

LR 513 INTERIM STUDY REPORT

NEBRASKA BEHAVIORAL HEALTH SERVICES ACT

Submitted by
Health and Human Services Committee
Michelle Chaffee, Legal Counsel

December 2010

LR 513 was an Interim Study to review implementation of the Nebraska Behavioral Health Services Act by the Division of Behavioral Health of the Department of Health and Human Services. It was introduced by Senator Tim Gay on March 29, 2010. On April 7, 2010 the Executive Board of the Nebraska Legislature referred it to the Health and Human Services Committee.

Resolution:

ONE HUNDRED FIRST LEGISLATURE, SECOND SESSION

LEGISLATIVE RESOLUTION 513

Introduced by Gay, 14.

PURPOSE: (1) The purpose of this interim study is to review and assess the implementation of the Nebraska Behavioral Health Services Act by the Division of Behavioral Health of the Department of Health and Human Services and, if appropriate, provide recommendations for legislation to strengthen the enactment of the act.

(2) The Nebraska Behavioral Health Services Act states that:

(a) The division is the chief behavioral health authority for the State of Nebraska and shall direct the administration and coordination of the public behavioral health system, including, but not limited to: (i) Administration and management of the state regional centers and any other facilities and programs operated by the division; (ii) Integration and coordination of the public behavioral health system; (iii) Comprehensive statewide planning for the provision of an appropriate array of community-based services and continuum of care; (iv) Regional budgets and audits of regional behavior health authorities; (v) Development and management of data and information systems; (vi) Prioritization and approval of all expenditures and reimbursement methodologies for behavioral health services and fees to be paid by consumers of such services; (vii) Cooperation with the department in the licensure and regulation of behavioral health professions, programs, and facilities; (viii) Cooperation with the department in the provision of behavior health services under the medical assistance program and audits of behavior health programs and services; and (ix) Promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services; and

(b) The department shall adopt and promulgate rules and regulations to carry out the act.

(3) The interim study shall be conducted by the Health and Human Services Committee of the Legislature in consultation with the Department of Health and Human Services, the Division of Behavioral Health, the state advisory committees created in sections 71-814 to 71-816, the Children's Behavioral Health Oversight Committee of the Legislature, the Legislative Performance

Audit Committee, the Behavioral Health Support Foundation, the Magellan Partnership Quality Improvement Team, the report of the Children's Behavioral Health Oversight Committee of the Legislature, and participation of other stakeholders representing state and local government, professionals, provider organizations, consumers, consumer advocates, and other parties, and information, deemed helpful to the Health and Human Services Committee.

(4) Issues to be considered by the Health and Human Services Committee for the interim study may include, but shall not be limited to:

(a) The division's completion of a strategic plan for continuing reform and transformation of the public behavior health system in accordance with the Nebraska Behavioral Health Services Act, including, but not limited to: (i) The development of an enhanced performance measurement system to gather data that is aggregated for systemwide use in planning, monitoring performance, and supporting decision-making, especially the best use of funding, including the adoption and use of standard performance measurement instruments and a consumer assessment tool specifically geared to outcomes associated with evidence-based practices; (ii) The evaluation and analysis of timely consumer access to behavioral health services and standards and adjustments to comply with service capacity and efficiencies; and (iii) Optimizing the use of available funding for behavioral health services by initiating regulatory reform to reduce redundancy, costs, and burdens in the delivery system that do not impact service delivery but achieve reduced costs; and

(b) The department's completion of the development of rules and regulations to: (i) Implement the Nebraska Behavioral Health Services Act; and (ii) Integrate state and federal regulations across and between the Division of Behavioral Health, the Division of Public Health, and the Division of Medicaid and Long-Term Care of the Department of Health and Human Services, including Medicaid rehabilitation options.

NOW, THEREFORE, BE IT RESOLVED BY THE MEMBERS OF THE ONE HUNDRED FIRST LEGISLATURE OF NEBRASKA, SECOND SESSION:

1. That the Health and Human Services Committee of the Legislature shall be designated to conduct an interim study to carry out the purposes of this resolution.

2. That the committee shall upon the conclusion of its study make a report of its findings, together with its recommendations, to the Legislative Council or Legislature.

Health and Human Services Committee members:

Senator Gay, Chair
Senator Pankonin, Vice Chair
Senator Campbell
Senator Gloor,
Senator Howard,
Senator Stuthman,
Senator Wallman

Public Hearing:

Tuesday, December 14, 2010
1:30 p.m.
Omaha Douglas Civic Center
1819 Farnam St.
Jesse Lowe Room
Omaha, NE 68183

Testifiers:

Scot Adams- Director, Department of Health and Human Services, Division of Behavioral Health (Exhibit 1)
Draft Nebraska Division of Behavioral Health Strategic Plan 2011-2015

Rhonda Hawks- Behavioral Health Support Foundation (Exhibit 2)

Monica Oss- Chief Executive Officer, Open Minds
Increasing the Value of Public Investment in Nebraska's Behavioral Health System: A Legislative Update (Exhibit 3)

Topher Hansen- Executive Director, CenterPoint; member, Nebraska Association of Behavioral Health Organizations

Jonah Deppe- Executive Director of the National Association of Mental Illness, Nebraska; member; Nebraska Association of Behavioral Health Organization (Exhibit 4)

Mary Angus, public comment

Written Testimony and Reports

J. Rock Johnson, JD- Letter (Exhibit 5)

Thomas G. McBride, M.S. - President/CEO- Letter (Exhibit 6)

Exhibit 7:

- Nebraska Behavioral Health System Strategic Planning Report; Commissioned by Behavioral Health Support Foundation; Rhonda Hawks and Ken Stinson, Principals; Prepared by Open Minds; March 15, 2010.
- Behavioral Health Oversight Commission Final Report; Approved June 22, 2009.
- Regulatory reform to Reduce Administrative Costs in the Nebraska Behavioral Health System, December, 2010.
- Specifications & Procedures to Measure System Performance & Access to Care; Designed by The Nebraska Adult Behavioral Health System Consensus Panel; Prepared for Behavioral Health Support Foundation by Open Minds; December 8, 2010

Additional Background Reports and Documentation

- Committee Report, Vol. 16, No. 3, Community-based Behavioral Health: Funds, Efficiency, and Oversight; Legislative Audit Office, April 2010
- Senator Gay and Rhonda Hawks letter to Senator John Harms
- Scope of Work Create A Regulator Reform Initiative to Reduce Administrative Costs for the Behavioral Health Support Foundation; Open Minds; June 7, 2010

Scot Adams, Director
Division of Behavioral Health
Department of Health and Human Services

LR 513 Testimony
Health and Human Services Committee
December 14, 2010

Good afternoon, my name is Scot Adams, Director, Division of Behavioral Health. Thank you for the opportunity to provide an overview on the two topics that LR 513 addresses.

