But in his mind, he is not stable enough to do that. And it's just with the guardianship, I can't say, OK, you're just, just stuck here. You got to have certain rules that you-- we have to follow. And I actually-- also, I volunteer and work at an agency in Fremont. It's Uniquely Yours Stability Support and so we deal with the dynamics of homelessness, trying to keep people in their homes and stuff. And I have a lot of people that come in with all these issues. So they're always calling me even after hours to find out, what do I do? I need help. And, you know, it's like unless anybody has ever been in this situation, like, of-- like any of you ever have been in this situation, you don't understand it. I would like you guys to actually go pair up with somebody that has special needs kids for a day or two and see what it's like. Because until you walk in this world, there is no way that you should judge no on this kind of bill. I would say yes because until you do this, you have no clue of what it takes day in and day out to deal with this; doctor's appointments and you name it. Like everybody's saying, it's-- I've got the same thing. My calendar

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is so full that it's so hard to even have five minutes to yourself. So basically, I'm really-- I'm all for this. And like I said, my wish is to have somebody actually go and spend time with people so they do understand and can really learn what it is to have somebody that has three children that are young adults, but they're still children and then still having to go back and forth to court. That's what I'm doing, my oldest one with some of his legal things because he's, like, oh, I wanted to have this-- dropped and everything, but he-- it will never happen because I've got the fullest. There's all different levels of guardianship. And oh, he's so defiant, so sneaky, and it's like he can't do certain things because it's the rules. And so it's just a lot of different stuff. And I-- yes, I went through all the training and everything else so my final say is that this is a good bill and I would like to see it be passed for people. Because it's not fair when somebody has to choose and cannot work and then they-- I'll say if they're on benefits or anything, then they can't get anything if they, you know, they stop working or they're just right between the cracks. And so one thing too with this, with the paid part of it, I would like to see that it doesn't affect people's benefits because that would be the biggest thing. And I'm speaking from reality because I have all this. I'm under the 200 percent poverty line so I am right there with them, so. But thank you for listening to me blab.

ARCH: Thank you, thank you for your testimony.

LISA O'CONNELL: Thanks.

ARCH: Are there any questions? Seeing none, thank you very much.

LISA O'CONNELL: OK. Thank you.

MARY PHILLIPS: Good morning.

ARCH: Good morning.

MARY PHILLIPS: My name is Mary Phillips, M-a-r-y P-h-i-l-l-i-p-s. I am here to speak a little bit-- to give you guys a little bit of a summary of today because I've spent my entire life supporting families and children with disabilities. I'm a retired special education administrator in both rural and urban school districts and populations and I'm a parent. I have a 34-year-old daughter who is currently-- who has had developmental disabilities all of her life. She attended school birth through the year she turned 21. She-- we were those parents that pushed for full, inclusive opportunities in the community

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and in school and she benefited greatly from that. While she does have a developmental disability now, she's fully immersed into DHHS DD waiver, lives in an extended family home, works part time with job coaching. And she's, by all means, one might say, very successful as an individual with a disability. However, there are still so many gaps and barriers to her care. You guys have had quite an education this morning, right? You've heard from a lot of families who are sharing the sacrifices that they have made, self-advocates who are asking for choice. You, you will probably hear from other folks advocating on behalf of, of providing more opportunities for families to have voices in the care of their loved ones as they age and mature and become adults. And we, we have volunteered in that capacity for the last 15 years since our daughter reached age of majority because that's what, that's what people do. So we have been transportation when transportation was needed. We have been the medical care when medical care was needed. We have been able to maintain her as an incapacitated adult child on our insurance so that she can have that supplemental care of, of, of gas for a dental appointment because of her anxiety. All of those types of things happen because really there was no pay for us. We didn't ask for pay. We even think that there would be a possibility of pay. We did it because it was the thing that you do and all of these families you've heard from, they-- everything they do, they do because it's the thing that you do when you're raising a child with a disability at-- with great sacrifice. Some people can bear that sacrifice much better than others. I represent hundreds and hundreds of families that do not have children with low-incidence disabilities that you've heard about today, that have made those types of sacrifices, who may not have the same abilities that I have educationally with the background in knowing special education, with the resourcefulness to go and seek out answers that I don't know how-- what the answers are. We need to support those folks because they don't have the wherewithal to go do it. And that's your job. That's your job to find out a way to support those folks legislatively so that they have the choice and the self-advocates have the choice to decide where am I getting my care and what will it look like? And it's not just something that we're placing our most vulnerable citizens at the disposal of people who do not know them at all to support them in ways that they believe, probably with the best of intent, is the best for that individual when it may or may not be. Because we have taken out of the equation those that know the people best. So thank you very much.

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

MARY PHILLIPS: You bet.

ARCH: Next testifier.

ALANA SCHRIVER: Hi. My name is Alana Schriver, A-l-a-n-a S-c-h-r-i-v-e-r, and I wasn't prepared to testify today so I apologize to not have a written statement for you. Not only am I a parent of a ten-year-old with developmental disabilities, but I'm also the director of the Nebraska Association of Service Providers, which is the state trade association for those home- and community-based agencies serving adults with developmental disabilities currently. So I'm happy to answer questions from either hat that I wear, but my question as a parent is one of more of logistics. I know with my son, his diagnosis came about from a catastrophic infantile epilepsy and so I didn't know during my pregnancy or have a lot of time to prepare. And we were told he was going to regress to a vegetative state. So Dad bounced and it was just me and you don't have time-- the way that the, the registry is now, you know, my son's already on the registry for adult services. He's been on since he was nine because, as many parents said here today, the waitlist is typically around eight years or longer. So, of course, I'm pro-choice. Anything we could do to speed that up by getting parents as guardians is going to be helpful. But when you first find out that your child's diagnosed, you need that money now. You-- you know, you can't wait eight or nine years on a waitlist for childcare or, or some other solution. And, and a lot of those people on the waitlist ahead of you won't want to be paid guard-- paid parent/guardians. They're going to want home- and community-based services and so until those spots open up in those home- and community-based services, the line sort of gets halted. And as my colleague Ric Nelson mentioned, we are in a staffing crisis. We're not on the verge of a crisis in care. We are in the middle of a crisis of care, not just in Nebraska, but the whole country. In Nebraska, it's exacerbated by our ridiculously low unemployment rates. There's eight jobs for every one person looking for a job. But we-- until we actually address the staff shortages-- we did an internal survey at NASP to see if those rate increases were able to alleviate some of those stressors for our providers. And, and not every provider in the state is in NASP. We have about 40--some people in NASP right now, but the, the largest amount of people in services are served by NASP providers. And even though everyone-- 100 percent of our providers were able to raise DSP wages and then address that

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compression that comes along with that, we are still-- over 80 percent of our members are having to deny referrals for new people coming off the registry into services and over 50 percent are still having to cut services and programs due to short staffing. So while the historic rate increases was an absolute godsend and caught us almost back up to the starting line, I think a lot of people think that 15 plus 2 percent permanent plus the ARPA was from starting forward, but we actually had a lot of ground to make up due to the pandemic. And so it kind of got us to where we needed to be last July, but in order for us to remain or try to be competitive in this market, let alone expand into services for kids 13 through 21 that I know as a parent we desperately need-- my kid's been kicked out of God knows how many daycares-- it really-- it's a moot point until we get services for home- and community-based providers up to the level of support financially that they need to provide high-quality services. And get that training and address the turnover and help people feel confident that they know how to do these difficult jobs. And they're prepared to do these difficult jobs so that we don't have the crazy high turnover and that the people in services know who's coming to their house that day. So it-- happy to answer questions from either the parent side of it or the service provider end. Thank you.

ARCH: Thank you. Questions? Well, thank you for-- while not being prepared, excellent testimony.

ALANA SCHRIVER: Thanks.

ARCH: Thank you. Anyone else wish to testify today? I see no one else. Senator Cavanaugh, you're welcome to close.

M. CAVANAUGH: Thank you, Chairman Arch and members of the committee. Thank you so much for being here today and listening to these important testifiers. I want to say thank you to Director Green for coming and giving us all an update on where we're at with the waivers. I think it's clear that we have a workforce shortage. We need it in every industry, but when we're talking about our most vulnerable populations, this is an industry that we should be definitely paying a lot of attention to. And hopefully in the next legislative session, we can work together as a body to create a dedicated plan to see how we can increase the workforce in this particular industry because obviously our most vulnerable people need to be taken care of and should be taken care of. So, you know, I appreciate everyone coming in. This is not something that's going to be solved quickly or easily. It's going to take a lot of diligent work and purposeful thought in how we do it.

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And I'm, I'm just very grateful to this committee for having invested so much time and energy into this population over the last several years. And on a personal note, I have enjoyed sitting next to Senator Williams for four years, even though he squeaks his pen and I remind him not to so that the transcribers don't get mad. But it has been a pleasure and an honor and I know that this is our last day of hearings together so thank you for your service.

ARCH: Thank you, Senator Cavanaugh. Any questions? Seeing none-- oh--

M. CAVANAUGH: Oh, he has--

ARCH: Oh, Senator Williams has a question.

WILLIAMS: Thank you, Chairman Arch. And I don't have a question, but I have a comment that I would like to make. So thank you for coming today and helping this committee. I will tell you-- and, and Director Green, you know this-- I, I think the vast majority of Nebraskans don't know what you go through. They have no way of knowing that. We sit here on this committee and, and we do hear these stories and they do make a difference. And your advocacy is clearly important and being a crazy, loving parent is what we hear a lot of stories about. I think your challenge is to not only tell it to this committee that does have the ability to do something about it, but be advocates outside of that so more people in the state do understand the dilemma that we are in. If I've learned anything in eight-- well, six years on this committee is that there is never going to be enough money to go around to fix all these problems. And money doesn't fix them all anyway, but being crazy, loving parents does. So thank you.

ARCH: Well said.

M. CAVANAUGH: Thank you, Senator Williams.

ARCH: Thank you, Senator Cavanaugh. With that, we will conclude the hearing on LR368. The committee will recess until 1:00 where we will hear three more LRs this afternoon.

[RECESS]

ARCH: Well, good afternoon. Welcome to the second half of the Health and Human Services Committee's day of interim study hearings. My name is John Arch. I represent the 14th Legislative District in Sarpy County. I serve as Chair of the HHS Committee. I'd like to invite the

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member of the committee, we'll have others join us here shortly, to introduce himself, which you may do now.

WILLIAMS: Matt Williams from Gothenburg, representing Legislative District 36.

ARCH: Also assisting the committee this afternoon is one of our research analysts, Bryson Bartels. Noah Boger is serving as the committee clerk and Morgan Baird is our committee page. I will quickly go over our policies and procedures again for those of you who might not have been able to tune in this morning. Please turn off or silence your cell phones. This afternoon, we will hear three resolutions. We will be taking them in the order listed on the agenda outside the room. LR404, introduced by Senator McKinney, will be first, followed by LR408, also introduced by Senator McKinney. We will conclude with LR367 introduced by Senator DeBoer. I know both senators have arranged for specific testifiers, but all three of these hearings are also open to public testimony. For those of you testifying on any of these resolutions, 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 limit your testimony to five minutes and 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's 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 this afternoon's hearings. Senator McKinney, welcome to the Health and Human Services Committee.

McKINNEY: Thank you. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. I am Senator Terrell McKinney, T-e-r-r-e-l-l M-c-K-i-n-n-e-y. I represent District 11 in the State Legislature, which is north Omaha. And we're here this afternoon to discuss LR404 to examine the racial and ethnic disparities within Nebraska's child welfare system. The purpose of this resolution is to examine the racial and ethnic disparities within Nebraska's child welfare system. Research overwhelm-- overwhelmingly demonstrates that children and families of color make up a greater percentage of individuals in the child welfare system as compared to the percentages in the national state general populations. And this is especially true for black and Native American children and families. Research also

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overwhelmingly demonstrates that individuals and families of color make up a greater percentage of individuals that law enforcement officials interact with as compared to their percentage in the national state general population. In thinking about the various paths-- pathways for entry into the child welfare system, law enforcement officers have a role to reporting, referring, and assisting child welfare workers in investigating families who come in contact with the system. The study shall examine the disproportionality in Nebraska's child welfare system and if and how the role of law enforcement on the front end of the child welfare system contributes to it. The study, the study shall include, but not limited to, collecting race and ethnic data regarding Nebraska's child welfare population as a whole, as well as specific parts within such systems-- such system compared to the state's general population. Next, sources of reports and referrals to the child welfare system included, but not limited to, law, law enforcement officials and the length of time in the child welfare system, including both alternative response and traditional response-- responses in the child welfare, in child welfare cases. Two, an examination of the pathways leading to the entry into Nebraska's child welfare system, including the role of law enforcement officials, the scope of law enforcement's authority and relevant statutes regarding rules and regulations controlling such entry and such roles. Three, gathering community input regarding the racial and ethnic disproportionality in Nebraska's child welfare system and law enforcement's role within it. And, four, a determination of potential solutions to reduce the racial and ethnic disproportionality in Nebraska's child welfare system focusing on the pathways of entry into the child welfare system and law enforcement's role in such entry and examination of the pathways leading to entry into the system. Like many issues, it's important that we begin to address issues within our state further upstream than we have in the past. It's no secret that the child welfare system in our state has had and still has issues that need to be addressed concerning the disproportionate amount of racial and ethnic representation in the child welfare system. It is important to note that these issues were persistent before privatization and before the pandemic, and if we don't do anything about it, we will continue to see these issues. It is my hope that today we start working towards real solutions and not just a bunch of lip service. I'm sure we will hear some that say they're doing a great job or trying. But even so, when you look at the news every day, you look at the newspapers, you look at what's going on in our state concerning child welfare and juveniles, something has to change and we have to do something about it. Our children and their

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families need real help that is aimed at eliminating poverty, lifting barriers and improving, and improving educational opportunities and outcomes, solutions that don't wait for kids to commit crimes to get help, offering help to the whole family and not just a child, addressing racism and cultural competency issues. We are, we are in need of a holistic plan. Too many kids are being failed and too many people are in leadership allowing this to occur and would rather not do anything or wait until something bad happens to try to do the right thing. This is a topic that we have to be unapologetic about and save feelings for another day. The child welfare system in the state of Nebraska is horrible, plain and simple. Kids are being lost in the system, aging out without proper support with families that only-- some kids are with families that only view them as a check and not as a human. Our child welfare system is also being used and our juveniles are being used to currently build an inadequate juvenile justice facility in Douglas County. But at the same time, we have former systems people leaving the system to go create fancy nonprofits to profit off the backs of our kids. In Nebraska, law enforcement has been responsible for an average of 17.4 percent of the reports over the last five years, consistently placing in the top three most frequent reporters. Data shows that the child welfare system disproportionately involves and polices youth and families of color, meaning the percentage of persons of color in the system is higher than their percentage in the general population. This is especially true for black and Native youth who experience higher rates of reporting and investigations and disparate, and disparate treatment once they're within the system despite evidence that black and Native families are no more likely than white families to harm children. Such overrepresentation grows within each major decision point in the child welfare system from reporting to investigations, out-of-home placement, and permanency. And there are, there are many individuals here that will hit on a lot of important facts and, and notes. I'll say a couple. I won't try to say them all because we've got other people here to say it. But clinicians are more likely to evaluate and report black children for maltreatment when presenting similar injuries as white children. And that the best indicators of, of whether a medical provider will drug test a mother are race and class, not medicine. Black children are also about 30 percent more likely than white children to be prescribed antipsychotic medication and are more likely to live in congregate care settings. Black children are also three times more likely to be adopted-- less-- three times less likely to be adopted than white children. And Nebraska disproportionately ranks the worst-- one of the worst nationally.

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Showing Nebraska's rate for every race and ethnic-- and ethnicity, this is espe-- for black and Native children, we rank as one of the worst currently. Some feedback from community, I would say in a, in a-- well, in a study published this year, the Center for Study-- the Center for the Study of Social Policy studied child welfare cases from 2005 to 2020 in a number of jurisdictions, jurisdictions to examine the system's failing of black families. The study consistently found examples of implicit and explicit biases and discrimination against black families exhibited by systems professionals, including multiple cases of describing black fathers are uninterested, not to be trusted, angry and unable to parent, despite evidence to the contrary or none at all, extra bailiffs being called into court hearings involving black fathers, a reunification worker at one jurisdiction stating the number one thing about African, African American fathers, they are not around. A probation officer, another stating that they did not connect black fathers to parenting classes because they felt culturally they are not interested, which is far from the truth. And many reports over, over recent years have shown that black fathers are the most involved fathers of all fathers across race lines. And again, I just hope that today will spark a real intentional effort and conversation to make the necessary changes to improve our child welfare system for our children and families. Thank you.

ARCH: Thank you, Senator McKinney.

McKINNEY: Yeah.

ARCH: Any questions at this point? Seeing none, thank you very much. At this point, we would welcome the first testifier.

ANAHI SALAZAR: Afternoon.

ARCH: Good afternoon.