First, with regard to the Chapter 206 regulations, I would note that this is a process allowed by LB 1083 (2004), to implement the Nebraska Behavioral Health Services Act (NBHSA). Work began on the revision to the current regulations in 2005.

At that time, decisions were made that while the NBHSA required many things to occur, priority was given to transitioning people from regional centers to community-based services while bringing up those community-based services. This was no insignificant task and in June 2010, the last of the mental health patients at Norfolk Regional Center were moved from the facility. Services to adults at the Hastings Regional Center had ended in April 2007.

The focus on changes to regulations began in earnest about two years ago. More than eight public meetings with various constituents were held to discuss, propose, negotiate and clarify the direction and intentions of the proposed regulations. Our intentions were to draft regulations for the Division of Behavioral Health and the Division of Medicaid and Long-Term Care in synchronicity, so at least three meetings were held with the Division of Medicaid and Long Term Care in addition to numerous meetings composed of Behavioral Health staff only. However, as the result of encouragement by the Legislative Performance Audit Committee earlier this year to get this task complete, the Division of Behavioral Health moved forward on its own..

The Division of Behavioral Health has been in close contact with regions, providers and others to ensure the necessary regulatory change and monitoring to implement LB 1083.

On October 18, 2010, the regulations were forwarded to the Attorney General's office for their review. Once that review is complete, they will be forwarded for the Governor to sign and then to the Secretary of State to be filed and become effective. With regard to the strategic planning process, the second focus of this interim study, strategic planning for the implementation of behavioral health reform has been an ongoing activity for several years. One can go to the Department's Division of Behavioral Health's web site to find a series of documents – literally scores of them – that can easily be considered strategic planning documents. About ten work groups were formed in 2004 to plan for the implementation of LB 1083. Much of this thinking remains cogent. Additionally, each regional behavioral health authority has a current strategic plan approved by the Division, and has had one since at least 2004.

Notwithstanding the presence of many strategic planning documents, the Division began planning for a singular statewide strategic plan about two years ago. Various constituent groups

provided input and opinions on what such a plan should be, including consumers, advisory committees, providers – individually and through associations – and our partners, the regional behavioral health authorities.

Today I have copies of a draft strategic plan to give to you. This plan has been in this draft form for about eight weeks now receiving comment and review by various persons, including the general public notified through a news release with a special website developed to receive these comments.

This draft will continue to draw public comment and now through this public hearing – I look forward to listening to people’s reactions today to this strategic plan and to making final adjustments to this document. For this opportunity, I thank the committee.

I would like to speak to the process by which this draft was crafted. We formed the Joint Strategic Planning Group, comprised of nine members from the mental health, gambling, substance abuse committees as well as regional behavioral health authorities and two staff from the Division of Behavioral Health. I am proud to note that seven of its nine members are persons in recovery or who live as a family member to a consumer. This occurred naturally and without prompting by me.

In addition, three national experts provided input and review of this draft: Sheryl Mead, an international voice for consumers; Dr. Tom Kirk, a former State Mental Health Commissioner from Connecticut; and, Monica Oss, the principle in Open Minds, a behavioral health-consulting group to payers and providers in BH systems.

We encouraged public participation through a survey managed by the University of Nebraska Public Policy Center receiving nearly four hundred comments, and meetings with different groups of interested parties including the committees noted above.

Given these unusual times, great flexibility in planning is necessary, and I think the plan reflects the exigencies of insurance parity, potential for healthcare reform, changes to regional center utilization and workforce deployment as well as electronic health records, the broad distances of Nebraska, and the need to begin to consider the development of community based sex offender treatment services.

Given the variety of documents, the ongoing nature of strategic planning, and the involvement of many partners now and in the future, we chose not to start from scratch with a blank sheet of paper, but rather to build on the strengths of our experience and that of Nebraska’s consumers as well as that of our other partners in Behavioral Health reform, consider the national landscape and what other states have done, and to retain the ability to be agile as a changing, turbulent environment continues to evolve.

The structure of the plan identified three major domains:

- The first are those things the Division of Behavioral Health ought to lead given its statutory authority and responsibility.

- The second are those items that the Division will work in partnership with others to attain.
- The final area is those good ideas that are unlikely to be pursued at this time due to constrictions of various resources.

There are five major strategies to implement further LB 1083: Accessibility, Quality, Effectiveness, Cost Efficiency and Accountability. Through these broad highways of activity, the Division hopes to improve behavioral health services across the state in ways envisioned by LB 1083 and its supporters. Within each of the five strategies are several more specific activities and objectives.

I think this plan offers solid ideas to give a general sense of direction that allows others to have confidence in the government's position. We anticipate and we will rely upon others' work in the implementation of this plan, some of which may be provided to you today. Further, this plan expects annual action plans to make real its goals. Together we will move forward to more fully implement the vision of LB 1083.

I would be happy to respond to questions from the committee and will remain available today for the hearing in case others' comments create questions I might helpfully respond to.