ANAHI SALAZAR: I can begin. Hi, my name is Anahi Salazar, A-n-a-h-i S-a-l-a-z-a-r, and I am here representing Voices for Children in Nebraska. Our child welfare system should promote a safe environment for the children they serve. For a long time in Nebraska, families of color, specifically black African American and Native American families, have experienced Native outcomes-- negative outcomes, I'm sorry, in the child welfare system. These families are overrepresented in the system from start to finish and from the stories shared at the town halls, their experiences have been frequently bleak. There is a relationship between disproportionality and disparity. Disparity

increases the potential for disproportionality to occur. This relationship is rooted in systemic racism and it's embedded in the daily practices, most of the time unintentionally, of the child welfare system. Disproportionality refers to the state of being out of proportion. When speaking about the child welfare system, disproportionality, disproportionality is describing the relationship that exists between the proportion of one group being proportionately larger or overrepresented than the portion of the same group of children in the general population. So 15 percent of children involved in the system were black and African American, yet black and African American children don't make up even 6 percent of Nebraska's population for a disproportionality ratio of 2.6. Native American children account for only 1 percent of Nebraska's population, yet they made up close to 4 percent of the children in the child welfare system for a disproportionality rate-- for a disproportionality ratio of 3.9. Even as Nebraska has worked to strengthen our early prevention efforts and reduce our numbers of children removed into foster care, this disproportionality has persisted. Disparity refers to the state of being unequal. Any efforts that focus on disproportionality and disparities need to also analyze the complexity of factors that contribute to their existence, including racial bias, poverty, and the disproportionate need. There needs to be a better analy-- analyzation of what is happening to people before they enter the child welfare system. Individuals working for the system need to be conscious of the lenses used to make decisions along any point in the child welfare continuum and how race plays a role. We must own the racial bias that exists in the system, namely that despite equivalent levels of risk, children of color are more likely to enter the, the child welfare system and more likely to spend longer times in care. Differential conclusions that negatively affect children and families of color and intergenerational trauma. Placement stability can create a better environment for children in the foster care system. With stability, children could develop healthier relationships with their foster homes as well as receive better care from foster parents. Black and African American children had an average of 3.1 out-of-home placements in 2020, more than any other race or ethnicity in Nebraska. Multiple placements can disrupt not only the mental health of the child, but also their race-- their education and overall well-being. Almost one-third of Native American and black and African American children are in out-of-home care for 25 or more months. Being away from family for so long can have lasting effects on children. Data repeatedly tells us that, that Native American children are more likely to be removed from their homes and to have terminated parental rights. The

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data gives us these facts in hard numbers, but behind each number is a child who experienced the trauma of removal, the turmoil of instability and placement changes, and the loss of cultural connection and the legal undoing of relationships and family ties. So what can we do with all this information? Testifiers present here today will propose some solutions and recommendations. In the meantime, from our perspective at Voices for Children, as a state, we can and should support successful unifications. So keeping children safe and families together should always be the goal. And then reaching timely reunification while preventing reentry into foster care has many benefits. Children do best when raised in a stable family setting. Another proposed solution: support kinship caregivers. Kinship care refers to placement with the individual-- with individuals who have a preexisting relationship with the child or children. Kinship care helps children with a sense of belonging and it can reduce the trauma that can, that can be endured during parental separation. These caregivers make incredible contributions, make many challenges-- face many challenges and need help. Thirdly, develop culturally responsive practices and services. We should conduct trainings on defining and exemplifying what is culturally responsive, as well as identifying racial bias and discrimination among child welfare staff and community reporters. Child welfare professionals should be able to identify the unique cultural strengths, beliefs and practices of each family they work with and integrate that knowledge into the intervention approaches. And lastly, increase investment in early prevention efforts by supporting communities. For children to thrive, our state agencies providing care must build trust and engage with communities. The disproportionate number of children and families of color living in poverty directly contributes to the disproportionality of child welfare system involvement. Every dollar spent on primary prevention, such as food, utility, utility and childcare assistance programs, affordable housing, home visiting and accessible physical and mental health services is a dollar saved in the child welfare system. I would like to thank Senator McKinney for bringing forward this interim study and I would like to thank the members of the committee for your time, attention and commitment to every child in Nebraska. If you have any questions?

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

WALZ: Thank you. Thanks for coming. Just real quick. One of the things that Senator McKinney said that was probably one of the most disturbing things was that black fathers were not referred to parenting classes. So working for Voices for Children, do you also

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find that to be true in your organization? And how do you address it or how do you think that should be addressed?

ANAHI SALAZAR: I-- we don't have any research currently on-- or data on that. But from hearing families at the town hall meetings, I would say that is very true. It was a very consensus feeling in the room and I think there is a lot of racism, not just in, in systems but also when confronting people. So I-- that's why one of our proposed solutions was the developing culturally responsive practices and services, and I think that would be integrated into racial biases.

WALZ: All right. Thank you.

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

ANAHI SALAZAR: Thank you.

ARCH: Next testifier. Good afternoon.

ALLISON DERR: Good afternoon. My name is Allison Derr, A-l-l-i-s-o-n D-e-r-r. I'm a senior staff attorney at Nebraska Appleseed. You all are receiving a full version of our testimony, but we had a lot to say so I will summarize it out loud for you. As previously testified to, data clearly demonstrates that disproportionality exists in our child welfare system. But concerningly, this is especially so in Nebraska, where our disproportionality rates are higher than the national rates in every nonwhite category. And in fact, a recent report placed Nebraska in the top ten most disproportionate states, performing poorly in every single category, being only one of two states to do so. It ranked us fourth-worst state for Native youth and third-worst state for black youth. But it's really important for you all to understand that this is not because families of color are more likely to harm youth. White families engage in the same behaviors and circumstances that put families of color into the system. They are just less policed and harshly judged. But what we do know is that every stage of entry into the child welfare system exacerbates and makes this disproportionality worse. So first with reporting, a person decides whether or not to report child abuse or neglect. Nebraska is in the minority of states that requires all persons, trained or not, to report suspected maltreatment or risk criminal charges. And the intent is a better-safe-than-sorry approach, but in practice, it results in the opposite in extreme overreporting. The past five years, on average, only 5.8 percent of our reports were found to be true, putting Nebraska in the ten states with the lowest rates of report

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substantiation, meaning our overreporting is much worse than the majority of states. And research shows that overreporting doesn't actually result in better maltreatment detection or safety outcomes for children, and instead drains child welfare resources on the wrong families and wrongfully traumatizes and investigates families. We also know that because families of color are more likely to be reported, they are the ones harmed and wrongfully traumatized by this overreporting and brought into the system. Second, once a report is received, the department is to assess it and decide if it fits our definitions of child abuse and neglect. But any scholar on child welfare disproportionality will tell you that these definitions can be pointed to as a great source of disparity because they're so vague and cast too wide of a net. For example, our definition of neglect says a child who is without, quote, proper care or without food, clothing or shelter. Meaning a family can be brought into our system simply for lacking resources. And well over the majority of our child welfare cases are because of that type of neglect, with over 85 percent of our maltreatment reports in 2020 being due to that definition of neglect. Because families of color are more at risk for poverty, they are, are more vulnerable for being brought into the system for being low income. They also interact with social service agencies more because they need public assistance, which makes it so they're more visible to be reported for being low income, creating this dilemma where they can either choose to access services and risk being reported or not access services and be reported for not getting help. And then lastly, when the department is assessing a report, it's deciding is this child safe in their current circumstances? And that question is asked throughout the entirety of the case. But the standards for that are notoriously vague and subjective, and the majority of child welfare decision-makers are white judging low-income families of color. No matter how well-meaning a professional is, human decision-making is informed by implicit biases and stereotypes and their own view of what a healthy and fit family looks like. And unfortunately, research demonstrates that that judgment results in disparities and disproportionality and child welfare decision-makers wrongfully assuming families of color are more unfit from the start and all the way throughout the end of the case. I think the good news here, though, is that scholars, advocates and community members have proposed a lot of really clear, concrete policy solutions that Nebraska could and should pursue to start to improve this. This includes amending our reporting requirements, amending our neglect and abuse definition. It includes adding race and equity checks throughout the reporting process and assessment process. It also includes the

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Legislature or this committee doing race and equity assessments of every child welfare policy pursued and requesting race and equity data. And of course, including community members of color in all of these conversations, especially tribal partners. Whatever solutions this committee chooses to pursue action on this is long overdue and well deserved. Families of color are being disproportionately traumatized by our system. The child welfare system is meant to rescue children that have been harmed, but in this case, the system is what's doing the harming. So we thank Senator committee-- Senator McKinney for his time on this issue and thank the committee for your attention and we encourage and implore action.

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

WILLIAMS: Thank you, Chairman Arch, and, and thank you for being here. You used the term early in your testimony of "less policed and more harshly judged." Can you give me some further explanation on the less policed comment?

ALLISON DERR: Absolutely. I'm glad you asked that. So law enforcement act as, as the kind of on-the-ground ears for the department. They are the ones in the community acting or interacting with families. We know that families of color and communities of color, and especially environments that are more low income, are more policed, meaning law enforcement are more present in those communities for various reasons. And so they are interacting and surveilling with families of color more than white families. And in those interactions, because they are mandatory reporters, they are in a position to have to judge the circumstances and situation the child finds themselves in. And so because they are interacting with families of color more, they are surveilling and judging them more than white families, meaning they're more policed. And when we say the word "policed," we can think about the-- when you're brought into the child welfare system as parents and families, you are being charged with offenses. You're being charged with child abuse or neglect. And so you are facing legal consequences for the circumstances that your family and child finds themselves in.

WILLIAMS: You also talked about overreporting with the black and Native community. Who is doing that reporting?

ALLISON DERR: So like I said, in Nebraska, every person is a mandatory reporter, so professionals and nonprofessionals alike. But in Nebraska, our top three categories of reporters are school personnel, law enforcement personnel and then relatives and friends. But a lot of

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the research talking about black families being overreported, one of the studies Senator McKinney referenced, in fact, law enforcement and medical personnel are especially susceptible to overreport black families.

WILLIAMS: OK. I'm not sure quite how to ask this, but I understand disproportionality and what we're talking about here and we're talking about potentially overreporting the black side. Is there any fear of underreporting on the other side that would balance the equation?

ALLISON DERR: I don't know if I would say underreporting, but there certainly is a lack of balance in the surveillance, like I talked about, of white families. And so because white families are less at risk for being low income or being impoverished, they are less likely to interact with people who are going to report them. And even if they do interact with folks that would report them, studies show they are less likely to be judged or their environment is less likely to be judged to be unfit. So that could-- that is likely what results in lower reporting for white families. But I don't know if I would say it's underreporting.

WILLIAMS: Well, thank you.

ALLISON DERR: Um-hum.

ARCH: Other questions? I have one. Just a second here.

ALLISON DERR: Um-hum.

ARCH: I want to go back to the question of overreporting because you, you said only 5.8 percent are found to be true. So is that-- that's obviously the average. Have you taken a look and seen what, what the black community, that, that percentage would be compared to the rest of the general population? Is it the same? What, what-- has there been research on that?

ALLISON DERR: Yes, absolutely. And I don't have the numbers directly in front of me, but I know Voices for Children, the Nebraska Foster Care Review Office and then also the child abuse and neglect reports the department puts out every year does break down that information by race. And just from my recollection, it is disproportionate for black youth, but especially disproportionate for a Native youth. And so the overreporting is worse for those populations. But also something that skews that data just a little bit is that those reports are also more likely to be found substantiated or true. Not necessarily because

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maltreatment is more likely to be true, but because of the biases that go into the decision-making of deciding to substantiate it.

ARCH: OK, thank you.

ALLISON DERR: But like I said, the data does exist.

ARCH: All right. Thank you.

ALLISON DERR: Um-hum.

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

ALLISON DERR: Thank you.

ARCH: Next testifier.

DEBORAH DANCER: Hello.

ARCH: Hello. Good afternoon.

DEBORAH DANCER: Good afternoon. Thank you. My name is Deborah Dancer, and it's D-e-b-o-r-a-h, last name, D-a-n-c-e-r, like the reindeer. I'm with Douglas County Community Response, or DCCR, serving as the chief administrative officer and functioning as our community collaborative leader. So DCCR collectively through Community Response has served over 1,000 families, indirectly serving over 1,200-- I should say 1,200 children. Housing was number one need with the average request just over 1,000 per request and representative of 62 percent of the dollars invested. Next, utilities at about \$450 per request, representing about 25 percent of the dollars listed. And these concrete supports include coaching and supplemental supports, such as CarePortal and childcare referrals and opportunities. A little about the 1,068 families served through community response, again, there were 1,268 children indirectly strengthened through that. We are working collectively to disentangle neglect from poverty and prevent entry into the child welfare system by focusing on child and family well-being. It has changed how we work since our formal beginning in 2015. Our work is data driven and we focused-- focus on reducing the number of screened-in calls to the CPS hotline. Indigenous, black and Latinx families are overrepresented in screened-in calls for neglect through the CPS hotline, and the same families are overrepresented in substantiated cases of child abuse and neglect. The data shows our top three reporters, again, this is in Douglas County, are in the sectors of education, medical and law enforcement. The data also showed us

that Douglas County contains the top five zip codes of those calls, and we have purposely concentrated our work there. And it happens to be in north and south Omaha in the zip codes specifically of 68104, 107, 108, 110 and 111. We are simultaneously evaluating our process and progress, demonstrating that this investment in families who have been minoritized and marginalized deserve opportunities to choose opportunities that strengthen them. The overrepresented populations in the screened-in calls in Douglas County have received concrete support through central navigation and coaching. Those who like data and results may appreciate that of those we served and impacted-- those that we served and impacted by overrepresentation receive the services intended. So indigenous or Native American families were represented in our work at a rate of 2 percent in comparison to the larger community served by the collaborative of 1 percent; black or African American families at a rate of just over 44 percent in comparison to the larger community served by the collaborative of 11 percent; and almost 15 percent for Hispanic or Latinx families in comparison to the larger community served in the collaborative of 13 percent. This tells us that we are reaching our impacted families, but also that there's more work to be done. Our vision is to inspire and mobilize a community response prevention system where children in Douglas County, Nebraska have a safe, quality family and community environment. We are also doing a national project, two national demonstration projects that will allow us to make this scalable. And we are working in conjunction with other communities, other community response organizations all throughout Nebraska. Now our system consists of community response, Central Navigation coaching, and has 17 partnering organizations that provide coaching and over 79 member agencies that meet and work collectively to advocate and further our community response to reducing child maltreatment. The strategies we use in our demonstration projects are collective impact, community response, communication, staff training, CarePortal, which is access to faith-based, faith-based organizational portal that supplements central navigation resources, and community cafes, which are parent-facilitated conversations with parents. A few critical values that shapes our work and-- is our commitment to promotive and protective factors, knowledge of parenting, child and family adolescent development, social and emotional competence, concrete supports, resilience, social connections. And this framework is like social determinants of health. It is a space to use similar language, acknowledge where we align and intersect and continue to be inclusive of community when we are working collectively. We have a system-wide commitment to promotion of equity where we create, create and amend

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foundational goals and outcomes and establish context for lived experience, labels in conversations, and also maintaining our planners and achieving the highest levels of shared power. There are other things that we do and obviously not enough time to tell you everything that we do, but we wanted to make sure that what we'd like to see continuing in our work is having more collective community work. And then also making sure that we're working together on our training suite. And that is, like, working on advocacy training, mental health interpreters training before the call to CPS training to give reporters and practitioners another option to address poverty disguised as neglect for families that they serve or observe, and that, that's pretty much it.

ARCH: OK. Thank you. I, I have a question. Help me, help me understand. It seems as though your, your focus is really strengthening the family, right?

DEBORAH DANCER: Um-hum.

ARCH: Where, where and how, when do you receive a referral to, to help a family?

DEBORAH DANCER: We are at the prevention end, so we are before. So this is ideally how it would work, is that individuals, people who we're working with would make a call to us first and that would be through Central Navigation. That's the idea. That's the, the point that we want to make. Unfortunately, we've been working behind the scenes for a long time. That's probably why some people haven't really heard of us. But we've just-- we didn't want to be the showcase or the, the front-and-center individuals because it is a collective. So now we are having the training where we're working with the mandatory reporters to really help support the effort to be mandatory supporters versus mandatory reporters. We're not taking away from reporting, but just giving other options. So we have built up through our communication team a website so that people can and-- can get to us right away, but we recognize that not everybody has access to Internet. So we're just equipping everyone to maybe rethink how they're, how they're coming to us and this collective work. And it's not just us, it's other communities, but I'm, I'm here representing Douglas County.

ARCH: So, so let me summarize that a little bit differently. So your, your belief is that there could be some reporting that's going on while not necess-- I mean, I know the department says report, we'll

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decide, right? But, but your belief is there could be some reporting going on that isn't necessarily meeting that clear definition. But they know that-- the reporter knows that there's going to be something that will happen to, to help the family or to intervene, yes?

DEBORAH DANCER: I'm going to say yes and no. The idea is, yes, they're thinking that that's going to happen. But we have these discussions in this group.

ARCH: Well, that's a different issue, right?

DEBORAH DANCER: Well, what they're saying is there's some frustration from some of the reporters--

ARCH: Right.

DEBORAH DANCER: --that it's going in. Like, let's say, for instance, from educators, that it is going into the CPS hotline, but it's not, it's not worthy of, of a report and that's all that happens. And so sometimes--

ARCH: I see. I see.

DEBORAH DANCER: --there may be referrals onto services, but there's many that get missed.

ARCH: Yeah.

DEBORAH DANCER: But that point is that they may very well be entered. That's where the overreporting comes. There's theories with families that if there is knowledge on how to, to come up with solutions-- and they're part of the solution so we're hopeful for that.

ARCH: Thank you.

DEBORAH DANCER: Um-hum.

ARCH: That's very helpful. Any other questions?

WALZ: I just have one question.

ARCH: Senator Walz.

WALZ: Is it a hotline that you have? Do you have a hotline or--

DEBORAH DANCER: We have a website.

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WALZ: Website?

DEBORAH DANCER: Yes.

WALZ: OK.

DEBORAH DANCER: So we're trying to be careful not to step on the toes. DHHS is one of our partners and so we're just trying to work with them. We're trying to work with the family helpline as well, and ours is Central Navigation. And so they're the regular business hours. So those aren't emergency help, but we are partnering with emergency help, like, let's say, homelessness, and we would work with our local continuum of care.

WALZ: All right. Thank you.

DEBORAH DANCER: Um-hum.

ARCH: Other questions? See none, thank you very much for your testimony. Next testifier. Welcome back.

MONIKA GROSS: Thank you. Get my glasses on. Chairperson Arch and members of the Health and Human Services Committee, my name is Monika Gross, spelled M-o-n-i-k-a G-r-o-s-s, and I am the executive director of the Foster Care Review Office, and I'm here today to provide some data on children in out-of-home care in Nebraska. We have a problem with disproportionality in our foster care system in Nebraska. It's not a new problem. And there's a chart in your packet that shows over the last four fiscal years the rates of children in the general population divided by race and the rates in the foster care population. I won't go through that in my testimony. It's in your packet and one of the previous testifier has already spoke to those figures. In the spring of 2022, our agency launched data dashboards on our website. The dashboards contain point-in-time data from the last day of the previous calendar quarter, the same data that's recorded in our quarterly reports. Our most recent quarterly report was electronically submitted to the Legislature yesterday, December 1, and the data that I'm about to share with the committee comes from that report. One of the distinct advantages of using the data dashboards is that the point-in-time data can be filtered in various ways to give the user more insight into the subpopulations of children and youth in out-of-home care. Because disproportionality in child welfare is such an important and pervasive topic, we believe it's important for us to share these data insights with the committee and the public. Our

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quarterly report contains a special section, which is part of your packet as well, breaking down the data related to children in out-of-home care, including by service area, age, gender and race and ethnicity. We looked at outcome measures related to time in care, number of caseworkers, number of placements and children missing from care. These measures are all related to stability and well-being for the children involved. Our study showed that children of color are represented in foster care at disproportionate rates, that these children spend more time in care, have more placements and more case managers. Other studies have shown that the more case managers a child has, the more time they spend in foster care. And that case--caseworker turnover was correlated with increased placement disruptions. Our study looks at these factors broken down by age, gender and race. On September 30, 2022, there were 3,633 children and youth in foster care in Nebraska. This figure includes only children who were in the care and custody of the Department of Health and Human Services and does not include youth who are under the supervision of juvenile probation. For those 3,633 children and youth, the median days in out-of-home care on September 30 was 457 days, roughly one year and three months separated from their families. The average number of caseworkers for those children was 4.3, and the average number of placements during their most recent episode in care was 2.8. When we break that down by gender, we find that boys spend slightly more time in foster care than girls, 20 days longer. When we break it down into age groups, we find that 13- through 18-year-old youth had the longest median days in care at 550 days. They also averaged 5.1 caseworkers and 4.6 placements. Next, we filtered the data by race and age and found startling differences by race. Black non-Hispanic children had the longest median days in care, the highest average number of caseworkers and the highest average number of placements. Black non-Hispanic children spent 661 median days in foster care, had an average of seven caseworkers and 3.9 placements in their current episode. Similarly, age group filters revealed racial inequities in every age group. For example, for ages zero to five, the median days in care was 353 if the child was white and 547 if the child was black. For those children ages 6 to 12, the median days in care was 381 if the child was white, 681 if the child was black, and 623 if the child was American Indian. For ages 13 through 18, the median days in care was 497 if the youth was white and 852 if the child was black. When we further filtered by race, age and gender, we found that black non-Hispanic teenage boys had 1,061 median days in care and black non-Hispanic teenage girls had 792 days in care. Both groups had the longest median days in care compared with other race groups of the

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same age. Black non-Hispanic teenagers had the highest average number of caseworkers at nine, the highest average number of placements, and the highest rates of being missing from care. When we look at just the Eastern Service Area in particular, we found that American Indian non-Hispanic children have the longest median days in care at 856, and black non-Hispanic children had the second longest median days in care at 758. White children in the ESA had median days in care of 519. Thank you, Senator McKinney, for introducing this interim study. And I want to thank the committee for listening to me today. I know I threw a lot of numbers at you. I'd be happy to answer any questions.

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

WILLIAMS: Thank you, Senator Arch. And thank you, Ms. Gross, for being here and, and sharing that information. I want to go just a little bit deeper because I, I think the numbers point out the disparity. The question is, is why? And from, from your judgment of looking at this and analyzing this, is this what I would call or define as systemic racism that is underneath this or the term I would continue to use or also use is "institutional racism?"

MONIKA GROSS: I don't know that--

WILLIAMS: I know I just went in the weeds with this.

MONIKA GROSS: Yes, and, and--

WILLIAMS: That's where I wanted to go with that.

MONIKA GROSS: Right. Right. And, and to be sure, we don't have data looking at, you know, the entire picture of what happens. You've heard a lot of testimony already about the front end of the system and, and children entering, and we don't have any data on that. What we can tell you is that once a child enters foster care, out-of-home care, black and Native American children stay longer than, than white children. Quite a bit longer, as you heard. I think we need to look at what our, our structures and our institutional practices are that, that perpetuate that. You know, this is not a new problem. And this is just one point in time, but I think we, we do need to look at those through a race equity lens to determine if, as your question asked, if, if there are structural or institutional racism factors that, that play into it.

WILLIAMS: Thank you.

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ARCH: I've got a question for you, because I know you've obviously been on both sides. You've been on the provider side as well as now the FCRO. What-- you, you heard earlier testimony regarding overreporting. What's your thought on our current reporting system and, and is there, is there-- and I'm not even asking necessarily bias on overreporting-- but is, is there overreporting going on and is, is that a bad-- well, maybe that's a judgment call I won't ask you to make, but what, what's your thoughts on overreporting?

MONIKA GROSS: Well, I, I think that there, there are a lot of reports, and I'm familiar with some of that data. Our data shows that 67 percent, I believe, of children in out-of-home care are, are in, in care due to neglect, which can be a broad range of, of different things. So, I mean, that would suggest that, that there are a lot of reports coming in related to neglect. And if, if an issue in a family can be resolved without removing the children, that is preferable. That's more desirable, obviously, than, than removing the child, because once the child is removed-- and, and I think particularly we need to consider when we're removing black children and Native American children what that looks like for them down the road. You know, we're talking about 1,061 days in care potentially. And, you know, that's nearly three years and that's the median.

ARCH: Thank you. Senator Walz.

WALZ: Thanks for coming today. I just had a question about the caseworker, the workforce and the diversity. Do you have any data on how diverse that, that workforce is? Example, the percentage of white caseworkers, percentage of--

MONIKA GROSS: Yeah, we don't.

WALZ: OK.

MONIKA GROSS: We don't. You'd have to get that from DHHS.

WALZ: OK. All right, thanks.

MONIKA GROSS: We know when caseworker, a caseworker for a child changes, but we don't, we don't have any demographics on the worker themselves.

WALZ: All right. Thank you.

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

MONIKA GROSS: Thank you.

ARCH: Next testifier. Welcome.

MAGHIE MILLER-JENKINS: Hi. My name is Maghie Miller-Jenkins, M-a-g-h-i-e M-i-l-l-e-r-J-e-n-k-i-n-s. Forgive me if I do this wrong. This is my first time coming up and testifying at Senate, so--

ARCH: It's all right.

MAGHIE MILLER-JENKINS: --I had a whole thing prepared, but time constraints and the way it happens. But the reason that I believe I was asked to come and testify today is to give you a little bit more of a person experience as opposed to just numbers. There have been a couple of people that came up and gave you some really good statistics on the state of DHHS and what CPS looks like. I'm here to give you a personal account of how it feels. When I was 12 years old, I was abducted by my aunt and my cousins, kidnapped, and moved through about 13 different counties in Nebraska when we ended up four months later stopping at David City. All of the counties that I had been through said that they didn't want to hold up the kidnapping charge because they would have to do-- press charges and do the whole jurisdiction process with that. And so they deemed me a black runaway, and that was the beginning of the end of my adolescence. I lost my entire adolescence to the troubled teen industry. So from 12 to 17 years old, I have been in every CEDARS in Lincoln. I've been into two in Omaha. I've been to CAPS, I've been to Uta Halee. CAPS is an abbreviation for the Child and Adolescent Psychiatry Services. Because when you are a black youth inside of the CPS system, from my experience and from many people that I have worked with-- I've worked with-- in the area of people with disabilities for ten years. I have worked as an advocate in the schools as a para for three years. And then the last two and a half years, I've been doing mutual aid in an alternative foster care, so foster care that's not foster care. I don't work with the state. I don't get funded, I don't get grants. I take children in-- young adults between the ages of 16 and 20. And I provide them with a step towards the next step of what their life can be free of charge. I get them hooked up with whatever services that they can have. I help them through school. I get them through doctor's appointments and that's all just me because of how traumatized I was from the CPS service. When I was 14 at Uta Halee, I was sexually propositioned by one of the

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staff member there. I was told I could run away, that I wouldn't have to come back to that facility if I was pregnant. It was an all-girls facility. There's no way to me-- for me to get pregnant other than the staff member there. He told me he would help me out and he would get me pregnant so I didn't have to go back to Uta Halee. Yep. Banged on the window, called in another staff. That, that man worked there until last year at Uta Halee because nobody says anything. I am a product of silence. We are taught at a very early age as young girls, especially young black girls, don't rock the boat, be quiet, be good, do what you're supposed to do. Because then when you grow up, you'll get everything that you deserve. It's not true. It's not true for them. It's not true of the youth now. It wasn't true for me back then. And it's a conversation that I feel, in rooms with people that have the power to really affect change, they need to be thinking about things like this. Yes, they'll give you a lot of numbers of thousands of black children who are put inside of CPS. What they won't tell you is how bad it is to deal with those CPS workers. The CPS workers are understaffed and overwhelmed. They don't have time for you. They don't have a bearing on your life either. They're not culturally competent. A white worker going into a black household would think that I was loud and aggressive, that depending on the types of food that I ate or the types of food that I have culturally in my home, they might say that I am out-- undernourished, malnourished because the type of food that I have is not consistent with what they consider healthy or necessary. That happens in a lot of cultural settings, but especially black, brown, indigenous, BIPOC households. My other personal experience that I think would be extremely relevant here is the work that I do currently, which is with the youth and young adults. In the last two years, I've served about 20, 25 people through my home, still serve about 15 of those people, but none of those 20 or 25 people are gone because with foster care, what happens is you age out. You end and then you're left with no one. If you got ripped away from your family and you lost those ties, when you get done, you don't have anybody. You're literally on the streets. And poverty should not be a criminal offense, but poverty is something that the CPS system will eventually tie into a charge. I have a girl that I serve that has her child-- her three children got taken away because a nurse at the hospital decided that she didn't come up to the hospital to visit her baby enough. She had two other children at home and she couldn't go up to the hospital. But the nurse turned her into CPS and we dealt with the CPS case for four months, which ended up resulting in her losing her children because she was poor, not because she was neglectful, not because she was abusive, not because of anything else. But they deemed

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it neglect because she's poor. We get hurt, ripped away and abused by a system that was not built to serve us consistently and it's not our fault. But thank you for your time and listening to what I have to say. And thank you for Terrell McKinney for bringing this up because it's an issue that I really, really hope that we can find some solutions for because my people need help. Do you have any questions?

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

MAGHIE MILLER-JENKINS: Thank you.

ARCH: Next testifier.

FRANK BAILEY: My name is Frank Bailey, F-r-a-n-k, last name, B-a-i-l-e-y. I'm a trauma therapist in Omaha, Nebraska. I've listened to all the numbers and I know that just based on the experience. If you talk about just how somebody comes in contact with-- through police contact, there was one that was just hit the news in Omaha during the winter. I do some trauma work at the [INAUDIBLE] Center in south Omaha. The lady was Native. She had her baby on the street. Her last name is Shakespeare [PHONETIC], you know. And come to find out, she has intergenerational trauma. She has childhood trauma. The child she had was due to a rape and she lived on the street homeless along with mental health. Right now, that lady is serving two years in prison. And I don't know where her child is at. When we talk about just contact through police, that's how all that happened. And you would think just through our legal system and professionals we have, somebody would say, hey, this woman has mental health issues going on. It's just not normal for anybody to have a child on the street like that and she was living on the street. But that's an example of what Senator McKinney is talking about. I have a private practice in Omaha, Nebraska. I have a IOP setting, majority of women that, that, that come into my IOP setting through CPS is through police contact. A recent client I have, came in contact with her because she was in an abusive relationship, domestic violence. The guy held her hostage. He choked her and so many different things. And so when you talk about somebody who is antisocial personality, they're pretty manipulative. So how could he inflict continued pain and suffering on this woman? Well, I'll contact the police and say, hey, she's a bad mom and these are things going on. And so all her kids were taken. So she, she has complex trauma. She's dealing with the system, trying to get her kids back. And it was through a man who, with domestic violence-- continues his domestic violence because of how CPS treats her. And only thing

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that I-- my only job is to help people process trauma, live with the pain that they're, they're dealing with when it comes to dealing with CPS so they get to the other side and get their kids. I have a few young men that I, I have in therapy. I'm a black therapist. I'm the only black therapist in Nebraska that does EMDR. So you would think that I would have a lot of referrals from CPS from anybody in the system. You know how many I get? Zero. All my referrals come from the people on the street. I'm working with somebody who tells somebody else that, hey, you need to send your kids or need to go over and see this man. So when I hear the numbers and what's going on, it's pretty, pretty mind-boggling, I have 20 years' worth of experience. I have ten years' worth of education. I use the latest intervention when it comes to emotional regulation to develop emotional resiliency. So you would think the system would be beating down my door, but it doesn't. The reason why it doesn't, when I'm working with a client, I advocate for the client. I don't allow the, the trauma that the system creates to continue to traumatize a client in a, in a, a, a team setting. I advocate for the client to try to protect the client. And so because I, I do that, I don't say I stand up and get mad, but I try to divert the conversation to another way. But because I'm like that, I don't get the referrals. So the system is very broken. It's, it's almost like what you're talking about that it's a pipeline for people to end up in prison. And probably the, the, the, the worst thing I've seen that the system does, when you're talking about entering through police contact, there's women that lose their kids. Does anybody know what happens to the women after they've lost their kids? They're thrown away like yesterday's trash. They become sexually trafficked. They end up in prison. They end up with mental health conditions all because of what is going on and until something changes, it's going to continue to go on. You know, I'm just trying to bring a perspective from the voices I deal with because I carry their experience with me inside me and there's nothing that I can do. I know how I'm treated by the system. But the thing is it's about saving lives. And I thank Terrell McKinney, because I think he's beginning to see it's about saving lives. And I can tell by what the, what the senators are listening to, they're interested in the same thing. It's the 21st century. It's time for us to make a difference. And I want to thank the senators for the time and that's all I have.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much for your testimony today. Next testifier.

TONYA WARD: Good morning, Senators. Excuse me. My name's Tonya Ward and I wear several hats. I'm elected official, sit on the learning

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community. I'm a nonprofit 501(c)(3) owner, Energy Rescue, and I'm a mother of three sons.

ARCH: Could you please spell your name for us?

TONYA WARD: Oh, Tonya Ward, T-o-n-y-a W-a-r-d, and I live at 4826 South 19th Street in 68107 zip code. My children and I have been through a number of horrible CPS situations, our personal experience with back-to-back shut offs by OPPD and MUD at our home and at our neighbors in our communities. We've suffered at the hands of CPS, cops, along with many of the 10,000 families who were trapped by the GOALS and the false truancy law that was passed using false premise that Nebraska had a truancy crisis, which is a bold-faced lie created by Ashford and Kleine, the criminal devils who made attendance days equal to truant days. The truancy law is a disgrace and it's still very dangerous and continues to plunge children and families down the thriving Nebraska school-to-prison pipeline. Recent events show Nebraska there are very serious reasons to stop using school attendance issues to punish our children. Several superintendents decided to stop using GOALS in their truancy districts-- sorry, GOALS truancy program in their districts. And the entire learning community, which I sit on, voted in our last meeting to stop funding the GOALS truancy program. So hopefully that will bring eyes onto the truancy law. I brought you today solutions. If, if utilities are shut off in a home where minor age children live safely and are not abused, when CPS and cops arrive at the home, they should bring all the money and resources available to help restore and pay those utilities, provide whatever services that family needs to keep the family whole and intact. But instead, Nebraska steals our children and dumps them into the unnecessary foster care system. That's why it's bulging with too many black and brown children. PTSD and stress can truly debilitate us, and it has emotionally and mentally damaged all of us. I'm, I'm sorry, I'm hopping around. When children are removed from their homes under housing conditions, only cops keep those details. I met with the-- spoke with the Foster Care Review Board and they told me they don't track the reasons why kids are brought into the system when it just says housing conditions. That can be from utility shutoffs. It could be from a number of things. But instead of that not being in the child's file once they are in foster care, it should be there. I've seen horrible CPS caseworkers. Chad Evans is a CPS caseworker who tried so hard to destroy my client and her young niece that she was trying to be the foster parent of. He lied about my client. He asked her inappropriate questions out of my presence, like, so do you watch porn? He was very rudely sabotaging all of our meetings and I was the

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advocate for the CPS case. And he did many inappropriate things with the little girl that were reported, but he had no repercussions and he wasn't punished. When this was reported to the supervisor, they did nothing. Even after years of complaining about Chad, I learned yesterday that this horrible CPS caseworker was promoted and paid even more money today or now to sit on the Foster Care Review Board. Oh, my God, I could have just thrown up hearing that yesterday. I feel, I feel sick. Part of the problem is DHHS and CPS and whoever is the new name to take over the foster care system is crawling with horrible caseworkers who have complaints about them, but nobody does anything about it. When someone brought up about black children being put in homes where their ethnicity and their culture and their heritage doesn't matter, for example, a little black girl-- little black girls and boys have hair that requires effort and proper products to keep their hair soft and manageable. I can't tell you how many little black children I saw in foster care with unkempt hair, unkempt skin that just required some simple lotion and some conditioner every day. And it's all about truly caring about the welfare of mental and physical conditions of children in foster care. But too many foster parents, it's just a paycheck. A solution is CPS can provide these children with a special backpack with toiletries for their hair and educate those foster parents who are not of their same race how to take care of them. One incidence that's really frustrating to me is there is a practice of Nebraska foster parents to kick the kids out at 19. They don't have anything, no belongings. They don't have anything. They're just kicked out. I took in a 16-year-old child who was a foster care kid and when he turned 16, the family kicked him out of the house. They used to lock him in his room when he went to the house so many days he spent at my house because he was my son's friend. The, the boy turned to the parents and said, can I get my things, my belongings? And the foster parents said, no, those aren't yours. They're for the next kid. Get out. So he's 27 years old today and CPS totally lost track of this child at 16. But he knew he could always come to our house. I never knew exactly where he was, but if he needed something, he came to us and we took care of him. So I thank you for hearing my heart. It's so hard for me to talk about all this pain. But Nebraska should have a state logo that says: If you're poor, prepare for lots of pain and injustice. And that's the truth.

ARCH: Thank you for your testimony. Thank you for coming today. Are there any questions? Seeing none, thank you very much.

TONYA WARD: Thank you.

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ARCH: Next testifier for LR404.

JAQUALA YARBRO: A little lower than I thought it would be.

ARCH: The chair's kind of low isn't it?

JAQUALA YARBRO: It is.

ARCH: I know. And it's not adjustable either, by the way. We face the same frustrations.