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH

DRAFT

NEBRASKA DIVISION OF
BEHAVIORAL HEALTH
STRATEGIC PLAN
2011 - 2015

Department of Health & Human Services

DHHS

N E B R A S K A



DRAFT

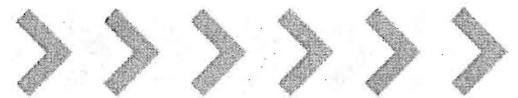
Department of Health & Human Services

DHHS

N E B R A S K A

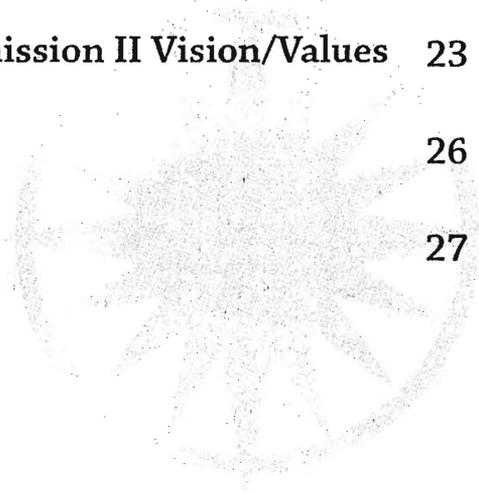
Nebraska Department of Health & Human Services
Division of Behavioral Health
301 Centennial Mall South, Lincoln, NE 68509
Ph: 402-471-3121
http://www.hhs.state.ne.us/Behavioral_Health/

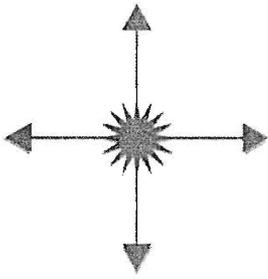
Table of Contents



Overview	1
Looking Back	2
Looking Ahead	3
Today's Division of Behavioral Health	4
Vision	6
Mission	6
Process of Development	6
The Strategic Plan	7
• <i>Strategy 1: Insist on Accessibility</i>	9
• <i>Strategy 2: Demand Quality</i>	10
• <i>Strategy 3: Require Effectiveness</i>	11
• <i>Strategy 4: Promote Cost Efficiency</i>	13
• <i>Strategy 5: Create Accountable Relationships</i>	14
• <i>Afterword</i>	16
• <i>Glossary of Terms</i>	16
Appendix A: History of Nebraska's Behavioral Health Services	17
Appendix B: Behavioral Health Oversight Commission II Vision/Values	23
Appendix C: National Outcome Measures	26
Appendix D: Acknowledgements	27

DRAFT





HELPING PEOPLE LIVE BETTER LIVES

Overview

Behavioral Health in Nebraska includes three distinct service areas: Mental Health, Substance Abuse and Problem Gambling. The publicly funded system is only one part of the overall behavioral healthcare system in Nebraska. Private funding sources such as insurance companies, private businesses, and individuals themselves also influence the way behavioral health services are provided in the state. Publically funded services are administered by many different agencies including three different Divisions within the Nebraska Department of Health and Human Services: the Division of Behavioral Health; the Division of Medicaid and Long-Term Care; and the Division of Children and Family Services. In addition, other state and federal agencies (for example, State Protection through the Nebraska Supreme Court, the Nebraska Department of Correctional Services, Nebraska Department of Education and the Veterans Administration) and local support

behavioral health services for specific populations. Partnerships and collaboration among these public and private systems as well as with individuals, families, agencies and communities are important components in systems of care surrounding each person.

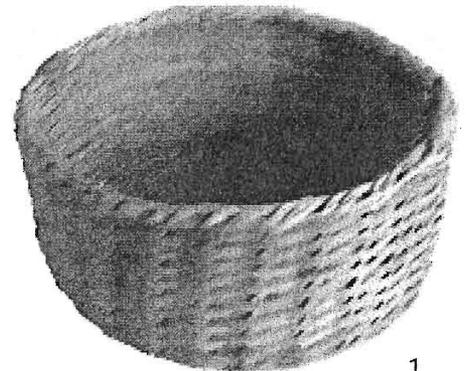
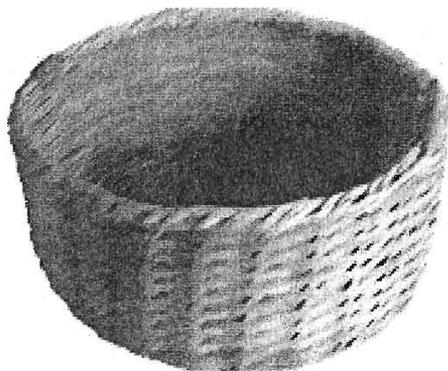
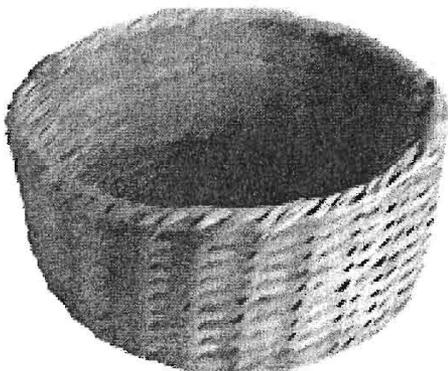
The role of the Division of Behavioral Health in Nebraska's public behavioral health system as defined by Nebraska statute (71-806) is to provide leadership in the administration, integration and coordination of the public behavioral health system. The Division carries out this role by taking the lead, collaborating with partners and participating in the overall healthcare system as a stakeholder. This can be illustrated by envisioning three baskets – each filled with responsibilities for ensuring quality services are available in Nebraska for children, adults and families when they are needed. The first basket represents the activities and responsibilities for which the

DIVISION OF BEHAVIORAL HEALTH ROLES

LEADER

PARTNER

STAKEHOLDER



THE JOURNEY

Division of Behavioral Health takes the lead and assumes primary responsibility. The second basket represents behavioral health activities that require active partnership and shared responsibility with the Division of Behavioral Health. The third basket represents the overall behavioral and health care systems (public and private) in which the Division has an interest and stake in as a partner, but may not have as active a role in carrying out activities or responsibilities. This planning document addresses the Division's role in the first two "baskets" and intends to suggest areas of focus for leaders of activities in the third basket.

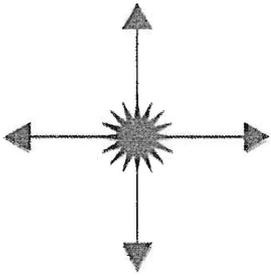
National healthcare reform, mental health parity laws, economic challenges and restricted state resources provide the backdrop for this plan. This uncertainty is tempered by the Division's desire to be in the best position possible to take advantage of national change, leading the way in care for Nebraskans while controlling cost of care. This plan is intended to be highly adaptable while we jointly work our way through these changes as a state and as a nation. The strategic framework suggested in this plan positions the Division of Behavioral Health to flexibly respond to proposed changes in the nation's healthcare system while moving forward with improvement of Nebraska's public behavioral health



system.

Looking back

Nebraska's public behavioral health system began in 1870 with the creation of the Nebraska Asylum for the Insane in Lincoln. Additional institutions were added in 1885 (Norfolk) and 1887 (Hastings). It wasn't until 1946 that the Legislature made it possible to receive care on a voluntary basis at these state facilities. This institutional system was administered by a Board that evolved into the Department of Public Institutions, overseeing 13 Nebraska institutions beginning in 1962. In that same year the three state hospital names were changed to Regional Hospitals. Two divisions were eventually established within the Department of Public Institutions to address Alcoholism (in 1967) and Community Mental Health (1973). Regional Behavioral Health Authorities were created in 1974 to coordinate the delivery of mental health services locally. Two years later, the responsibility for coordination and delivery of substance abuse services was added to their responsibilities. The Gamblers Assistance Program wasn't formed until 1992 and wasn't placed in the Department of Public Institutions until 1995. Soon after, in 1996, the Nebraska Partnership for Health and Human Services Act combined and reorganized several departments into the three agencies forming what is now known as the Department of Health and Human Services. Subsequent legislative actions over the last decade have accelerated the process of change in the way Nebraska's public behavioral health system functions (for a more complete history see Appendix A).



HELPING PEOPLE LIVE BETTER LIVES

Many positive changes have been made in Nebraska's public behavioral health system as a result of legislative reform efforts in the last 10 years.

- » More than 32 new community-based Behavioral Health services have been developed by providers in collaboration with the Regional Behavioral Health Authorities since 2004.
- » More than \$30 million has been shifted from regional center operations to community-based services. In addition to new services, capital improvements, training, and other infrastructure needs were addressed.
- » Adult behavioral health inpatient, residential, outpatient, and other services were closed at regional centers in Norfolk and Hastings.
- » Services at Lincoln Regional Center were realigned to reflect its changing role within a community-based system of care.
- » The Nebraska Family Helpline, Family Navigators, and the Nebraska Network of Care website emerged as uniform statewide resources to access community-based care.
- » Housing support services were funded and developed across the state.
- » Significant expansion of gambling prevention, education and treatment services occurred as a result of new legislation.
- » \$14 million in new treatment services for sex offenders accompanied substantial revision to Nebraska's approach to sex offender management.
- » Consumer-oriented focus and training continued to develop annually to increase consumer involvement at all levels of Behavioral Health reform across Nebraska.
- » Consumer Specialists are now employed in every region and by scores of providers.

- » PREVENTION WORKS
- » TREATMENT IS EFFECTIVE
- » PEOPLE RECOVER

<http://www.samhsa.gov>

Looking Ahead

The evolution of Nebraska's public behavioral health system is now intertwined with rapid changes in national health care and in our national and state economy. There are also other initiatives underway across the nation that will ultimately influence state funding and reporting requirements. For example, the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) is drafting its own strategic plan at the time of this writing, which will influence requirements for federal block grants now used to fund many of the Nebraska's behavioral health services. (For more information about SAMHSA's proposed strategic initiatives: <http://www.samhsa.gov/about/strategy.aspx>).

Trends toward leveraging technology for use in service delivery (for example, using secure internet or video in service delivery), electronic health records and service tracking, and other innovations we cannot yet envision will also influence the way we deliver care in the future.

The role of public behavioral healthcare will undoubtedly change as decisions are made about national healthcare. The Division of Behavioral Health believes healthcare discussions and

THE JOURNEY

legislation must include behavioral health. As the health care landscape evolves, the role of Federally Qualified Health Centers in the delivery of integrated health/behavioral healthcare is anticipated to increase. The Division of Behavioral Health, in its role as the single state authority for behavioral health, hopes to partner more fully with these Centers over the next five years. Currently the Division of Behavioral Health funds services that are not covered by Medicaid (such as working with sex offenders) and services that make recovery possible, for example Peer Support Services, Respite Care and Support Groups.

The philosophies guiding how care is provided for persons with behavioral health problems are also evolving. The Division of Behavioral Health embraces the philosophical underpinnings of “person-centered and self-directed” approaches to care in recovery-oriented systems to guide work over the next 3-5 years. This philosophy serves as a litmus test against which the implementation of technology and services will be assessed. This places the person and their networks of support at the center by setting up transparent service mechanisms that value collaboration between provider and consumer. Person-centered care promotes resilience and recovery for individuals and families. This philosophy reflects the values espoused by the members of the Nebraska Behavioral Health Oversight Commission II by emphasizing individualization, respect, hope, and personal responsibility (see Appendix B). Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities as they take responsibility for their sustained health, wellness and recovery.

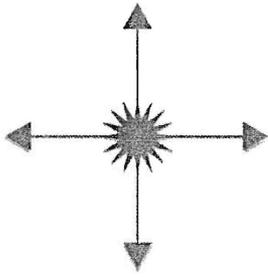
Today’s Division of Behavioral Health

The Division of Behavioral Health is designated by Federal Law as the state’s single authority for mental health and substance abuse issues which places responsibility with the Division to coordinate, not control, public behavioral healthcare. About 75% of the \$165 million in public funds administered through the Division are dispersed to six regional behavioral health authorities to support programs and services (commonly referred to as “regions” or “regional networks”). Gambling funds are contracted directly from the Division of Behavioral Health to a statewide preferred provider network. The Division is also responsible for administering the State’s Inpatient Psychiatric Services on three campuses in Lincoln, Hastings and Norfolk. Today’s State regional centers are responsible for, in order of priority: 1) judicial confinements of mentally ill individuals, 2) public safety and the management of sex offenders, and 3) the treatment of involuntarily committed individuals who can’t be safely cared for in the community.