JAQUALA YARBRO: Good afternoon. My name is JaQuala Yarbro. I will spell that, J-a-Q-u-a-l-a, last name is Y-a-r-b-r-o. I am the founder and CEO of Compete Technologies. We are a predictive analytics firm in north Omaha. I also am founder and CEO of where-- oh, I guess I'd be the ED of our nonprofit. It's called the Compete Institute of Socioeconomic Policy and Education. I'm a data person. I just like numbers. I like to work with kids. I like to work with families. I like to look at data and say, hey, here's this predictive model. And if you want to achieve this in 18 months, 24 months, 36 months, this is all you have to do. And that sounds very, very simple, except we live in Nebraska and we happen to be black. And so I have notably worked with-- we are the race equity consult for contracting through Nebraska Children's and Bring Up Nebraska for the national movement, Thriving Families, Safer Children. So we're very aware of the Douglas County Community Response. We also partner with not just them, but I want to say 22 other collaboratives in the state of Nebraska to provide race equity consult. We are primarily, like I said, predictive analytics. And it is, it is very, very tough. To get straight to the point, our proposal has always been oversight and accountability. The dichotomy of the Department of Health and Human Services is one that I don't think any one person created. However, due to the systemic developments, what we would call-- I would call it "corporate culture" because I think a lot of my counterparts and, and partners are comfortable with that term. But it is systemic racism, to answer your earlier question. We have partners to support that research, such as the Burns Institute. They're part of this national movement. They've been providing some resources to us as well as Evident Change. Evident Change reviews the structured decision-making tool, which is what the department uses to decide what should happen when they get a call, right? If abuse and neglect is reported, they have a manual that says, hey, do A, B, C, D. What is pronounced, even as recent as I would say November, which-- oh, I guess was two days ago, is a new report that comes out to show this data is-- I mean, the disproportionality of

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black and, and Native children in the system and the outcomes is it's enough to get national attention, I would say that. To answer-- I don't know if it was yourself, Senator Walz, or Senator Williams. One of you guys asked about the, the racial demographics of the CFS workers. I don't have current numbers on that, but I do know that in 2020-2021, CFS released a report to show that for every 23 black employees, they had 25 Hispanic employees, but there were over 300 white employees. I think the department has taken some steps to say, you know, we need to reform, we need to change. There's a family-first prevention going on, there's a strategic transformation that's going on, all of which are not very equitable. And I do mean that's why we need this investigation into the dichotomy of the department because the child welfare system is really a cradle which serves as a dragnet for black kids in education, in housing, in the juvenile justice system, and then eventually going into the prison system. We focus on causal data, causal versus-- causal correlations, I want to say. And not to get too technical, but a lot of the data, a lot of people say that they are data based, but we have been charged with this because we're actually data scientists. So we take a look at is that a transaction within the data? What does the data actually tell you? Are you, are you getting-- like you said, why are these, these reports happening? Why are these students being brought into this dragnet? That data is there. What we look at and what we have been advocating for is the lived experience, the qualitative piece, which has been largely controlled by child welfare and their partnering agencies. So what we are proposing is upon an investigation into the dichotomy of child welfare and their control and the ultimate perpetuation of disparities for people of color, that you also appoint, in perhaps an amendment of LB1173, that there'd be a community board that is not selected by the department to act as an oversight and accountability committee that has authority. But also we would advocate for authorities given to the Foster Care Review Office because as the Foster Care Review Office does a great job. They make great recommendations, but the department does not have to adhere here today. So I could go on for days, but please ask me questions.

ARCH: Thank you for your testimony. Are there any questions? I just have one.

JAQUALA YARBRO: Yes.

ARCH: Tell us a little bit about the company that you, you were talking about, your, your-- you've got a, you've got an IT company.

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JAQUALA YARBRO: Yes. So Compete Technologies, we actually started in 2013 and we were an after-school program. So we saw the, the data that showed that black kids were just underperforming in school, on ACT, everything, right? We said, OK, we'll start with college prep. So in 2013, we partnered with five schools in Omaha Public Schools and were able to bring up ACT, ACT scores. We also were part of making that mandatory because students used to not be mandated to take ACT, right? So with the changing of administration, a lot of those priorities changed. And so we had to, to pivot and do more service-based opportunities within the schools. And so Compete Technologies, we, we started just being an ACT prep program. What we noticed was all of our students ended up going to jail, all of them, probably 98 percent of them. And so because I ended up going to court for my students, because some of them, their parents had to work or they didn't have transportation, I actually made a-- formed a great relationship with the judges. They helped me to become a juvenile justice-- a juvenile probation provider so that these kids could still come and get our services and then we would be compensated for it. Tough part is we haven't, since 2017, received one referral from juvenile probation. And so, again, the dichotomy of the department is something that we're very, very interested in. There has to be some oversight there because there are tentacles-- and I hate to say tentacles like an octopus, but I'm very, I guess, illustrative. But I, I would say that there, there is a need for some reform. I don't think that we have mandated players at the table that can get this done. So we can be opportunistic. We can be, you know, as optimistic as we want to about this. But what Compete has identified is from education to child welfare to even housing and especially juvenile justice, which is where all of our kids end up, so much so that we have an underutilized facility. And we just built another one that we don't even need to put kids in that is-- the, the cells are the size-- the holding cells are the size of a-- are smaller than solitary confinement. So that's a whole nother thing there. But what I could say that what we do best is we serve as sort of like that central navigator. We're actually in the community and people can walk through our doors and get that support. So if they need to-- you know, sometimes families walk in to say, hey, I got this court order, what do I do? Well, first off, you need to go to court, right? We help people to understand their court orders. We help them to understand what their rights are because they do have rights in the state of Nebraska. And it's not necessarily, I guess, dictated to them. So we see a lot of our families go to court ill prepared, if they go to court at all. And so there are very small reasons for why these families are losing their kids and staying in the system longer

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and so that's just a very small part of what we do, but we're really kind of a one-stop shop in the community.

ARCH: Well, thank you.

WALZ: Senator--

ARCH: It's very interesting. Senator Walz.

WALZ: One quick question. You mentioned a community board oversight that's not part of the, of the department. Can you expand on that? Like, what, what would you envision this community board to, to do? Who-- what would they be doing?

JAQUALA YARBRO: Absolutely. So the-- currently with LB1173, the department has-- there's like a tri-head that oversees complaints within a department, any reform within the department. But it's supposed to be part of the strategic transformation movement that's going on right now within the department to address the disparities and develop better community relations. The problem is they were able to handpick the organization that was like the nondepartmental oversight that's a part of that team. And so what needs to happen is, excuse me, there needs to be a community board of individuals like I would-- I mean, shameless plug, like myself, like our senators, like the individuals who are in this room because we are frontliners, we're on the ground. Those who-- with normally lived experience individuals who I'm seeing being brought to the forefront in this work, the level of policy development, procedural development, their level of understanding in that area is not one that is conducive for success, right, and any progress in that area. And so we need people, we need the opportunity, first off, to be in the room. First off, there should be a room. But since there is a room, we need the opportunity to be in that room to represent people and to really have that qualitative piece, add it to the data, because that community board is who will, for one, we're hands-on with the community. We know what our problems are. We know what our cultural norms are and we're acquainted with one another. I think what's very important too to, to take a look at is those who, who are within the department who are black who have some authority or notoriety don't have any community ties because they were recruited from outside the state of Nebraska. And so I think that the community board of homegrown individuals needs to be probably application based, maybe people who submit an application to you all or a body that you guys would appoint to, to do so. I think that it should not discriminate based on their criminal background because if

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they are interested in this, they might have a criminal background and they may have had their kids removed. Those are all things that currently prevent families from advocating for themselves with a lot of the ongoing efforts without naming them specifically. If you have a, a criminal background or if you've had your kids removed or whatnot, there are individuals being removed from their place in this work because of that. And so there is a need. Equity, the opposite of equity is disparities. We don't own any stake in the game when it comes to child welfare and our children are chattel, so.

WALZ: Thank you.

JAQUALA YARBRO: Very welcome. No other questions?

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

JAQUALA YARBRO: All right.

ARCH: Next testifier for LR404. Welcome. You can proceed.

ELIZABETH BROWN: Chairperson Arch, members of the Health and Human Services Committee, my name is Elizabeth Brown, E-l-i-z-a-b-e-t-h B-r-o-w-n. I'm an enrolled member of the Omaha Tribe of Nebraska, and I am from the Inkecabe clan which is a Buffalo clan. I am also the president of the board of directors of the Nebraska Indian Child Welfare Coalition, NICWC. NICWC is a grassroots collective of tribal and other partners dedicated to the full enforcement of and compliance with the federal and Nebraska Indian Child Welfare Act. We strive to protect Native children from being unjustly removed from their families, tribal communities, culture and heritage. Thank you for the opportunity to testify today on LR404. The disproportional-- disproportional-- the disproportionality rate of Native American children in the child welfare system nationally and especially in Nebraska is significant. Native American children comprise of only 1 percent in Nebraska population, but represent 3.9 percent in the children-- of children in the child welfare system. This is almost four times greater than the percentage in the state population that makes Nebraska the fourth most disproportionate state for Native American children in this country. Historically, the U.S. government has inflicted egregious harms and abuses on Native children through family separation by the boarding schools and the Indian Adoption Project. This continues today through state child welfare interventions, according to the disproportionate numbers of the Native children in the Nebraska child welfare system. In 1978, Congress

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passed the Indian Child Welfare Act to seek to remedy some of those harms to preserve the security of Indian tribes and families. However, the federal ICWA is not well understood or enforced and is under threat by a case heard by the U.S. Supreme Court last month challenging its constitutionality. Therefore, state action and protection is needed now more than ever. Thankfully, Nebraska Legislature passed LB566 unanimously in 2015 to provide clarity to state agencies and courts regarding the provision of ICWA. We need to ensure these strength-- these strengthened provisions remain in place and are consistently implemented to protect Native American children and families in Nebraska. We recommend several measures we believe would help to improve the system. First, tribal partners need to be at the table. Too often, tribes are left out of decisions and aren't considered when statutes are enacted or amended. If we consult with tribes prior to enactment of state statute amendments, we can prevent unintended consequences. Second, the option of customary adoptions should be allowed in Nebraska. This is the practice of transferring custody to adoptive parents through tribal court without terminating parental rights, which is more culturally appropriate and exists in other states. Current Nebraska state statute requires termination of parental rights to finalize an adoption, which prevents an adoption subsidy through Nebraska DHHS to the adoptive family. Finally, NICWC provides numerous trainings across the state currently and is open to providing more educational opportunities to juvenile court stakeholders. We know additional culture competency and cultural responsiveness, responsiveness trainings are needed, but these are only a few suggestions. Culture is a protective factor, not just for Native American children and families, but for all families. Much more needs to be done to preserve culture and to protect families and we hope to participate in future conversations and efforts. Thank you, Senator McKinney, and the committee for examining the supporting issue. And we urge the committee will take meaningful action on this in the upcoming legislative session.

ARCH: Thank you. Are there any questions? Seeing none, thank you for your testimony. Next testifier for LR404. Welcome.

GRACE JOHNSON: Hi. My name is Grace Johnson, G-r-a-c-e J-o-h-n-s-o-n. I am a mental health therapist and a drug and alcohol counselor. I have worked on child welfare cases. I worked as a family support worker prior to getting my master's as a therapist. And I've-- after achieving my master's, I had started working on ICWA cases, which you had heard about previously. And so I live in Omaha, Nebraska, but most of my cases were involving Native American children in the welfare

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system or CPS system. I had to-- during my time with these cases, I had to become an advocate because many times the children and the families didn't-- they didn't have the advocates. Now this is something that's very dear. I am-- I'm an enrolled member in Oglala Lakota Sioux Tribe and having to testify and work with these children and these families and the system has brought to light to me to seeing a lot of the issues that you see with families that enter into the system. These children and these families tend to have a lot of trauma. They don't enter the system because the families are healthy, right? They don't enter in because their family is functioning correctly. People talked earlier and they gave a lot of testimony about what brought people into the system. And I always bring this up as intergenerational trauma is real, it's there. And we-- this is what we see many of the families entering into is because of addiction, intergenerational trauma. Now if we're not addressing the underlying cause of this, if we're not looking at this matter as a real thing, it's-- we're just putting a Band-Aid on the situation. We're not necessarily doing any real work. You're just going to continue to be putting out fires, going to continue to be just putting a Band-Aid on it. There is no real solution here if we're not addressing that. There needs to be-- there has been a push in the state for trauma-informed care, but I think it needs to be advocated for more. I think there needs to be more work on this. There needs to be more training on this. I really do believe there is a need for intergenerational trauma or just trauma work and addressing addiction. I-- when I worked with the families, I had to work with the parents too, correct? I really advocate for more family therapy, advocate for more education on what is attachment when children are born, parental skills. There's a whole list of things here that are not, were not addressed and we're not talking about. Unfortunately, we have a shortage of therapists in the state, rural and urban. So we are working on-- with-- in a situation where we just don't have enough qualified people, really. But working on intergenerational trauma, I have found to help a lot of the parents understand where their-- where they ended up in the system and how they got here. Because sometimes they're just completely confused on it happened and they don't know how it happened, even though they were participating in it. And it becomes like a David and Goliath situation where the parents don't have-- they don't feel they have the support, the understanding, and they don't necessarily have those that are supporting them. I had said I worked as a family support worker and I had a bird's-eye view of the whole system. I was the one who took the kids to the family for, for the visitation, right? The system is broken and it's, it's-- I can't blame anybody. It's just that the

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workers are overwhelmed. There's not enough funding and support. It's a, it's a huge, complex problem that there's multiple layers that need to be addressed. But I would say addressing intergenerational trauma is one of the underlying causes you're going to-- you're definitely going to have to work at and look at. Do you have any questions?

ARCH: Any questions? Senator Williams.

WILLIAMS: Thank you, Senator Arch, and thank you, Ms. Johnson, for being here. And I just want to expand on your testimony that you, you talk and, and your, your work is mostly with Native American children, and you're talking about intergenerational and, and addictive issues. In your judgment, would those same issues be there for the other minority populations that we're talking about today, the black population, the Latinx population?

ELIZABETH BROWN: Absolutely.

WILLIAMS: Thank you.

ARCH: Other questions? Seeing none, thank you for your testimony. Next testifier for LR404.

JUDI GAIASHKIBOS: Good after--

ARCH: Do you happen to have, do you happen to have a green sheet?

JUDI GAIASHKIBOS: I did not fill one out--

ARCH: OK.

JUDI GAIASHKIBOS: --because I wasn't planning on testifying.

ARCH: OK.

JUDI GAIASHKIBOS: I was just listening, but I'll fill it out on my way out.

ARCH: She'll get you-- yeah, she'll get you a, she'll get you a blank. But, but please do fill that out and provide that.

JUDI GAIASHKIBOS: OK. Thank you, Senator Arch and members of the committee. I'd like to thank Senator McKinney for introducing this interim study. As I said, I am Judi gaiashkibos, J-u-d-i g-a-i-a-s-h-k-i-b-o-s. I am the executive director of the Nebraska Commission on Indian Affairs and I am a member of the Ponca Tribe and

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I am also Santee Sioux. And I decided to come to the hearing and listen and I want to thank all the fabulous testifiers that preceded me. At first, I didn't know that there was going to be any Native voices here so I was really getting nervous. But I thought the African American community did an outstanding job of presenting their case about this terrible, terrible state of affairs for our people with DHHS and what's happening in our state concerning chil-- our children. Myself, I would just like to say historically I am a survivor descendant of the Indian boarding schools. My mother and two of my aunties went to the Genoa Indian School where the motto was "Kill the Indian, Save the Man." And as you've been reading in the papers, we are right now in search of finding 86 children that are buried over at Genoa, Nebraska. That was a part of our nation's history that isn't talked about. It's pretty invisible. People don't know that this is what was done. And that brings us up to, to where we are today and informs how our people are treated, how-- why we have missing and murdered indigenous women, because we are invisible people. We are throwaway people. And so we have a lot of things happening. Poverty is probably the underlying. There's causational reasons why we're in the system and our children are so vulnerable. I want to give you an example of a case that just came to our agency last week, right before Thanksgiving, to demonstrate, demonstrate this broken system that we're dealing with. I had a call from one of our providers here in the state. I'm not going to say the name of the organization, a very well-known, highly respected caretaker of children. This entity had received a child that was getting ready to age out of the state system through the Bridge to Independence, OK? So the child was sent over to their care for five days, as that is provided for, and it was time for the child to be sent to an apartment, independent living. This young woman was a Santee Sioux tribal member and she was getting ready to age out. She had been trafficked. She had no car, no education, no resources. But she's living at this nonprofit for five days. And they called me because the person who's the director knows me and they wanted resources. What, what were they-- what could they do to help this young Native girl from the Santee Sioux Nation who was in their care? So I gave them a lot of resources, Society of Care, Legal Aid, the Santee Sioux Nation, on and on. And then I was told that this young girl was going to then be put in an apartment after the five days were up. So I followed up on this with the director and he said, here's her caseworker. She's now in an apartment and they're going-- I mean-- sorry, she's in a hotel room. She's in a hotel room. And she-- we no longer have her. She's been put in a hotel room and she's going to go to an apartment. Well, I think that young lady is really at risk

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to what is going to happen to that young Santee Sioux Nation girl who is now aged out of the system. That is a failed system. And I just shudder to think what will happen to that young girl. So I'm giving you an example of something is broken and it needs to be fixed. And how can we work on that this next session to help all of our children be treated better? And for all of what you heard, you've heard all the reasons why our children are treated differently including our hair, you know, the black children's hair that a common right to be treated with dignity is denied. Those little children and the ignorance and the lack of training to the caseworkers, it's just a shame that they aren't utilizing us and having us give more training. That's what our agency is there to do and that's what I'm committed to do. So I just felt like I wanted to say that. And I think Grace did a great job and the NICWC. They're doing great work and there are many other nonprofits that are doing great work, but we need the state to help us and we need the-- you all to make sure that the right things are done and that this can't continue to happen. Do you think that's a good scenario with that young girl? That was right before Thanksgiving and I went home and I'm like, oh, my gosh, something's really wrong with this world.

ARCH: Well, thank you for your testimony. Are there any questions?
Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And, and, Judi, thank you for being here and thank you for your advocacy. I think when many of us hear you use the term "forgotten and throwaways," that, that touches a real nerve and, and makes us all feel like we need to be forgiven for something. My question is there's been a great deal of discussion, in particular over the last year to 18 months, concerning something I brought up earlier, institutional racism. But it's-- primarily that discussion is dealing with the, the black Americans in our country. Would you say that same kind of institutional racism exists for Native Americans?

JUDI GAIASHKIBOS: Absolutely.

WILLIAMS: Can you expand on that?

JUDI GAIASHKIBOS: Without a doubt. Well, I'll just use myself as an example. I had a-- one of ten children, lived in a three-room house until I was 10 years old with 13 people, had an outhouse. We had caseworkers come to my home quite often and I was the child that was designated because I was pretty precocious and articulate to convince

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the caseworker that they shouldn't take us out of the care of my parents who were doing the best they could. And I didn't know that we were poor. I-- my grandmother-- I slept in a rollaway bed with my grandmother and little sister in the kitchen. And I went to school and I loved school. And till I went to a friend's house, and her father was a dentist in Norfolk, Nebraska, and she had two beds in her bedroom and no one slept in one of those beds. I was like, wow. Then I thought, my life's really different. But that doesn't-- didn't mean my life was less than hers. But I was blessed by my grandmother, my Santee Sioux grandmother, who told me stories and knew her language and culture. My friend didn't even know her grandmother. So the caseworkers, they look at us as pitiful. They don't understand our history that we are dual citizens. You know, definitely there's a bias against people of color and also during pre-ICWA. Indian children are beautiful little children and they wanted our children and they thought they needed to continue to try to assimilate us and make us be cookie-cutter Americans and that other-- that we would be better with a white family, but we wouldn't have my grandmother telling me those stories.

WILLIAMS: In your judgment, as a person who has dealt with this from the day you were born, why are so many people afraid today to talk about openly and discuss the issue of institutional racism?

JUDI GAIASHKIBOS: I think it's-- you talk about intergenerational trauma, I think it's ancestral guilt and it's a real dark stain on America's history. And it's hard for-- and also you haven't learned, learned about us in history so you don't really know the facts of all of this. It's just painful for non people of color to, to own this and to say it, as well as it's painful for us to have to sit here and tell you about it. And believe us, we live this, we know this. So I think it's you have to stop and say it's time to, to own this and say this really did happen in America. It didn't just happen to-- in Germany, but this is on our land here. For Native people, we have nowhere to go. You know, we can't go back to learn our languages over in Europe. And so America was really built on the backs of slaves and black people and our first peoples' lands were stolen. And that's why they-- we had the boarding schools. It was cheaper than having wars. Every battle with Native tribes was \$1,000,000 and the government said, we have to stop having wars. So how we do it is we kill our children. My mother and her sisters, they were the last soldiers in America that fought the wars, that freed the land so that everyone could have this beautiful country of America. And we all still want to live here with you. We love our Mother Earth, but we want to find a way that our

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children can still be who they are and not have to be an assimilated cookie-cutter American, but can be a proud, you know, Osni Ponca or whatever your tribe is. And we go to fight in the wars, our Native warriors fight at a higher rate than anyone. So it isn't as though we're not proud of this country. So I hope, Senator, that that kind of maybe-- it's painful, it hurts. We don't-- there's been so many bad things that have happened in the last few years with COVID and all. We don't want to feel sad. We have inflation. People don't want to learn all these things and say, let's just move on. You were conquered people. It's time to get over it. But we don't think so, you know.

WILLIAMS: Thank you.

ARCH: Senator Murman.

MURMAN: Yeah, thank you for your testimony. And you'll have to forgive me for my ignorance, but you talked about the Genoa Boarding School and the past history of how Native Americans were treated and so forth. I, I suspect that, and you'll-- correct me if I'm wrong, but the traditional family wasn't always the way that different tribes operated or had traditional families. Like, like we think of a mother and father and children.

JUDI GAIASHKIBOS: I think that would be true.

MURMAN: Is it different?

JUDI GAIASHKIBOS: It's not a core family of a mom and dad, two children, a garage, and everybody gets a bathroom and a bedroom. No, you did whatever you had to do. And you know, the tiyospaye, the extended family, we managed. And if there were relatives that needed a place, they were a part of our home and we opened our home to that. So that's kind of that tribal, communal way of looking at living that the dominant world, the nontribal world doesn't relate to. So that's I think why then the people that are deciding what happens to these children say that home is not fit. That's not a good place for those kids to be. But I wouldn't trade my life and my experience as a poor child living in that little house for anything because I have so many great memories, you know. But I don't know, I'm sure it was nice to live the other way, too, but that's just the way it was.

MURMAN: Well, I'm, I'm thinking about back in, like, the late 1800s and early 1900s, when these-- the boarding school was really, I think, going at its strongest. And, you know, when this part of the country

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was first being, for lack of a better term, "civilized," I guess. Probably not the best term. Sorry about that. But there were differences, I think, with the family structure quite often, like you said, more communal. And how does that still have an effect on, on the family and social services today?

JUDI GAIASHKIBOS: OK. So going back to the Genoa Indian School, that was the fourth school opened by General Pratt to "Kill the Indian, Save the Man." Carlisle being the first in 1879. There were over 20,000 students that went through that school and the whole purpose was to separate the children from their families. To destroy a people, that's what you do, you separate families. That's still happening in America today. So you take away their language and your-- their ability to be that tribal person, hoping then that they will-- however, not allowing us to have aspirations to go to college and do things, but to be the servant labor for the rest of the world. So we were trained. My mother learned how to be a cook. Then originally they only went to sixth grade, then they finally let them go to high school and but it was never intended that they could go to college and become an attorney like my daughter or a teacher like my daughter. It was always that you could do something here but stay in your lane, be the conquered people, and be our servants, just like it was for the African American people. We need you. And now we have the Hispanics and they are doing a lot of that. And who's next? I don't know. But that's, that's our America. And that's why people don't want to talk about it. You know, it's painful. And there's nothing wrong with our family system. That's a good thing. It's a good thing to have lots of aunties and grandmas and people that step in. So when you were at the boarding school, you lost that. You didn't know. You didn't get to see what it was like. You went home and you were traumatized. It was-- I compare it to a military. You have PTSD. The men go away to fight in a war. They survive. They see horrible things happen. They go back home. They don't tell their mother, their wife what they saw. Likewise, people ask me every day, what did your mother tell you about being at the boarding school? Very little. She survived. She didn't want to inflict that pain on me, but I could see it in her. And I am still today healing from that intergenerational trauma. It's an ongoing lifetime thing. So I think that it's really time for the Nebraska Legislature to step up and do something good. And you can, it's time, really it is. With leadership like Senator McKinney, it's time to move forward. And I'm just really proud to be here. And I want to work with you and all the people that testify to do something better. We can, we can do better. We can be better. Nebraska is a good place to live.

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This is my homeland, I love it. I am proud to be an Osni Ponca Santee Sioux person. I, I-- we all need to live together in harmony. But for you to be better, I shouldn't have to be less. And our families know how to take care of, of our own people. And maybe it's not the way you think is best, but we like-- we're pretty happy with our traditions and who we are. And some of us have to learn those because those were taken away from us. We are regaining our language that was taken from us. That's a long, hard process.

MURMAN: I agree. Thank you.

ARCH: Thank you for your testimony today. Next testifier for LR404. Is there anyone else that wishes to testify on LR404. Senator McKinney, you're welcome to close. We did receive one comment from the Department of Health and Human Services for your information.

McKINNEY: Senator Arch, thank you. Thank you to the individuals that came down and took time out of their day to come and testify on LR404. I think it's very important and I think it's a conversation that we should have more often. But it's a conversation I think we should have often, but also do things after we have that conversation. Senator Williams, you asked whether it was systemic or institutional racism, and I would say yes. And I would say that because currently-- and it's nothing against our current CEO of the Department of Health and Human Services, but she is a black woman. And although that is a fact, we still have disproportionate outcomes for black, Native American and Latinx kids. And that points to institutional and systemic racism. Because although represen-- representation is important and having somebody who looks like you is important, what also-- what is also important is making sure that those systems that those individuals are working in are open to change, willing to change, and are, you know, doing things proactively to, to do that, do those type of changes. And I don't think that's occurring. And I think it needs to start occurring because until we start to change these systems, we will continue to see these disproportionate outcomes for, for these families and these kids. It's also-- and that goes with diversifying the, the caseworker workforce and making sure that they're culturally competent and not fresh out of undergrad working for the department and going into a home talking to families that they've never interacted with before in their lives. We also have to make sure that when we do make changes in this body, we look at it through a holistic lens and a racial equity lens because, for example, we ended the contract with Saint Francis. When we did that, Saint Francis-- the state took over it. When the state took over, the state began to not

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refer as many youth in, in, in foster care to day reporting services. Why this is important, the youth going to those day reporting services are some youth that are very highly at risk in that if not supervised or have proper supervision or somewhere to go during the day, they end up in our streets. And if you paid attention to the news in Omaha over the past year, you'll see that we have increased juvenile contact with law enforcement and offenses. And this is partly the reason, which is why I would also advocate for in the future racial impact statements, not only for the criminal justice system but for the, the child welfare system. Because we have to ensure that if we're making changes, we're looking at it holistically in order to decrease any negative impacts that possibly will occur with any type of change because it can be a pipeline to prison. If you go to NSP right now or LCC, you walk through there and talk to those men, a lot of those men were in the child welfare system. But because they were failed as time progressed and they aged out and went into adulthood, they ended up there. And now we have an overcrowding situation, which is why we need to start looking at these things more upstream and getting to the root. Because if we don't get to the root of these issues and keep throwing Band-Aids at them, nothing will ever be solved. The state will continue to waste money on these solutions that aren't working. We can't build our way out of this issue. We can't hire a new face out of this issue. We have to be intentional and break down these barriers to make sure that these families are properly taken care of and our kids are properly taken care of. A kid shouldn't be suspended from school because they were late to school. That, that has never made sense to me. When I was in high school, I was suspended before because I was late to school. My mom didn't have a vehicle and the city bus was late a few times and because of that, I was late. So because I was late, I was suspended. Made no sense to me. If I'm showing up, I'm showing up. I was an athlete. I had decent grades. It wasn't like I was showcasing anything to say, like, Terrell is late and said this is a big problem. But because we don't look at these policies holistically, we say, oh, let's just, let's just put a penalty in place and then they'll show up in school on time. That's not the case all the time because life happens. We have to account for life happening and human error, but we also have to be human and treat our kids and our families as humans no matter what-- where you come from. Whether you're a Native American family, a black family, a white family, an Asian family, we should all be treated properly with equity. And equity is important because although getting treated equally is great, we have to account for the historical traumas that have been in place for years. And like Ms. gaiashkibos stated, this

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country and these systems weren't created with us in mind. And because of that, we have to go back and look at these systems to make sure they're working and are for everyone and has everybody in mind. And with that, I'll thank you. And if you have any questions, I'm open to them.

ARCH: Are there any questions? Well, thank you very much for bringing this LR. And with that, we'll close LR404 and we will move to open LR408. And I believe that is yours as well, Senator McKinney.

McKINNEY: Yep.

ARCH: If you could, if you could leave the room quietly, I'd appreciate it. We have two more LRs that we need to hear this afternoon. All right, you may proceed.

McKINNEY: Thank you, Chairman Arch and members of the Health and Human Services Committee. We are here today to discuss LR408 to exempt-- to study and examine ways to grow and diversify Nebraska's healthcare workforce. The purpose of this resolution is to propose ways to grow and diversify the workforce by engaging communities that are underrepresented in the current healthcare workforce. The state of Nebraska should focus on developing a healthcare workforce that reflects the communities in our state. Health disparities have long existed for racial and ethnic minority populations, or some individuals suffering from disproportionately from, from treatable care, from disproportionately-- from suffering disproportionately from treatable, curable and preventable diseases. A lack of diversity in the healthcare workforce could worsen these healthcare disparities. According to a study from the George Washington University Milken Institute School of Public Health dated in March 2021, black, Hispanic and Native American individuals are all significantly underrepresented in the healthcare workforce in the United States. The state of Nebraska must work with healthcare providers and healthcare educators to educate, recruit, retain and cultivate a diverse healthcare workforce that mirrors the communities they serve. You ask why. Diversity in healthcare helps ensure that all ethn-- ethnicities, backgrounds, cultures, beliefs and perspectives are adequately represented, thus providing the best care for everyone. People feel safe around people they can identify with. There's a certain level of comfort that comes with knowing you're in the care of a professional that not only sees you, but understands the nuances that come with being you and those nuances are being accounted for when you're-- when caring for you. When patients cannot find providers that resemble them

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or their facets of life, being misunderstood or not perceiving appropriate treatment is likely an end result. Diversifying healthcare makes, diversifying healthcare makes care more accessible to patients who might otherwise be overlooked. The more diverse, the better they can respectively and know-- knowledge-- knowledgeably assist their patients. Diversifying healthcare makes care more accessible to patients who might otherwise be overlooked, as I stated, because the more diverse, the better. Patients who are the same race as their providers report better outcomes and are most likely to be prescribed preventative cares. The Center, the Center for Disease Control and Prevention reveals black and Native American-- black and Native women are two to three times more likely to die of pregnancy complications than white women. There's a plethora of black women sharing their birth stories and detailing these events of mistreatment, not being believed by doctors and nurses, and not having their symptoms taken seriously and outright malpractices during their deliveries. Something we also must look at is looking at diversifying healthcare workforce as a tool to decrease poverty and to lift historically impoverished communities out of poverty, which is one of the biggest drivers of poor healthcare outcomes, educational outcomes, prison overcrowding, overrepresentation in the child welfare system, and the widening of the, the widening of the racial wealth gap. I think this is a very important-- I think it's something that we should all look at because, you know, I've heard the horror stories throughout my life from family and friends about going to the doctor and having some type of pain or ailment and the doctors just looking at them like they were crazy and didn't make sense, to only leave and be rushed to the hospital later because the doctor failed to recognize what was going on with those individuals. And why I say-- it, it's another tool to work to decrease poverty. I think the healthcare industry, like every other industry in a state, needs to be a part of the, the solution when it comes to decreasing poverty in our state, especially in communities like mine. And with that, I open myself up to any questions and if you have any concerns.

ARCH: Thank you, Senator McKinney. Are there any questions at this time? Seeing none, we'd invite the first testifier. Mr. Hale's jumping up quick. Welcome.

ANDY HALE: Thank you. Senator Vice Chairman Williams and members of the HHS Committee, my name is Andy Hale, A-n-d-y H-a-l-e, and I am vice president of advocacy for the Nebraska Hospital Association. Our nation is made up of people of varied nation, national origins, ages, religious affiliations, languages, genders, disabilities, social,

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economical and occupational statuses, geographical locations, among many other traits. With our country growing more diverse each year, so should our healthcare workforce. Studies have shown that having a diverse healthcare workforce gives healthcare organizations access to more perspectives, improves productivity, enhances organizations' ability to solve complex problems, and more importantly, increase-- increases patient satisfactions and outcomes. Patients need to feel comfortable and at ease with their healthcare providers in order to establish good communication and therefore good care. A provider who understands a patient's unique background is in a better position to explain test results or a diagnosis. And a patient who feels their provider represents them is more empowered to ask questions and to be assertive and likelier to follow the provider's advice down the road, leading to a better outcome. The COVID-19 pandemic has exploited these existing health disparities, disproportionately impacting communities of color, Pacific Islanders, Latinos, indigenous and black Americans; all have a COVID-19 death rate of double or more than of white and Asian Americans. There is also a workforce component to all of this. You've heard us on many occasions, from the healthcare industry, really sound the alarm bells on workforce shortages, but there's a segment of the population that is sitting on the sidelines, and those are the legal immigrants. And again, I want to stress legal immigrants. The NHA has been working with a group to come up with permanent solutions for people that are here legally and cannot work. There are around 2,000 Temporary Protected Status recipients, the TPS recipients, and more than 5,000 residents are DACA-eligible in Nebraska that cannot work. I do have a few of our members that have made great strides in our programs with not only reaching out and, and, and cultivating a workforce, but putting them to work, encouraging them in leadership positions and so forth. And you'll hear those testifiers behind me, as well as those in the education system that have done a great job as well. I'd like to thank Senator McKinney for introducing this LR and I appreciate him and his staff's work in bringing awareness to this issue. And I'd be happy to answer any questions.

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

WALZ: Thanks for coming today. I am glad that you are aware of the need for diversity-- administration. Like, are they trying to address the-- that issue and in what ways or what-- are there things that we can do to--

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ANDY HALE: Well, you'll hear from the-- our members that have really focused on this and have programs specifically addressing needs in certain populations. And as far as the specific ask, as of right now, you know, obviously this is just a study, but I think when you look at workforce and how do we make sure that everyone who is able to work can work and how do we cultivate that workforce? I think that is something that we will have next session in regards to specific asks to workforce in regards to this population and overall workforce issues.

WALZ: All right. Thank you.

ANDY HALE: You're welcome.

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

ANDY HALE: Thank you, Senator.

ARCH: Next testifier for LR408.

KENNY McMORRIS: Good afternoon, Senator Arch, members of the Health and Human Services Committee, I am Kenny, K-e-n-n-y, McMorris, M-c-M-o-r-r-i-s, have the pleasure of serving as the chief executive officer for Charles Drew Health Center in Omaha. I'm also here representing the Health Center Association of Nebraska and the seven Federally Qualified Health Centers in our state. Nebraska health centers serve an incredibly diverse and complex population. Over 95 percent of our patients fall below 200 percent of the federal poverty level, with 70 percent of, of them being racial and ethnic minority and 37 percent of our patients being uninsured. Last year, health centers served over 113,000 Nebraskans across 72 service locations within our state, providing primary medical, dental, behavioral health, pharmacy and wraparound support services regardless of insurance status or ability to pay. Providing high quality, culturally appropriate healthcare is at the heart of the community health center movement. We know that there are significant health disparities in Nebraska, whether they are based on income, race, ethnicity, insurance status, immigration status, employment status or education and gender. Much of these issues have to do with things that happen outside of our four walls within the health centers. However, data shows that implicit bias that healthcare providers hold can exacerbate these issues. For example, as previously mentioned by Senator McKinney, black mothers in the United States are more than three times as likely to die during and after childbirth as white mothers and more likely to

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die than black mothers in any other developed country in the world. Hispanic, African American and Native American Nebraskans are significantly more likely to report worse treatment when seeking healthcare than those of other races. Developing and sustaining a diverse workforce is critical to breaking down systemic barriers to equitable care. We recognize that workforce shortage-- shortages exist across our state. We feel those shortages in our own health centers every day. We also look for innovative solutions to these critical workforce issues. To improve that, we build systems to recruit, train, support a diverse workforce that is representative of the patients in which we serve. Based on the most recent Nebraska healthcare workforce study, while there have been most-- modest increases in the number of female physicians, the race and ethnicity distribution physicians had remained relatively unchanged since 2017. There's a similar trend in dentists, physician assistants and pharmacists, and based on data from the Behavioral Health Education Center, only 1 percent of behavioral health providers in Nebraska are black. In order to adequately understand cultural, cultural perceptions about accessing healthcare services and addressing centuries of systemic barriers that lead to distrust, we must build a workforce that is representative of all patients. Expanding training opportunities that afford individuals the ability to learn where they will live and where they will practice, develop pathway programs, promoting mentorships for students and expanding financial support through scholarships and loan repayments are all ways to increase the workforce in our healthcare community. We cannot begin to improve healthcare access in Nebraska without having a workforce that is representative of the communities in which we serve. We are committed to working with all of our partners in healthcare, the Legislature, the administration to develop innovative, innovative solutions to work-- to address this workforce crisis. I want to give a special thank you to Senator McKinney for raising this and introducing LR408 and the committee for taking time to listen to, to what we have to say. I'll answer any questions that you may have.

ARCH: Thank you. Are there any questions from the committee? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Mr. McMorris, for, for being here. This committee and this Legislature, this past year, tried to step up and address one particular piece of this issue in workforce and that's a nort-- nursing shortage that we have in our state. We have more nurses retiring in our state than we have seats in all of the nursing schools put together. What we found out in, in some of the testimony, though, is that we have certain nursing schools that

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have many more applicants to them than they can take in, and yet we have vacant seats in some of our other nurse training schools. You can lead the horse to water, but you can't make them drink. How do we make that connection with the minority population that we're talking about today, that there are these opportunities available for them and now we created some scholarship dollars for that through legislation that we just passed this past session. How do we connect those dots?

KENNY McMORRIS: Yeah. Great, great question, Senator Williams.

WILLIAMS: It was a long question. I'm sorry.