The Division of Behavioral Health carries out its responsibilities by taking the lead, serving as a partner and advocating for overall improvement of Nebraska’s behavioral health system for children, adults and families. The Division is charged by statute to administer the state hospitals and publicly funded community-based behavioral health services¹. Nebraska statutes also include specific leadership and partnership responsibilities that guide organizational priorities for the Division of Behavioral Health².

Leadership Responsibilities

- » Administration and management of the Division, Regional Centers, and other facilities and programs operated by the Division.



HELPING PEOPLE LIVE BETTER LIVES

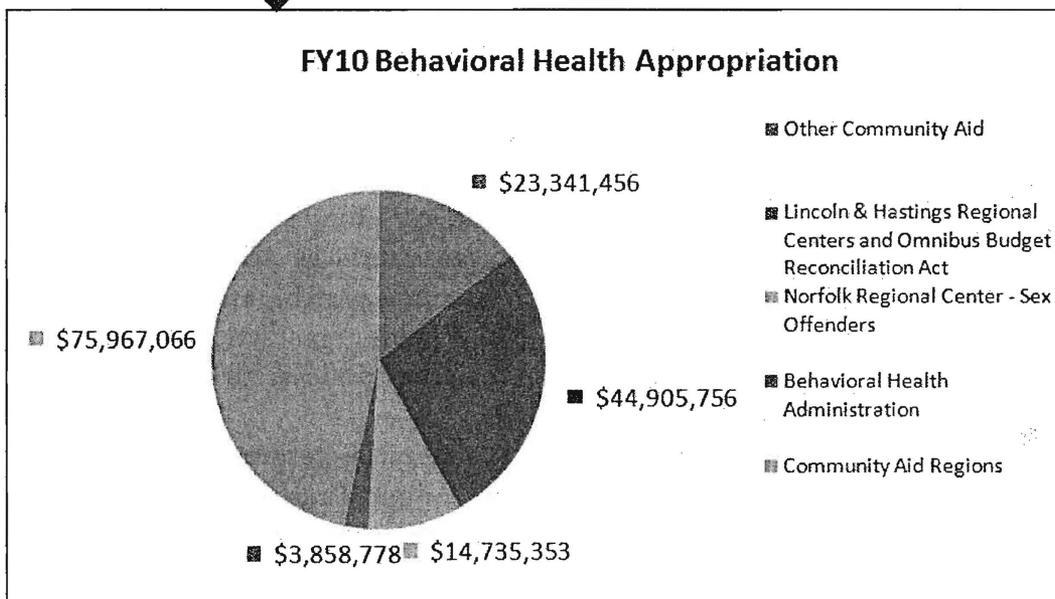
- » Integration and coordination of the public behavioral health system.
- » Comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care.
- » Coordination and oversight of regional behavioral health authorities.
- » Development and management of data and information systems.
- » Audits of behavioral health programs and services.
- » Prioritization and approval of all expenditures of funds received and administered by the division, including the establishment of rates, reimbursement methodologies and fees.
- » Creation and promulgation of rules and regulations to carry out the Nebraska Behavioral Health Services Act.
- » Cooperation with the Department in the provision of behavioral health services under the medical assistance program.
- » Promotion of activities in research and education to improve the quality of behavioral health services; recruitment and retention of behavioral health professionals; and access to behavioral health programs and services.

¹ 2007, LB296

² § 47-126. Source: Laws 2004, LB 1083; Laws 2006, LB 1248; Laws 2007, LB296.

Partnership Responsibilities

- » Cooperation with other divisions within the Department in the licensure and regulation of





VISION – DIVISION OF BEHAVIORAL HEALTH*

The Nebraska public behavioral health system promotes wellness, recovery, resilience and self determination in a coordinated, accessible consumer and family-driven system.

**The Vision was developed by the BHOC-II for the public behavioral health system. The full document is available at http://www.hhs.state.ne.us/Behavioral_Health/BHOCCommission*

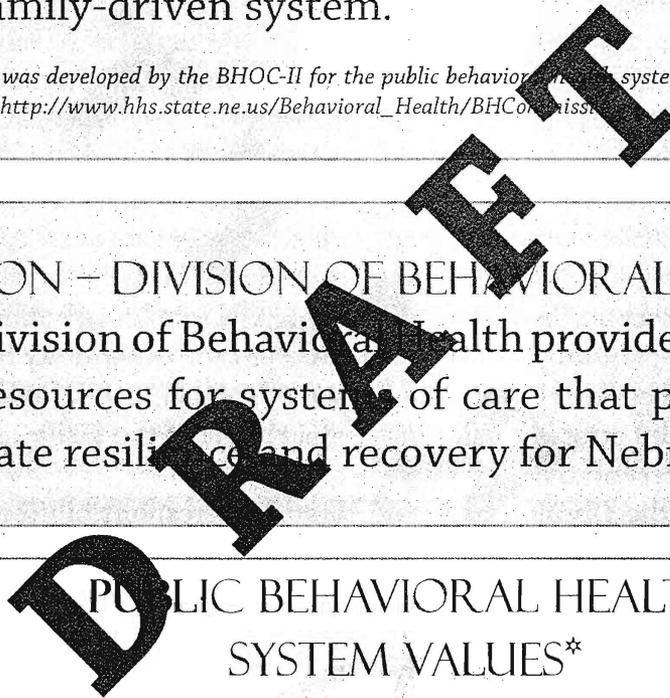
MISSION – DIVISION OF BEHAVIORAL HEALTH

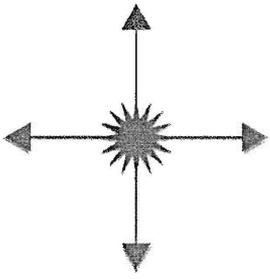
The Division of Behavioral Health provides leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

PUBLIC BEHAVIORAL HEALTH
SYSTEM VALUES*

- » SELF DIRECTION
- » INDIVIDUALIZED AND PERSON-CENTERED
- » EMPOWERMENT
- » HOLISTIC
- » NON-LINEAR
- » STRENGTHS-BASED
- » PEER SUPPORT
- » RESPECT
- » RESPONSIBILITY
- » HOPE