KENNY McMORRIS: Yeah. No, no. It's a great, it's a great question. We spend our time at Charles Drew Health Center trying to solve this on a pretty regular basis. It starts with creating a pipeline at an early age. We know our kids in our communities, in our schools, that are talented, that have an interest in the healthcare profession, and we have to be intentional about providing those opportunities in a real and meaningful way to those young people. Exposing them to careers in healthcare, I think this does address-- and you make a great point, Senator McKinney, some of the economic challenges that we talk about in terms of improving the quality of life and lifting people out of poverty. Our academic institutions do a, a decent job of being intentional about recruiting within, and I'm going to speak specifically about north and south Omaha, but we can do better and we have to do better. We know it's pretty clear that you increase the likelihood of being able to retain individuals if they are from the communities in which they are serving and the state in which they are living. There's a level of commitment there. And I believe if our state is truly interested in addressing brain drain, we're going to start and be very intentional about working with our public school systems and school systems to be able to address and make sure that we are training and cultivating a culture of learning within the healthcare fields. I think the earlier that you start, the better off you will be and you will cast a net wide enough to really take the spark that's there for many of our babies and, and blow it into a flame. So it really starts early. I think the other part is, is really looking at how do we address a lot of the institutional and systemic problems that we have in our systems? A lot of our families are waking up every day trying to make the impossible possible. Life has challenges. How do we create an environment that uplifts them and supports them to help them reach their ultimate goals? This could happen across all industries. Specifically, I'm speaking about healthcare, but you can say in housing, you can say education,

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employment, entrepreneurship. So this is really about a process and being very intentional at an early age, addressing the issues that have been generational. These are generational problems that we're facing. It's not going to be a one size fits all, but it really starts with making sure that we're investing in our kids and supporting the families, whatever that family structure may be.

WILLIAMS: Thank you.

KENNY McMORRIS: [INAUDIBLE] with the question on that.

ARCH: Any other questions? Seeing none, thank you very much for your testimony. Next testifier for LR408. Good afternoon.

TIERRA ROBINSON: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Tierra Robinson, T-i-e-r-r-a R-o-b-i-n-s-o-n. I'm the director of adaptive learning and inclusive excellence in our Office of Inclusion and Diversity at Nebraska Medicine, which is a nonprofit integrated health-- 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 specialty and primary healthcare centers in Omaha area and beyond. I want to start by expressing my gratitude to Senator Terrell McKinney for introducing LR408 and giving us an opportunity to have this important conversation today. At Nebraska Medicine, we are committed to building a strong, resilient and diverse workforce. As an inclusion and diversity department, we are placing a greater emphasis and awareness on the multidimensional layers of diversity throughout our organization. We have made it a priority to focus on strategies that will allow us to advance health equity, reduce disparities in healthcare and address biases. This, this is important because when we are intentional about our efforts that support marginalized populations, we lift everyone up. It is important to our patients that we have a workforce of individuals that look like them, caring for them. It increases their trust in our-- in us as a healthcare system. COVID has impacted our workforce tremendously and therefore, it is critical that we not only focus on recruiting a much needed diverse workforce, but also supporting our currently existing workforce. This has included proactive approaches of establishing diverse employee health resource groups, developing career pathway programs and engaging in community partnerships. Our employee resource groups, or known as ERGs, affirm and empower the multiple and often intersecting identities of our workforce. Our ERGs include an Emerging Professionals Program, LGBTQ+

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Employee Alliance, African American and Black Alliance, LatinXcellence, Asian American and Pacific Islanders, Administrative Professionals Network, All Abilities and Disabilities Partnering Together, NursingWise, and RISE: Respect, Inspire, Support and Empower Women's Group. Through our work for these ERGs, we are able to, to offer culturally relevant and affirming programming throughout the calendar year. In March of this year, we launched a Health Equity Diversity and Inclusion-- Inclusion Council known as our HEDI Council. This is a cross-functional council that works collaboratively to champion, advance and support the work identifying gaps in access to care and examining the culture and climate of our workforce. Members of the HEDI Council and two HEDI Council committees include a diverse range of Nebraska Medicine and UNMC clinical and operational leaders, subject matter experts and community partners. Through the council, we have prioritized the greatest needs for recruiting and retaining a diverse workforce. In July of this year, we completed a comprehensive environmental scan that highlights our growth opportunities within the healthcare system. Through the work of two system-wide committees, we are addressing issues related to patient and family experience, workplace culture and community engagement in the context of equity-based care and practices. In addition, we are working to ensure that our healthcare system is accessible for all patients, families and employees requiring accommodations. Through our recently established accessibility community-- committee, we have had an opportunity to partner with the Nebraska Commission for the Deaf and Hard of Hearing to identify strategies to ensure that we can provide the highest level of care to this particular patient population. This includes culturally competent care training to approximately 150 Nebraska Medicine leaders and colleagues. There are various barriers and challenges that we face as a healthcare system while attempting to increase our efforts. More specifically, with the increase in the reliance on our contract labor, we have experienced significant budget challenges. We recognize that a significant challenge is that these changes don't happen overnight and will require a long-term commitment to systemic and meaningful change with intentional effort. We look forward to partnering with the Legislature on this important priority and below we've highlighted a few opportunities for the Legislature to support this work. One, providing continued support for inclusive and differentiated strategies in higher education; two, supporting broader loan repayment and expanded student loan forgiveness for healthcare workers and providers; and three, supporting early investments in healthcare certification programs and the development of career

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pathway programs. Thank you for your considerations and I'd be happy to answer any questions.

ARCH: Thank you. Are there any questions? Seeing none-- oh, Senator Murman.

MURMAN: Thank you. I agree with you that we should have a goal of more inclusive medical providers, doctors and so forth. But if I'm going to have brain surgery or heart surgery, I don't care what color the person is, or I don't care for any-- actually, whatever I'm doing but it's-- the most important thing is that they're skilled in what they're doing and their knowledge and, you know, their academia all through the process. So how do you balance that with trying to, you know, fulfill a quote-- for lack of a better word, fulfill a quota or check boxes for different types of diversity?

TIERRA ROBINSON: I absolutely agree that the skill set of the healthcare professional is at utmost importance. I'd say the balance is when we think about from a workforce perspective, is making sure that the brain surgeon who's going to operate on you is happy, happy with their employer, happy feeling like they are-- they belong to an organization where they can be their authentic self and that they can be in the right mind, body and spirit to be able to perform the job that they are tasked to do. And we know that when you're able to function in that capacity, that's what allows you to be successful as a provider. And then back to thinking about the person that you are operating on, it matters to that person because representation matters. And as Senator McKinney mentioned, when patients have a provider that they can relate with and that looks like them, it causes for better outcomes in patient care.

MURMAN: I totally agree with you, but I still think the skill and the academics of the provider is the most important thing above culture or checking boxes on, you know, color or whatever. That skill is the most important thing and the, the knowledge of the provider. Thank you.

TIERRA ROBINSON: Thank you.

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

TIERRA ROBINSON: Thank you.

ARCH: Next testifier, please.

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SELENE ESPINOZA: Good afternoon, everyone. Dear Chairman Arch and members of the Health and Human Services Committee, it's a great pleasure to be here with you today and to speak on behalf of a topic that's near and dear to my heart: creating healthcare career ladders for individuals like myself with underrepresented backgrounds. My name is Selene Espinoza. Selene is spelled S-e-l-e-n-e, Espinoza, E-s-p-i-n-o-z-a. I want to give you a small-- a short personal testimony in regards to why this work is very important for myself. I also wanted to testify to when systems work together the positive outcome that we can have in our communities. I am a proud immigrant daughter of a family-- a mother, single mother that came to the United States when I was two years old. My mother migrated here legally with a working visa for Conagra. She worked for-- here for about 11 years, received her residency and her citizenship and I became an American citizen under her citizenship. I met here with my mother after almost 11 years of not seeing her and moved to this beautiful country. I did not speak the language. I didn't know my siblings and my father. And I could tell you, at least, it was a very challenging moment as a teenage young female to move to a country into a family that I had no familiarity with. But coming from my grandparents' household, education was the number one priority that I would keep in mind and in heart that that was the dream. That was the possibility here in America to come and get an education. Coming here, I moved to south Omaha and I became a member of a future medical scholars at-- in high school. And again, not speaking the language, but having a dream that would-- I would get into the medical workforce. The most important and that made my story a success I could consider was the support from my educational system to my employer system. I went from high school to Methodist College and received a surgical assistant degree. I have currently worked in surgery for 21 years and I am proud to say that that really made the difference. The educational system supporting us with financially with scholarships and then my employer also supporting us with the diversity and the needs that I needed as a-- coming in as a foreign to the country. And after 21 years of my practice, I continue to see the lack of diversity in healthcare workforce. That's why I took, you know, as a personal challenge to go back to my community and create this beautiful program that I'll speak to you about. And this couldn't have been done without the support of CHI Health. CHI Health has engaged in vast growing number of partnerships, initially, growth and diversity workforce. We actively partner with Omaha, Ralston, Papillion and La Vista schools and Grand Island schools. In fact, CHI Creighton University and Bergen two-year medical academy model where we look at its students to complete a CNA

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certification. We also engage our students in clinical rotations to recognize the best practice by the Nebraska Health Department in education and the health science careers and technical education standards. For the purpose of today's speaking on behalf of diversifying our workforce, I will speak to you on our program, it's Siembra Salud/Health and Diversity Program. This program addresses two distinct workforce challenges that our healthcare system is now facing. One, we know that there is a deficit of skilled workers to meet current and future demands of healthcare services and also the lack of racial, ethnic and cultural diversity. Our program focuses primarily on, on our Latino and refugee communities, and approximately 11 percent of our metro-- Omaha metro residents identify as Hispanic or Latinos. I recently-- in our community assessment of the data demonstrated that there is a large burden in chronic disease and social risk factors in those communities, poor health, unemployment, property, unstable housing and food insecurities within the Hispanic and Latino communities or also the non-Hispanic white residents. Our program works on three levels. We work, one, to increase the number of youth exposed to healthcare sector careers. We provide students with exposure to a broad array of the high demands in careers and clinical tours; two, we increase youth career readiness. We made a partnership with Latino Center of the Midlands, where we bring our students to gain experience in healthcare careers; and three, we increase the number of Latino and refugee employed within our healthcare systems. I want to thank the Health and Human Services Committee for listening to us and understanding that this is really, truly a critical moment in our healthcare field so we do support diversity workforce. And also want to thank Senator McKinney for this introduction that it is very important resolution. I'll be pleased to answer any questions you might have.

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

SELENE ESPINOZA: Thank you.

ARCH: --for your testimony. Next testifier, please, for LR408.

NICOLE CARRITT: Good afternoon, Chairman Arch, members of the Health and Human Services Committee. For the record, my name is Nicole Carritt, N-i-c-o-l-e C-a-r-r-i-t-t, and I serve as the assistant vice chancellor for health workforce education relations and the director of world health initiatives at the University of Nebraska Medical Center. I am appearing today on behalf of the University of Nebraska

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system to address LR408. We want to thank Senator McKinney for bringing this important issue to the committee. UNMC has long been committed to educating and preparing the state's health workforce to ensure students are well prepared to meet the unique healthcare needs of rural and urban areas of Nebraska and beyond. Through longstanding programs such as immersive high school programs, guaranteed admission pathway programs for rural and urban underserved residents and interprofessional student interest groups, UNMC is helping diversify the healthcare workforce that will improve access to quality healthcare in communities across Nebraska. While not an all-inclusive list, I'd like to highlight some pathway programs with those aims. The UNMC High School Alliance is an immersive experience in the health science professions. More than 70 junior and senior level high school students from more than 25 participating high school districts in the Omaha metro area get to learn from experts and practice hands-on skills each year. The program is an inside look at what it's like to be a healthcare provider and researcher. Courses cover various healthcare topics such as infectious disease, anatomy and medical decision making taught by UNMC faculty on our Omaha campus. Students use their experience in the UNMC High School Alliance to set themselves apart on college applications or as a springboard to participate in STEM enrichment programs at UNMC. Multiple students have been accepted into the Urban Health Opportunities or UHOP program where they'll study pre-medicine at UNO with a reserve spot to matriculate to UNMC to the College of Medicine after that. The Rural Health Opportunities Program, RHOP, Kearney Health Opportunities Program, KHOP, and Urban Health Opportunities Program, UHOP, are decades-long model programs designed to address the healthcare needs of rural and underserved urban areas of Nebraska in more than 10 healthcare disciplines. The health professions pathway programs recruit, educate and graduate leaders from Nebraska who are committed to returning to Nebraska's communities to practice healthcare and be critical links to community vitality and strong local economies. The Summer Health Professions Education Program, or SHPEP, aims to strengthen the academic proficiency and career development of students underrepresented in the health professions and prepare them for a successful application and matriculation into health profession schools. The Robert Wood Johnson Foundation funds this program. The six-week summer program provides scholars interested in medicine, dentistry, nursing and pharmacy academic enrichment in the basic sciences of math, clinical experiences, career development activities, learning and study skills seminars and even financial planning. With a sharp focus on enhancing Nebraska's workforce,

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colleges and programs within UNMC are regularly seeking and pursuing new programmatic opportunities to support career expansion or career ladders, as has been previously mentioned, and pursuing grants and other funding to support new and enhanced programs and partnerships. Diversifying the workforce is a long-term endeavor that cannot be accomplished in a couple of years. It's a long-term and nonending commitment. We can't simply wait for individuals to seek out healthcare careers, but must develop robust pipelines from underrepresented communities into the health professions beginning in primary education and supported by intrusive advising, mentoring and role modeling. As you've heard in the comments today, UNMC has developed successful pathway programs in collaboration with multiple partners across the state and nation. However, gaps have emerged over the last five years that hinder the ability to build those robust pipelines, particularly the diversity of such. Statewide programs focusing on early exposure to the health professions from primary education through middle school are rare. While the federally funded statewide Area Health Education [SIC] or AHEC Program previously provided the early exposure programs through its five regional centers. Federal funding requirements have changed the program's focus to those students already enrolled in a health profession training program. Meanwhile, programs for high school students like Nebraska HOSA-Future Health Professionals exist and the number of chapters set up by participating high schools in collaboration with the Nebraska Department of Ed across the state is growing. UNMC has hosted the statewide HOSA conference several times and frequently supports these students' engagement. As it relates to pre-health and health professions training programs, students and their families, particularly those from underrepresented communities, must see a pathway into the health professions as a viable option whether into a certificate program or application to a postsecondary institution. Without earlier exposure to the health professions and intentionally developed and supported strategies and opportunities, the gap is likely to remain or even widen. As a state, we know we're not reaching our full potential to meet the increasing demand for a robust and diverse healthcare workforce, and the University of Nebraska system and all of our campuses are dedicated to being a partner in the solution. Thank you for your time and hearing our comments and I'd be happy to answer any comments, questions you might have.

WILLIAMS: Thank you, Ms. Carritt. Are there questions? I have a few.

NICOLE CARRITT: All right. I'll take them.

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WILLIAMS: Really interested in your High School Alliance program. And my question is, with the expansion of the medical facilities at UNK with UNMC as the partner, is there any hope of being able to do some kind of high school program like that in the rural parts of our state?

NICOLE CARRITT: That's a great question. The High School Alliance has actually looked at mul-- with multiple rural communities in the central Nebraska area about an opportunity to model the High School Alliance in the Omaha area to a more rural community and there have been discussions about whether that could be expanded to include what's happening on the Kearney campus as well.

WILLIAMS: That would be very helpful for the healthcare shortage in our rural areas. As we heard from an earlier testifier, young people tend to stay close to the area where they're educated and they want to go there, so that-- second question, and, and I think you, you heard me point out the issue-- one of the issues that I have with nursing schools is that some of them are full and have many applicants and some of them are not. Is-- are there discussions about finding ways to expand UNMC's-- the seats available in UNMC's nursing schools?

NICOLE CARRITT: Well, we're looking across all of our campuses and part of that goes back to some of the earlier discussion, I think, about just in the early exposure of the nurse-- nursing professions to some of our more underrepresented communities across the state and when we do have open seats, are there opportunities to recruit from those communities? Some of it's a cultural issue, so thinking about-- it's that longer term, earlier pipeline kind of work. But the UNMC College of Nursing is actually looking at some new and expanded ways, particularly on the Kearney campus, to expedite admissions twice per year-- admissions, those kind of things to make sure that we're keeping up again with the nursing shortage.

WILLIAMS: Just one more question along that lines-- and I've talked to Dr. Sebastian many times about this, and you know that. For instance, the UNMC nurse's school that is on the UNL campus several blocks straight north of us here has approximately, round number, 600 to 700 applicants for 80 spots. And so they have to be very selective and there are many applicants that are-- that certainly would be qualified that get turned away.

NICOLE CARRITT: Um-hum.

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WILLIAMS: I'm still mystified, then, that we have open seats other places, but I, I keep asking the question as a business person, I would look at that as a significant opportunity. The university is always looking at ways at increasing enrollment, increasing the tuition dollars coming in and, and meeting these kind of needs. And yet there seem to be stumbling blocks to take that number from 80 seats in a freshman class-- or not a freshman class but the first year in the nursing school to 100 or 120. And yet to me, when I hear what the reasons are for not being able to do that, I look at that and say, that's solvable. So I would just plant that as a seed because I think that's part of our solution, too. We've got to expand that number because even if-- as use-- as you heard and know if we put, if we put a butt in every seat, we still are not meeting the needs of those graduating or, or retiring, excuse me.

NICOLE CARRITT: Thank you. Absolutely.

WILLIAMS: Any other questions?

NICOLE CARRITT: All right. Thank you.

WILLIAMS: Did you want to make a, a-- I'm sorry. I made a statement there. Would you like to respond?

NICOLE CARRITT: No, I'm just saying I, I absolutely agree. Thank you.

WILLIAMS: Thank you--

NICOLE CARRITT: Thank you.

WILLIAMS: --for your testimony. Invite the next testifier for LR408. Are there any more testifiers for LB-- LR408? If not, Senator McKinney, you're welcome to come up and close. And while you're doing that, we have some online comments that have come in that will be listed from a Michelle Ploeger and a Nicole Barrett.