**See Appendix B for descriptions of these values developed by the Nebraska Behavioral Health Oversight Commission II.*





HELPING PEOPLE LIVE BETTER LIVES

Process of Development

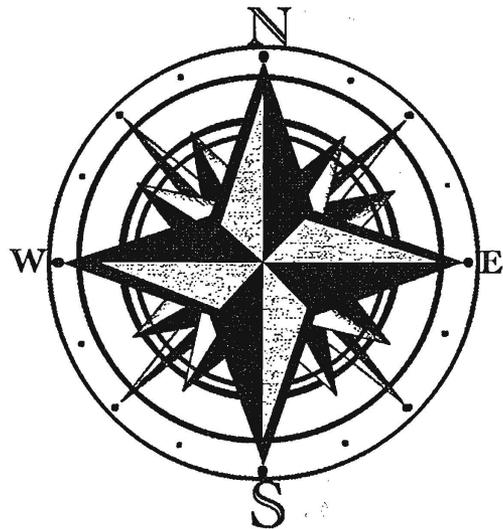
Nebraskans have engaged in a number of past planning initiatives related to behavioral health, both in the public and private sectors. The construction of this plan was based on review of many of these documents, including the work done by the legislatively formed Behavioral Health Oversight Commissions (LB 1083 [2004]; LB 928 [2008]), and a public/private consensus group currently meeting in Omaha. A complete list of planning documents influencing this plan is available at <http://www.bhstrategicplanning.nebraska.edu>. The tasks of incorporating consumer viewpoints, reviewing prior planning documents and suggesting key areas of focus for this planning document were given to a joint strategic planning workgroup made up of representatives from the three Committees guiding the Division of Behavioral Health, Substance Abuse, and Problem Gambling), Behavioral Health Region, and the Division of Behavioral Health. A list of people participating in this workgroup is attached in appendix D. The work of this group was augmented by consultation with national experts in behavioral health and opportunities for public review and comment. The process was facilitated by the University of Nebraska Public Policy Center.

Hundreds of Nebraskans participated in the development of recommendations in the planning documents and initiatives that were reviewed by the joint strategic planning workgroup. Many of the recommendations evolved from a great deal of dedication and hard work by stakeholders directly impacted by the public behavioral health system.

The Strategic Plan

This strategic plan builds on work begun by the Nebraska Legislature and Behavioral Health Oversight Commissions I and II by setting goals for the Division of Behavioral Health that contribute to the development of recovery-oriented systems of care that are community-based and include prevention, intervention, clinical and recovery supports. The strategies chosen by the Division of Behavioral Health set the stage for development of objectives that are specific, measurable, attainable, realistic and timely for mental health, substance abuse and problem gambling. The objectives will be consistent for community based services, inpatient services, and prevention activities, but all of them must support the Vision.

Statutory responsibilities and results from past and current planning initiatives led to four goals and five key strategies to move the Division of Behavioral Health toward realizing the vision put forth by members of the Behavioral Health Oversight Commission II.



THE STRATEGIC PLAN

2011-2015 GOALS:

1. The public behavioral health workforce will be able to deliver effective prevention and treatment in recovery-oriented systems of care for people with co-occurring disorders by 2015.
2. The Division of Behavioral Health will use financing mechanisms which support innovative service content, technology and delivery structures (e.g., telehealth; in-home acute services; Peer Support Services) by 2014.
3. Regional Centers will only be used for court ordered and sex offender care by 2014.
4. An effective system to safely manage sex offenders in outpatient settings will be ready for implementation by 2015.

THE DIVISION WILL:

- » INSIST ON ACCESSIBILITY
- » DEMAND QUALITY
- » REQUIRE EFFECTIVENESS
- » PROMOTE COST EFFICIENCY
- » CREATE ACCOUNTABLE RELATIONSHIPS

Strategies for realizing the vision, meeting the mission and achieving the Division's goals center on Accessibility, Quality, Effectiveness, Cost Efficiency and Accountability. These strategies serve as a way to structure the actions and activities funded or directed by the Division of Behavioral Health.

Each strategy is presented with three parts.

» The first relates to the role of the Division of Behavioral Health as a *leader* in the public behavioral health system.

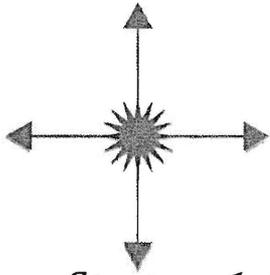
» The second suggests key *partnerships* the Division should focus on as part of the strategy.

The third suggests broad *outcome measures*.

More precise, specific measurements will be developed in the first year following the adoption of this plan. Appendix C contains examples of National Outcome Measures (NOMS) that the Division of Behavioral Health regularly collects and reports now. Additional development of key "dashboard"³ indicators will allow progress to be monitored over time as the public behavioral health system moves toward system improvement.

³ Funding for the Consensus Panel developing the "dashboard" is through the Hawks Foundation; Paid facilitators for the panel are provided by Open Minds Inc © 2010.





HELPING PEOPLE LIVE BETTER LIVES

Strategy 1: Insist on Accessibility

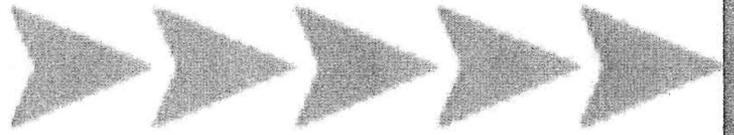
Access to publicly funded behavioral health services is influenced in Nebraska by geography, workforce limits, culture and language barriers, organizational barriers and cost. Accessibility is more than offering a service – it is creating an environment that allows people to make a choice to move into and out of the effective services that are close to home.

Strategy: Increase access to appropriate and effective integrated behavioral health services, particularly for underserved or vulnerable populations.