McKINNEY: Thank you, Senator Williams and members of the Health and Human Services, Services Committee. And thank you to everyone that came to testify today as well, taking time out your day on this Friday to speak about this important issue is really appreciated. And the conversation kind of went how, how I thought it should have went, you know? We've-- conversation about how do we cultivate this workforce? How do we do it? What are we not doing? How do we connect the dots? I think that's something that we should really look into because like, like you just said, I think it's a solvable issue to increase the

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diversity in the workforce. We just got to hone in on how do we solve this issue? And like Mr. McMorris said, we have to create a pipeline early in our, in our educational systems. Whether it's in Omaha or in Kearney, we should be finding ways to work with our schools and our school districts to start, you know, starting a pipeline. And one, one trend that I think might be helpful is when you look across the industries, a lot of industries are not necessarily requiring that you have a four-year degree. So maybe looking at those entry-level positions or those certificate programs or two-year programs may be the-- a, a way to start getting people inside the healthcare field. Because what I've noticed from family that I-- that have went into the healthcare field, once they become a CNA, six months later, it's like, hey, I want to become a medication aide. Then after they're a medication aide, they want to move up to something else. So I think when an individual is passionate and they see a real pathway for, for advancement, I think they'll be motivated enough to keep growing. But we have to find pathways and entry points to get them into it and then allow them to grow but have-- but cultivate an environment in a system where they feel free to grow and they see it as a viable opportunity to help, you know, grow our healthcare system, but also help them and their families as far as making sure they have livable wages and things, and things like that. Senator Murman, you mentioned skill set versus just checking a box. I would say I would hope whoever is doing a heart procedure is qualified to give a heart procedure. But what I also would say is most people that I know, especially from a black community, we are told early and we are conscious of it, that we know that just being black and just getting a education in-- with every industry and then let's use healthcare as-- for an example. We have to-- because of systemic issues, we have to be twice as good. I would make a strong argument that if you ended up with a black doctor and you're on a heart-- and you're, you're on a table for a heart procedure, that individual skill set is just as good as his white counterpart. And so, yeah, you just don't want to throw people into anything. But I would say that if we are able to diversify our healthcare workforce, I would feel comfortable no matter who that person was doing that procedure, because I think we also have to trust our medical schools as well, that they are graduating individuals that are fully qualified and have the skills to perform what-- whatever procedure, no matter where they come from. And with that, I'll open myself up to any questions that you might have. Thank you.

WILLIAMS: Are there any questions for Senator McKinney? Seeing none, thank you, Senator McKinney, and that will close LR408.

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McKINNEY: Thank you.

WILLIAMS: Anybody here need a-- anybody need a quick break?

WALZ: Just need some water.

MURMAN: Already did it.

WILLIAMS: We'll go forward then and open our hearing on LR367. And welcome, Senator DeBoer.

DeBOER: Thank you, Senator--

WILLIAMS: The last scheduled LR and the last scheduled hearing for this committee this year. You have it.

DeBOER: I know, and I'm thinking this may be the last time for your senatorial career this time around.

WILLIAMS: I hope so.

DeBOER: OK. Well, thank you, Senator Williams, and members of the HHS committee. My name is Wendy DeBoer, W-e-n-d-y D-e-B-o-e-r, and today I'm here to discuss LR367, an interim study to examine home visiting in the state of Nebraska. The first item that I'm going to pass out to you is a map. And this shows-- it's a map of Nebraska. It shows where home visiting is currently occurring in Nebraska. Home visiting is an evidence-based service that supports the health and well-being of families with young children. It is voluntary, free for families and cost effective. Home visiting programs pair young families with trained professionals who tailor services to meet the family's specific needs. These trained professionals can be nurses, social workers, peers or more. And they turn-- and they work to form trusting relationships with families to help them reach their goals in child development, family health, parent/child relationships, school readiness and more. Outcomes associated with home visiting participants include that they are more likely to be enrolled in school and more likely to be employed, are more likely to access prenatal care, have fewer CPS reports to the hotline, are less likely to need emergency medical care, are more likely to start breastfeeding and to breastfeed longer, engage in more positive parenting techniques such as reading time between parents and children compared with families that are not enrolled in home visiting. Outcomes associated with children enrolled in home visiting programs include that they have improved early language and cognitive development, have greater

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math and reading achievement in elementary school and have reduced absentee rates and suspensions, suspensions compared with children not enrolled in home visiting. Here's what can be sort of confusing about home visiting. There are 26 different evidence-based models of home visiting in use across the country with only a handful of them being implemented in Nebraska. Each model varies in the professional requirements of the home visitor, the length of service, the type of curriculum utilized and eligibility requirements. The goal is to connect a family with the best and most appropriate model to meet their needs. For example, if you are a new mother coming home from the hospital with your baby, the Durham Family Connects model may fit your needs best because it connects you with a nurse who conducts home visits with you focused on the health of you and your baby. Or if you are a family who is at risk for involvement in the child welfare system, the Healthy Families America program might be a better fit because it is more intensive with weekly visits. I've invited testifiers today from the evidence-based home visiting models which are in use in Nebraska to speak after me to give you a better understanding of how they function, who is eligible for the programs and how they're funding-- funded. Home visiting has a long history in Nebraska. In fact, if you speak with our public health departments, they were conducting home visits for new mothers decades ago, a practice that was lost in an era of budget cuts. The first legislative effort in the Unicameral was in 2007, when then Senator Gwen Howard passed a bill to allocate \$600,000 for nurse home visiting services. This line item has remained in the budget bills annually and has since increased to \$1.1 million. In 2010, the federal government created the Maternal, Infant, and Early Childhood Home Visiting Program, or MIECHV, as it's pronounced. That was authorized for five years and sent out base allocations of funding to states to increase access to home visiting services. The MIECHV program has consistently been reauthorized by the federal government due to broad bipartisan support on the federal level and is anticipated to be reauthorized again in December of this year. I've invited Sara Howard from First Five Nebraska to give the committee more insight into the MIECHV, MIECHV reauthorization and what it might mean for our state. Excuse me. In closing, home visiting programs in the state of Nebraska are doing incredibly important work for our youngest children and families. Often called the silver bullet for child abuse prevention, a robust and coordinated home visiting network in Nebraska can not only improve outcomes overall for children, but particularly for those who are at risk of court involvement. After me, you're going to hear from organizations that are implementing home visiting in Nebraska,

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including the Nebraska Children's Home, a public health department, Sixpence, Early Head Start, and the VNA. And finally, First Five Nebraska will close with some statutory options to expand home visiting. I'm going to pass out a chart of home visiting models in Nebraska.

WILLIAMS: Would you get Senator DeBoer a glass of water?

DeBOER: Thank you, Senator Williams. I'm going to pass out a chart of home visiting models in Nebraska that will help you follow along as our testifiers come up. I appreciate the committee's time and attention to this issue, and I'll be happy to try to answer any questions that you may have, though I would encourage you to ask the experts behind me, especially in light of the fact that my voice is about to go.

WILLIAMS: We'll help you with that. Are there questions for Senator DeBoer? You mentioned a senator that brought legislation earlier. I think you said it was Gwen Howard. Is she the mother or much older sister of Senator Sara Howard?

DeBOER: I believe the young aunt of Sara Howard.

WILLIAMS: A young aunt. Oh, now I understand.

DeBOER: Yes.

WILLIAMS: Seeing no questions, we will ask the first testifier for LR367 to come. Welcome.

LANA TEMPLE-PLOTZ: Hello. Thank you. Good afternoon, Senator Williams and members of the Health and Human Services Committee. My name is Lana Temple-Plotz, L-a-n-a T-e-m-p-l-e-P-l-o-t-z, and I'm the CEO of NCHS. NCHS is a statewide accredited child and family serving nonprofit with three core programs. We will actually be 130 years old next year. Our three core programs are family support, foster care and adoption. Our teams provide a range of support to caregivers of all kinds, including relat-- including relative and kin caregivers, perspective and post adoptive parents and birth parents to connect them with needed resources for healthy development and family preservation. We provide home visiting services for parents of children birth to age five in Douglas County. And I will say that home visitation, universal home visitation is one of our strategic aspirations of our plan so we are very invested in ensuring that every family in Nebraska has home visiting available to them. Parenting is

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difficult and, and stressful no matter what the circumstances of the parent. I always tell folks who ask me that no one ever has a baby, looks at that baby and says, if I could screw this up, that would be totally awesome. Everyone wants to be a good parent. And so for us, home visiting professionals provide support and education, alleviate stress and promote healthy parent/child relationships. Families get connected to home visiting services through a variety of ways, including self-referral, peer participants, maternal homes, HHS and other community referrals. During a home visit, a family resource specialist meets with parents and young children to engage them in an activity or an assessment, using a strength-based curriculum that guides each meeting to work towards goals identified by the parents. The family resource specialist is a partner for parents providing connection to items such as diapers, food pantries and housing, transportation, utility or rental assistance and mental health services. And we heard in the previous testimonies for the previous LRs how poverty is such a, a factor when it comes to being able to provide for your families and being able to provide good parenting to your kids. Our history of supporting caregivers through home visiting has evolved over time, and our passion and belief in its effectiveness has only grown. NCHS began home visiting in 2010 with our Teen and Young Parent program and then in 2013, we began offering Healthy Families America, or HFA, as a federally funded MIECHV site in Douglas County. In 2020, we further expanded our HFA programs with a child welfare adaptation team designed to provide community prevention supports for alternative response families that have come to the attention of the child and-- Children and Family Services. And this was made possible by federal Family First Prevention Services Act funding and TANF funds. We have three HFA teams and one Teen and Young Parent team of family resource specialists. Last year we served 153 participants in Douglas and Sarpy County. The programs are free to participants and voluntary, although eligibility criteria varies with the public funding sources. We use a mix of federal funds such as MIECHV, TANF and FFPSA funds and private dollars to provide our home visiting services. Each time we've had the opportunity to grow our reach in home visiting has been through increased public investment. Home visiting is a bipartisan and popular approach to promoting positive outcomes for families and it's a cost-effective prevention strategy. National research has shown a return on investment between \$1.80 and \$5.70 for every dollar spent on home visiting. These cost savings are attributed to reduced incidence of child maltreatment and child protection involvement, fewer children requiring special education or repeating grades in school and lower criminal justice

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expenses. We have prioritized advocating for expanded access to home visiting within our ten-year strategic plan because we believe in its effectiveness and potential to truly partner with families to provide the supports they need to be successful. NCHS aspires to see all parents have access to home visiting in Nebraska regardless of income or zip code, through a robust, mixed delivery approach to pregnancy, early childhood and parenting. Thank you, Senator DeBoer, for introducing this interim study and to the HHS Committee for holding this hearing. I'd be happy to answer any questions that you have.

WILLIAMS: Thank you. Are there questions? Seeing none, thank you for your testimony.

LANA TEMPLE-PLOTZ: Thank you.

WILLIAMS: Invite the next testifier.

LANA TEMPLE-PLOTZ: I was supposed to jazz you up. Did I? Did I wake you guys up at all?

WILLIAMS: At least you didn't mention Gwen Howard in your testimony. Welcome, Ms. Lopez.

PAT LOPEZ: Good afternoon, Senator Williams and committee members. I have a few comments to make. I am Pat Lopez, P-a-t L-o-p-e-z, and I'm currently the health director at Lincoln-Lancaster County Health Department and I want to share some information with you today about our Healthy Families America program that you heard a little bit about in Family Connects home visitation program that we provide. The Healthy Family in America [SIC] is the signature home visiting program of Prevent Child Abuse America and it's the nation's oldest and largest organization dedicated to the prevention of child abuse and neglect. And these services are provided to pregnant women or parents of an infant under three months with identified risk factors. And you have some in-depth information provided to you in a letter by Kim Engel, who's our director in the Panhandle, about this, but I want to give you a little information about our program. Our department began implementing the evidence-based Healthy Families America program in 2012 after a two-year pilot program. The program has been accredited since 2014 and was reaccredited in 2018, and we will go through a reaccreditation again in the spring of 2023. A few data points for consideration specific to our program in Lancaster County is that since its inception, we've provided an average of 4,400 visits per year to address the varied needs of families ranging from access to

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care to providing employment resources. An average of 87 percent of our Healthy Families America families initiate breastfeeding compared to-- and sustain compared to 85 percent in Nebraska and 83 percent in the U.S. And an average of 94.2 percent of children are connected to a medical home and 82-- 89 percent, almost 90 percent of mothers complete their postpartum visit within six weeks and 98 percent of our families have implemented safe sleep practices. And I want to just share a couple of real life examples that are not atypical of the outcomes from this program. We visited with a single mom who had no support from the birth father. The infant was placed in neonatal intensive care after birth for seizures and a possible mini stroke. Public health nurse began home visits and monitored the infant's development and the infant began to show developmental delays at the 12-month screening. The public health nurse referred the family to early intervention services at Lincoln Public Schools for an evaluation and they began receiving services. Since receiving those services, there has been an improvement in meeting all developmental milestones and no further delays. The mother is now working in a long-term care community, which has enabled her to become self-sufficient. In the next example, we worked with a new mother for the past two years, which may seem like a long time, but it really isn't in the life of our youngest community members. One of her goals was to complete college, but she let this goal go after getting pregnant because she didn't think she could achieve it. After starting in the healthy fam-- starting in Healthy Families, her home visitor helped her reenroll and start classes again. Together they found her an internship that was needed to complete her bachelor's program. I'm so excited to say that in August of this year, she graduated with her bachelor's degree in Education and Human Services [SIC] and has secured meaningful employment and is now self-sufficient and able to take care of her child. Our funding for Healthy Families America program has been and continues to be through a braided funding model which Senator DeBoer mentioned, so the MIECHV funds and then the Family First Prevention Services Act and TANF, which I know the committee is very familiar with, and we also are very fortunate to have City-County funding and our community that supports us. The second program I'd like to speak with you about today is our Family Connects home visitation model. This is a program that was developed in Dur-- from Durham. It's a new program for us. We just received funding in our current budget and that was approved by our city council and county board, and we're building that foundation for the program now. We recognize that bringing home a newborn can be a challenging time for any parent. Our Family Connects services will be

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provided regardless of geography, economic or educational status, demographics or previous number of children. It's open to all parents of a newborn. This evidence-based model, as I said, was developed in nerth-- in North Carolina, and I was one of those nurses Senator DeBoer mentioned that a long time ago-- I'll date myself-- in public health visited every parent of a newborn in my area here in Lancaster County. So I have a great passion. I'll finish quickly. These--

WILLIAMS: I think you've earned the right to finish your full testimony. [LAUGHTER]

PAT LOPEZ: I'm very cognizant of how long you've been here today. Home visits are provided by a registered nurse within the first three weeks of birth and one to three visits are provided. The families connected with these resources-- and some people will ask about why is it a nurse? Well, this is really focusing on the health of the mother and the newborn, so there will be blood pressure screening, postpartum depression screening and ensuring that women are following through with their OB provider and continue to receive the care that they may need; and the same is for the infants. You can read my testimony, but it's critical in connecting them to their healthcare provider and other services that will be needed. We'll do breastfeeding and nutrition support and we also look at the social determinants of health. And I know that you senators have heard that word and are familiar with that, often, but we know that is looking at poverty and all other kinds of areas. We were asked frequently by our city council members, sometimes, about why didn't we just focus on one segment of parents, maybe those who had the most need. And I think the critical thing is that every family, I just want to emphasize that, is vulnerable at the birth of a child. And so it's really important that we reach every new parent and we have other mechanisms that we can refer people to. So child-- we do the caregiver-child interaction assessment and coach and provide parents with supportive care and for us it really will work well because we do have MIECHV here. We have Healthy Families America. So if families need more intensive assistance, we can get that provided for them. Family Connects, as we call our program, is-- has been implemented in 17 states and over 40 communities, and that's Iowa, Illinois, Arkansas and Oklahoma, to name a few to give you a point of reference. In-- all of the 94 percent of the families in Family Connect have been reported to have received and followed up with at least one referral to community-based organization. Our other local health directors see this as a need in their areas to support positive health outcomes for mothers and infants that has a lasting impact and, and we are excited that we are

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able to offer support to all parents and newborns in our community so they have a strong start during this critical time. Thank you for your time and attention as you consider the important role home visitation has in the health outcomes of mothers and our youngest community members. Thank you.

WILLIAMS: Are there questions for Ms. Lopez? Senator Murman.

MURMAN: Yeah. Thank you for your testimony. I don't know if you were here for the earlier hearings, but we heard that the more connections that a family has with HHS or with services, the bigger the chance are the children will be removed from the family. Do you have any ideas on that?

PAT LOPEZ: You know, I, I heard some of that. I didn't hear all of it because I was at another hearing but I have to say, I have the exact same-- exact different opinion from my work, actually, in the field and working with families. What we've done is really prevent families from having that situation. And you know, I can share something that happened early on in my time. I was working with a family and there was a situation of child abuse in that family, but with the intervention with that family, they went on to be extremely successful. And I ran into the mother about five years later and she had finished her education and was a clinical social worker working with other families. So we rarely-- I mean, our goal is to keep families together and by doing this at an early point when families really need the support, Senator Murman, that's where we found that we can make the biggest difference in prevention. That's really what we're doing.

MURMAN: Thank you.

WILLIAMS: Any additional questions? Seeing none.

PAT LOPEZ: Thank you.

WILLIAMS: Thank you, Ms. Lopez.

PAT LOPEZ: I'll miss you next year.

WILLIAMS: Invite the next testifier for LR367. Good afternoon and welcome.

KAREN PINKELMAN: Good afternoon. Long afternoon for you, like all the time. So good afternoon, members of the Health and Human Services

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Committee. My name is Karen Pinkelman, that's K-a-r-e-n, Pinkelman, P-i-n-k-e-l-m-a-n. I'm the associate vice president for early childhood programs at Nebraska Children and Families Foundation. I currently work on the team providing technical assistance to prenatal through age three grantees. Through partnerships with school districts which makes us slightly unique, Sixpence serves 1,400 of Nebraska's children in both center-based care and home visitation. I'm here today to speak in support of Sixpence Parents as Teachers home visitation programs throughout the state. The first years-- the first three years of life are especially crucial moment in young children's development. During this period, the human brain creates as many as 1 million new synaptic connections per second as neural-- neural circuits-- circuitry is laid for new cognitive, social and behavioral skills. Because of this rapid brain growth, the relationships, interactions and environments that very young children experience, even in the prenatal months, can profoundly affect their lifelong trajectories for better or for worse. These experiences play a critical-- crucial role, role in determining whether children arrive at their first day of kindergarten ready to learn alongside their peers. Development, social, positive behaviors as they grow older and eventually take their place as productive members of the communities. Sixpence works with the school districts. One of the big things that Sixpence does is they have team parents within that school district so they have a higher graduation rate. They work for school counselors to ensure that they have college set up or that they have postsecondary education. And when I was listening to your question before, as far as home visitation programs, I think they really are an alternative to Child Protective Services because they're voluntary and so some of those families who need those connections and need those supports are asking for them before Child Protective Services get involved. And so it really is a preventative measure before those children get replaced and placed out of the home. The nice thing about Sixpence programs is we have community partnerships so it really connects that school district with the community members and community partnerships and all of the resources that are available. It's a big part of the Sixpence grants and the school districts have to match Sixpence funds by 100 percent. So it also educates parents about their infants' and toddlers' needs and coach them on techniques to meet those needs. Sixpence enables parents to finish their high school degree, attend college and pursue employment to best provide for their families. It helps families get economic stability and also helps them to have services, make sure they have health insurance, children having immunizations and that they are on the educational trajectory to

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have-- be ready for kindergarten. So I think-- I'd like to thank you for giving me this opportunity. If you have any questions, I sure can answer them.

WILLIAMS: Are there questions for Ms. Pinkelman? I have one.

KAREN PINKELMAN: Yes.

WILLIAMS: In your, your home visiting program with Sixpence employees, are there mandatory reporting requirements to DHHS?

KAREN PINKELMAN: Yeah. Everybody in the state is a mandatory reporter so that if there is a cause of concern, then you have to, by law, report for children.

WILLIAMS: Any additional questions? Seeing none, thank you for your testimony.

KAREN PINKELMAN: OK. Thank you.

WILLIAMS: Invite the next testifier for LR367. Good afternoon and welcome.

STEPHANIE KNUST: Good afternoon. Let me get my glasses on. Thank you for allowing me to testify today. My name is Stephanie Knust, spelled S-t-e-p-h-a-n-i-e K-n-u-s-t. I am the Nebraska Head Start state collaboration office director working within the Office of Early Childhood at the Nebraska Department of Education. My primary job responsibilities include encouraging collaboration between Head Start and other programs, services and initiatives in the state and facilitating the involvement of Head Start programs in state policies and decisions affecting families with low income. My role here today is to provide information about the federally funded Early Head Start program. Early Head Start programs provide intensive, comprehensive child development and family support services to low-income pregnant women and infants and toddlers under the age of three and their families. This is done either in center-based settings or through a home-based home visitation model, which is our focus today. Currently in Nebraska, approximately 45 percent of Early Head slots are funded for home-based home visitation services. During the 2021-22 school year, approximately 800 children and their families and nearly 140 pregnant women received home visitation services through Early Head Start. The full range of Early Head Start home-based home visitation services are provided through weekly home visits to each enrolled child and family by a certified home visitor. At a minimum, programs

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must provide one home visit per week per family that lasts at least 90 minutes, provide a minimum of 46 visits per year per family, provide a minimum of 22 group socialization activities, implement a high quality research-based curriculum for infants and toddlers that promotes measurable progress toward children's development, observe and assess children at least four times per year for progress in specific developmental domains and programs are also required to provide a research-based parenting curriculum and implement an individualized family partnership agreement process with families that involves goal setting. Additional standards and requirements exist in the areas of program governance, health and nutrition services, services for children with disabilities, transition services and others. The Department of Health and Human Services federal poverty guidelines are used to determine income eligibility for participation in Early Head Start. Children from birth to age three or pregnant women who are from families with incomes at or below 100 percent of the federal poverty guidelines are eligible for services. Children from homeless families, families receiving public assistance and foster children are also categorically eligible for the program. Federal funding for an Early Head Start program comes from the Department of Health and Human Services directly to local community entities known as grant recipients, of which there are 19 in Nebraska. The federal government funds community grant recipients at 80 percent of the total costs of program services and then there is a 20 percent nonfederal match requirement. Individual child outcomes data in several developmental domains is observed, assessed and shared with parents multiple times over the course of a program year. And in addition, each individual program analyzes and reports aggregated child outcomes data to governing bodies and federal funders. Children enrolled in Nebraska Early Head Start programs consistently make gains across every domain of child outcomes assessed including language acquisition, cognition, social emotional and physical development each year. Federal program outcomes in the areas of health, nutrition, disabilities, family well-being and family self-sufficiency are also reported annually to Congress. And during the 2021-2022 program year, 95 percent of enrolled Head Start families received at least one program service designed to promote family outcomes and 60 percent received some form of emergency crisis intervention, such as help meeting immediate needs for food, clothing and shelter. Thank you again for allowing me to provide some more information regarding the federal Early Head Start program and thank you for your willingness to support home visiting in Nebraska. I'm happy to answer any questions.

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WILLIAMS: Are there questions?

WALZ: I did have one.

WILLIAMS: Senator Walz.

WALZ: I've got to remember what it was. I'm pretty familiar with Head Start but under the model in curricula, you talked about providing a minimum of 22 group socialization activities and just that familiarity with-- like-- what's an example of that?

STEPHANIE KNUST: Well since we're implementing-- or Head Start programs are implementing a home-based model where home visitors are going into the home, they're also required to provide socializat-- socialization activities for the parents and children to come together at certain times for activities. So that's an opportunity for an activity where the parents can get together, learn something, something that they're interested in, work on some of their family goals that are in common and then parent-- parents and then children also have a chance to socialize.

WALZ: And that's within the home or outside the home?

STEPHANIE KNUST: No. It can-- well, yeah, it can be anywhere. Lots of places have them in centers or parks or other places in the community.

WALZ: OK, good. Thank you.

WILLIAMS: Any additional questions? Seeing none, thank you for your testimony. Invite the next testifier for LR367. Good afternoon and welcome.

SANDY SPICCIATI: Hello. My name is Sandy Spicciati, S-a-n-d-y S-p-i-c-c-i-a-t-i, Spicciati.

WILLIAMS: OK.

SANDY SPICCIATI: I am here representing the Visiting Nurse Association, which is entering our 126th year of serving Omaha and surrounding communities providing community health services, including home visitation services to vulnerable and under-resourced families, parents and children. Thank you, Senator DeBoer, for introducing LR367. Visiting Nurse Association supports the need to study early childhood home visitation in our state with the potential to expand home visiting services. As stated in the resolution, home visitation

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is a prevention strategy used to support pregnant moms and new parents which promotes infant and child health, fosters educational development and school readiness and prevents abuse and neglect. VNA offers four voluntary early childhood home visiting programs in the metro area. Two are evidence-based models, Healthy Families America and Nurse-Family Partnership. Two are nonevidence-based models that utilize the Growing Great Kids evidence-based curriculum: Love & Learn Teen and Young Parent Program and Project WIN. VNA in partnership with OneWorld Community Health Center provides public health nursing or family support specialist visits in the early, excuse me, in the evidence-based model Healthy Families America. The eligibility criteria for HFA is the family must live in Douglas County, be 22 years of age or older, have low income, be pregnant or parenting a child less than three months of age or have a child involved in the child welfare system under the age of two. Additionally, families must score high on the program's risk assessment to be considered eligible. Funding for this program is provided through contracts and grants from Nebraska federal MIECHV, Nebraska state general funds, TANF and private foundations. Our second evidence-based program is the Nurse-Family Partnership. This is evident-- this is VNA's evidence-based home visiting model in Pottawattamie County, Iowa. Eligible participants in this program must be experiencing their first time pregnancy and enrolled in the program prior to 28 weeks of pregnancy. The program is funded through contracts and grants from the Iowa federal MIECHV funds and private foundations. Our third program is the Love & Learn Teen and Young Parent Program. This program offers a multidisciplinary approach with a public health nurse and a parent coach assigned to every family. This program utilizes the evidence-based curriculum, Growing Great Kids, and eligibility requirements include pregnant and parenting individuals under the age of 26 who live in Douglas or Sarpy County. The Love & Learn Program is funded through contracts and grants from private foundations. Our last program is Project WIN, Welcoming Infants into Neighborhoods. This program provides public health nursing and may include a parent coach, home visiting, utilizing the evidence-based curriculum Growing Great Kids. Services are provided to pregnant or parenting individuals with a child under the age of three. Services can be extended up to age five. These services are-- families must live in Douglas and Sarpy County in Nebraska and Pottawattamie County in Iowa. This program receives funding through contracts from Early Childhood Iowa and grants from private foundations. So you might be asking, why are you offering four different home visiting programs? Well, the answer is there is no one home visiting program that is appropriate for every

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family. VNA is a very strong proponent of the evidence-based models. However, many under-resourced families facing complex issues are not eligible for this stringent criteria of evidence-based models but desire and need these critical and intensive home visiting services. For example, a four-month-old infant may be seen in the emergency department multiple times for a minor health condition or a health issue. This is the family's third child under the age of three. They are not involved in the child welfare system. The family would not be eligible for an evidence-based model but would be eligible for Project WIN program. This family would be seen by a public health nurse and depending on the county, a parent coach and-- an average of twice a month for approximately one year. The family receives health screening assessment, parent education, parent/child interaction, coaching and support for life skill development leading to a healthier family, reduced abuse and neglect, promotion of child development, school readiness and improved self-sufficiency, all utilizing the Growing Great Kids curriculum. VNA is also part of a family support referral system in Pottawattamie County, Iowa, through the Child and Family Resource Network. A collective messaging and referral process is in place for individuals and communities regarding home visiting and other family support services that span across nine counties in western Iowa. Having a streamlined system in place allows families to be referred to agencies based on their desires and needs without duplication of services. I'm not aware that Nebraska has a coordinated intake system, currently. However, I would encourage further dialog to consider implementation of such a coordinated intake process. At any given time, VNA home visiting programs can serve 270 families in Douglas, Sarpy and Pottawattamie counties. Currently, we are near capacity in all programs and we hold a waitlist for our Project WIN program. I'm here today in support of the proposal for an interim study to examine home visitation. Any questions?

WILLIAMS: Thank you, Ms. Spicciati.

SANDY SPICCIATI: Yes.

WILLIAMS: Are there questions? I have one. Since all the members of our committee that serve a legislative district and work, live and play where you work have deserted us this afternoon. What do you do in the rest of the state or are there services, and you don't do it, but are there services in the areas that we serve that are available similar to what you do?

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SANDY SPICCIATI: Absolutely. You received a map today and that highlights all the home visitation programs throughout the state. In our area, in Omaha and Council Bluffs area, if we have a referral for someone or working with a family who is moving to a different area in the state, we have connections with different home visitation programs that we can refer them to.

WILLIAMS: OK. Any additional questions? Seeing none, thank you for your testimony.

SANDY SPICCIATI: Thank you.

WILLIAMS: Invite the next testifier for LR367. As Senator Howard is coming up, I would ask are there any other testifiers following Senator Howard? If not, then don't bother to turn the lights on.

SARA HOWARD: Oh, all right, let's do it. OK. Make sure I have everything.

WILLIAMS: Welcome, Senator Howard.

SARA HOWARD: Thank you, Senator Williams. Thank you for allowing me to testify today. My name is Sara Howard, S-a-r-a H-o-w-a-r-d. I'm a policy adviser for First Five Nebraska. First Five Nebraska is a statewide public policy organization focused on promoting quality early care and learning opportunities for Nebraska's youngest children. My position at First Five is focused on the area of maternal and infant health policy because we know that healthy moms and babies are critical to ensuring the long-term success of children in our state. I'm here to testify on Senator DeBoer's interim resolution, LR367, and first, I want to thank Senator DeBoer for her interest in home visiting in the state of Nebraska. This is really exciting because it's the first time that this Legislature will have really considered home visiting. So I'm going to give you the statutory, sort of background on home visiting and then we're going to talk a little bit about the federal reauthorization bill for MIECHV. OK. So all the way back in 2007, my mom introduced a bill to-- in the Appropriations Committee to fund a nurse home visitation model. So you guys probably remember, my mom was a social worker for the state of Nebraska for 34 years. And when she started to learn about home visiting programs, she realized that people are more likely and interested to let a nurse come into their home before they would ever let a social worker come into their home because it's very likely that a social worker is going to remove your kids. And so she was able to get \$600,000 in the budget

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for nurse home visiting. Well, then when I got here, we-- I wanted to increase that amount and so I put in an appropriations bill and the state of Nebraska asked me if I would remove the nursing piece. So then the language of the appropriation actually changed to evidence-based home visiting, which kind of opened it up to all of these different types of home visiting, similar to what you've heard about today. And that allocation has since increased to \$1.1 million and it sits in the baseline budget. So all of you here have already voted for home visiting. You're welcome. And thank you for that. So remember that \$1.1 million that sits in the budget, because now I'm going to talk to you about the federal allocations under the MIECHV program. So the Maternal, Infant, and Early Childhood Home Visiting Program is a federal program that has to be reauthorized every few years, and it was actually just voted out of the House of Representatives this morning, which is really exciting. The entire Nebraska delegation voted for it and Representative Smith actually co-sponsored it, which is really exciting. MIECHV is structured in a little bit of a different way than most of our federal programs in the sense that it's a baseline. The states just get a specific amount. We don't have to kick in anything. Right? You remember for Medicaid, we've got an FMAP; for SNAP, we've got to pay for some of our admin expenses; for MIECHV, we just get \$1.2 million and we just continue to get it over the course of the reauthorization for five years. With the bill that was voted on in the House this morning, we'll be getting \$1.7 million annually. That's just our base amount for home visiting, which is super duper exciting. However, that \$1.1 million that we have in the budget now becomes maintenance of effort. So we're not able to go below that \$1.1 million anymore without potentially seeing a penalty. The other piece that comes out of the new federal MIECHV bill, and this was something that Adrian Smith in particular and the conservative members of Congress were very excited about, is that there's actually the opportunity for states with a matching dollar amount; they can grow their programs and they can grow the amount that they're pulling down from the federal government for home visiting. That's at 25/75 percent. It is late on a Friday. You're not going to remember it. It is in my testimony. But for our purposes, we, if we want to grow our home visiting programs utilizing federal dollars, in 2024, we would need to find about \$250,000 in the budget in order to draw down about \$750,000 from the federal government and grow our home visiting programs. As you can see from this handout, this is our little map of MIECHV funded programs. These are only MIECHV funded programs. Your other map is programs that are home visiting programs that are funded by a variety of sources. This is only MIECHV. If you

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flip it over to the back at the top, you can see where-- how Nebraska in particular is braiding funding around home visiting. So not only are they using the federal MIECHV funding, but they're also using those state general funds, the \$1.1 (million) I told you about, and we're using those TANF rainy day funds, which I know this committee is very familiar with. So right now we're going to see increases of TANI--TANF rainy day funds and that's an allowable purpose. What you've heard from some of our testifiers is that we're also starting to use Family First Prevention Services dollars, or FFPSA dollars, to pay for home visiting and that's because now we'll be able to-- that is an allowable use of FFPSA IV-E dollars. So the question that you would ask me would be what are our statutory options in order to increase access to home visiting in the state of Nebraska? So the first one is similar-- do you-- well, you all were there-- when we were dealing with the YRTC situation, we went in and we said, well, sure, we'll just check the statutes. There's got to be a statute. And there was no statute. Right? And so all of us had to put together a statute around what a YRTC is and what our state expectations are for Youth Rehabilitation and Treatment Centers. In Nebraska, there is no statute for home visiting. We've never defined it. We've never said what our expectations are for the way that we use state dollars around home visiting. So your first step as a Legislature and your first logical step as a Legislature would be to define what home visiting is in statute and build out your own statute around home visiting. The second thing I would recommend, and this is sort of-- it goes back to Sandy's thoughts around a coordinated intake. The second thing I would recommend you do is ask DHHS to create a website where all of the evidence-based home visiting models you can access or find out where they are at-- just a website. It's all in one place. Right now if you look, you can see where the MIECHV funded programs are, but you're not able to see our Sixpence programs or VNA programs that aren't funded by MIECHV and so it makes logical sense that we would also consider having a website and that would become the base for what would look like a coordinated or centralized intake system for home visiting. The last two pieces are financial. One, if we're smart, and you guys definitely are, I would recommend taking that \$1.1 million that's currently in the budget every other year and moving that into statute so we know that we never go below our maintenance of effort. The other piece I would recommend that you consider is increasing that allocation or that amount by about \$900,000, so that over the course of this next reauthorization, we'll maximize all of the federal dollars that are available to us for home visiting. So you're looking at a fiscal note of about \$2 million. That being said, home visiting

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is, and Senator DeBoer said it best, it's really truly considered the silver bullet for child welfare. It's when a family is at risk but it's not time for a call to the hotline. Right? Maybe I have some concerns about where their next meal is coming from, maybe I'm-- I have some concerns about mom not quite knowing how to parent well or something along those lines. Home visiting is a support that you can provide to a family before they ever get a call to the hotline. It's sort of-- in other states, they call their coordinated intake for home visiting a warm line, which is, which is kind of what you would like to see. Right? It's a warm line for families and a support for families before they ever get to the urgency or the crisis level of a hotline call. So with that, I really appreciate your time and attention on a Friday afternoon to home visiting. It is a really lovely program and it's a really lovely system and opportunity that we have in our state and I'm happy to try to answer any questions you may have.

WILLIAMS: Questions for Senator Howard? Senator Walz.

WALZ: I don't really have a question, I just-- thank you for coming to testify. You are a really smart person and I think you should run for the Legislature or something. [LAUGHTER]

SARA HOWARD: They're not letting me do that anymore. They kicked me out.

WILLIAMS: Well, I do have some questions.

SARA HOWARD: Real ones.

WILLIAMS: Is-- on the additional funding, the 25/75 match, is there any cap on that?

SARA HOWARD: So it's a set amount that we are eligible for. So if we-- it kind of-- it goes up over the next four years. So it starts at two-- about \$250,000 and then we are capped out. So essentially it is.

WILLIAMS: And in your, your financial request or thoughts down here, you're-- you would be going to whatever that, that max is?

SARA HOWARD: I would get us to our max over the course of the five years.

WILLIAMS: OK. Second question, here we are, December 2, with legislative session starting in, in about a month. Do you have a plan

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to have your one, two, three and four put into a draft of legislation that you might find somebody that would introduce?

SARA HOWARD: Yes. Yes, Senator DeBoer has been working with me on that.

WILLIAMS: I've never had you answer a question with one word.

SARA HOWARD: Yes, yes. Although-- yes. Yes. Yes.

WILLIAMS: That was seven yeses. Are there any additional or final questions for Senator Howard?

SARA HOWARD: No?

WILLIAMS: Thank you for being here.

SARA HOWARD: Thank you for your time today. I really appreciate it.

WILLIAMS: Are there any additional testifiers on LR367? As Senator DeBoer is coming up then we do have, again, online comments from Nicole Barrett, Izzie [SIC] Lopez, and Jessie Dewaele. Senator DeBoer, welcome again.

DeBOER: Thank you, Senator Williams. I'm just going to take a moment. We're going to miss you next year, Senator Williams. So I just wanted to say thank you to everyone who came up to testify today, I think this was helpful, and to everyone who's been helping to educate me about this really important topic of home visiting. We address so many problems in this building that it's really hard to see how can you get at these, these big problems that we look at, at these build-- in this building? So to have something that has such a positive impact for frankly, not a terribly large amount of commitment from the state is the kind of thing that I think we always look for and never think we're going to be able to find. So I think this next session and going forward, we're really going to have to look at doing more with home visiting. I mean, it gets bipartisan support everywhere. This is a good program. It does not, as far as I know, have a substantial pushback against it. So I hope we can continue to work on home visiting in Nebraska. Thank you.

WILLIAMS: Any final questions? Seeing none, thank you, Senator DeBoer. And that will close the public hearing on LR367 and close our hearings for the day and, I believe, for the year. Right?