<p>Leadership Initiatives:</p> <ol style="list-style-type: none">1. Lead the development and implementation of standards for service access related to factors such as geography, linguistics, culture, transportation, availability of behavioral and primary healthcare services, and cost.2. Promote public awareness of behavioral health as a vital part of overall health and well-being.	<p>Broad Outcome Measurement Areas</p> <p><i>Leadership Initiative #1:</i> Publication and implementation of standards for access for each area (mental health, substance abuse, problem gambling) and each service.</p> <p><i>Partnership Initiative #2:</i> The Division of Behavioral Health will work with the Division of Public Health to identify measures to assess the impact of public education.</p>
<p>Partnership Initiatives:</p> <ol style="list-style-type: none">1. Partner with Regional Behavioral Health Authorities to assure full and comprehensive needs assessment is complete as a baseline for accountability.2. Partner with the criminal and juvenile justice system to ensure prompt access to well designed, supported and effective behavioral health services for individuals and families.3. Partner with stakeholders and the Office of Consumer Affairs to ensure access to appropriate housing, education and employment for persons with multiple needs.4. Partner with the Division of Public Health and Federally Qualified Health Centers to ensure behavioral health populations have access to primary health care services.5. Create recovery oriented systems of care.	

Measuring the success of strategies aimed at increasing accessibility to behavioral healthcare starts with identifying how accessible or inaccessible care is. Methods for computing and reporting measures of consumer satisfaction with accessibility, access/penetration measurements and service utilization data will be identified.

THE STRATEGIC PLAN



Strategy 2: Demand Quality

Recovery-oriented systems of care encourage quality services and positive outcomes. Quality behavioral healthcare requires development of workforce skills to ensure person-centered care is consistently delivered. Quality is continually monitored so improvements can be swiftly incorporated by providers and administrators in partnership with consumers and their networks of support.

Strategy: Improve the quality of public behavioral health services for children and adults.

Leadership Initiatives:

1. Implement a quality improvement system measuring outcomes and system performance based on the National Outcome Measures, the Institute of Medicine quality domains and other nationally recognized behavioral health measures.
2. Implement a workforce development plan to ensure public behavioral health professionals have exemplary skills.
3. Convene a team to review the impact of a changing health care environment on the public behavioral health system with an eye toward integration, innovation and improvement.

Broad Outcome Measurement Areas

Leadership Initiative #1: Demonstration of the system's ability to monitor and evaluate quality on an ongoing basis via transparent reporting.

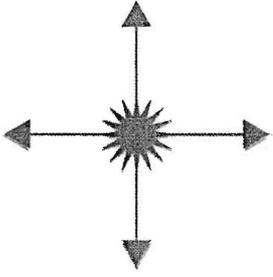
Leadership Initiative #2: Publication and implementation of a dynamic workforce development plan for each level of behavioral health professional including Peer Support Professionals.

Leadership Initiative #3: Development of recommendations by the proposed team.

Partnership Initiatives:

1. Partner with state agencies, Nebraska higher education, and other stakeholders to improve data collection, data analysis, and evaluation capacity.
2. Partner with people who have lived experience via the Office of Consumer Affairs to identify measurable, meaningful quality indicators.
3. Partner with the Divisions of Medicaid and Long-Term Care and Public Health to improve overall health of behavioral health service consumers.
4. Partner with stakeholders to identify the staffing, technology infrastructure and analytical skill sets needed within the Division of Behavioral Health to carry out quality monitoring functions.

Additional quality measures may include behavioral health measures in the individual state system performance and agency scorecards of the Commonwealth Fund and the National Center for Quality Assurance's HEDIS measures for clinical care and recovery dimensions. Data from consumers of service related to satisfaction with services and their connections with meaningful activities like school or work must also be considered at all levels.



HELPING PEOPLE LIVE BETTER LIVES

Strategy 3: Require Effectiveness

Effectiveness in behavioral healthcare includes implementation of practices that show the most evidence for achieving positive outcomes. Effectiveness requires sound data collection and monitoring practices that support consumers of service or their providers.

Strategy: Improve outcomes for children and adults through the use of effective services.

Leadership Initiatives:

1. Lead a continuous quality improvement process for services funded by the Division of Behavioral Health, focusing on clinical supervision, peer support, co-occurring mental health and addiction services, gender, trauma and cultural competency.
2. Develop standards for services based on results of the quality improvement process, focus and on other empirically supported approaches.
3. Implement processes to ensure fidelity to empirically supported approaches.
4. List and monitor promising and innovative practices.
5. Increase the number and type of empirically supported services and practices that work for Nebraskans.
6. Eliminate Division of Behavioral Health funded activities and practices that are not supported as effective.

Broad Outcome Measurement Areas

Leadership Initiative #1: Implementation of quality improvement approaches for each area of focus.

Leadership Initiative #2: Publication of standards for each Division of Behavioral Health funded behavioral health service.

Leadership Initiative #3: Publication and implementation of fidelity standards and protocols for monitoring them that are agreed upon by consumers, providers and payors.

Leadership Initiative #4: Clear mechanism for registering and monitoring promising practices in Nebraska.

Leadership Initiative #5: Financing and tracking mechanisms in place to gauge number, type and outcomes associated with practices in mental health, substance abuse and problem gambling.

Leadership Initiative #6: Adoption of a protocol for assessing effectiveness.

A number of National Outcome Measures are tied to measuring effectiveness (See Appendix C). For example, effective services keep people out of the criminal justice system, in stable housing and in school or work. Additionally, the Division of Behavioral Health is interested in measuring the effectiveness of public safety driven services like court ordered and sex offender care.

THE STRATEGIC PLAN

Strategy 3: Require Effectiveness (con't)

Partnership Initiatives:

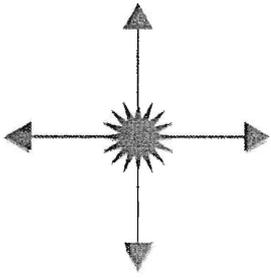
1. Partner with public health on implementing effective behavioral health prevention and early intervention using the strategic prevention framework.
2. Partner with national and state experts to ensure consumers, their networks of support, providers and administrators have access to the latest knowledge on empirically supported approaches.
3. Partner with Regional Behavioral Health Authorities to identify and implement continuous quality improvement approaches.
4. Partner with Regions, providers and people with lived experience through the Office of Consumer Affairs to identify and document promising and innovative practices that are linked to increasing effectiveness.
5. Partner with the Division of Public Health and Division of Medicaid and Long-Term Care to further the principles of recovery oriented systems of care.

What is the difference between a practice that is *evidence-based* and one that is *empirically-based*?

Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation are “Evidence-based.” The phrase “empirically-based” is used in this plan to encompass practices that have an evolving body of research or data to support their use, but not enough rigorous scientific testing to make it evidence-based. This stands in contrast to approaches that are based on tradition, convention, belief or anecdotal evidence.

What is *Fidelity*?

Fidelity of implementation occurs when implementers of a research-based program or intervention (e.g., teachers, clinicians, counselors) closely follow or adhere to the protocols and techniques that are defined as part of the intervention. For example, for a school-based prevention curriculum, fidelity could involve using the program for the proper grade levels and age groups, following the developer’s recommendations for the number of sessions per week, sequencing multiple program components correctly, and conducting assessments and evaluations using the recommended or provided tools.



HELPING PEOPLE LIVE BETTER LIVES

Strategy 4: Promote Cost Efficiency

Future resource availability is uncertain and changing. Balancing available funding, partnerships and other community based and network resources with flexibility and efficiency will promote cost-efficient practices in behavioral healthcare.

Strategy: Develop flexible and balanced funding to support an efficient and accountable person-centered, recovery oriented system of services.

Leadership Initiatives:

1. Develop and implement performance based and recovery oriented contracting.
2. Build the capacity for cost-benefit and cost-effectiveness studies within the quality improvement systems of the Division of Behavioral Health.

Broad Outcome Measurement Areas

Leadership Initiative #1: Publish cost benefit opportunities related to possible contracting mechanisms.

Leadership Initiative #2: Infrastructure in place in the Division of Behavioral Health to efficiently collect and report cost data resulting in timely reports related to financing mechanisms and tracking of person-centered cost data.

Partnership Initiatives:

1. Partner with state agencies to achieve a balanced level of state and federal funding for behavioral health care.
2. Partner with stakeholders to ensure the behavioral health needs of Nebraskans are addressed in a community based and changing healthcare environment.
3. Partner with the Division of Public Health to produce a single, integrated behavioral health professional credential that recognizes professional specialties in Substance Abuse, Mental Health, Problem Gambling and treatment of complex problems like sex offender care.

Measurements to gauge improvement in cost benefit and improvement in cost effectiveness will be identified and regularly tracked by service and by person.



Strategy 5: Create Accountable Relationships

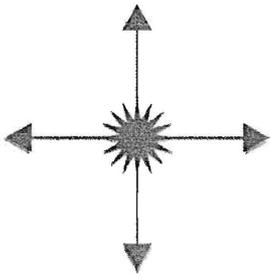
The construct of accountability in relationships is essential to development of recovery-oriented systems of care. Accountability maximizes the full potential of our limited resources and in working to gain lifelong partners to support the recovery community. It is an important dynamic beyond outcomes, because it is the ultimate link to outcomes. The Division of Behavioral Health is committed to creating a culture of accountability and collaboration in all of its relationships.

Strategy: Encourage transparent, accountable relationships with and among system stakeholders.

<p>Leadership Initiatives:</p> <ol style="list-style-type: none">1. Develop measures of accountability in the Division of Behavioral Health relationships with other state agencies and organizational stakeholders.2. Develop measures of accountability within the Division of Behavioral Health.3. Ensure relationship expectations of constituents are met by the public behavioral health workforce.	<p>Broad Outcome Measurement Areas</p> <p><i>Leadership Initiatives #1 & #2:</i> Publication of agreed upon measures of accountability.</p> <p><i>Leadership Initiative #3:</i> Identification and implementation of measurement related to constituent perceptions of the public behavioral health workforce.</p>
--	---

<p>Partnership Initiatives:</p> <ol style="list-style-type: none">1. Encourage colleague divisions and agencies to provide people in recovery access to necessary supports.2. Partner with stakeholders outside of the Department of Health and Human Services to support people with multiple behavioral health needs.3. Partner with people who have lived experience through the Office of Consumer Affairs and providers of service through the Regional Behavioral Health Authorities to use all available tools, strengths and resources as a way to maximize personal responsibility in recovery oriented systems of care.
--

System-level measures include things like improvement in social networks, resilience and support capacity. It also includes improvement in variables like trust and positive community regard.



HELPING PEOPLE LIVE BETTER LIVES

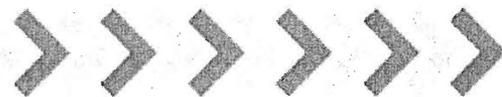
Although this strategic plan focuses on the roles of the Division of Behavioral Health as a leader and key partner in the public behavioral health system, the importance of behavioral health access, quality, effectiveness, cost efficiency and accountability extends beyond the public system. The third “basket” represents the larger health care system and the role of the Division of Behavioral Health as a stakeholder in that system. The Division of Behavioral Health has a particular interest, or stake, in ensuring that individuals with multiple behavioral health needs have access to appropriate services as healthcare changes.

Together, we can all work toward a healthier Nebraska by:

- » Working toward development of a health care system where behavioral health needs are considered as vital and important as physical health needs.

- » Promoting consistent standards for data collection and quality improvement across all behavioral health and healthcare systems.
- » Incorporating empirically supported practices in broader healthcare efforts.
- » Examining Nebraska’s public behavioral health system in the context of health care changes, including integration with primary healthcare and movement toward at-risk contracting.
- » Encouraging an atmosphere of relationship accountability and social responsibility among behavioral health providers.
- » Assisting communities and networks of support to create accountable relationships that do not look to government to replace familial or personally chosen supports.
- » Upgrading workforce and program philosophies to fully understand and integrate care for people with multiple needs (health and behavioral health).

DRAFT



THE STRATEGIC PLAN

Afterword

Behavioral health means many things to many people. What most people agree upon, though, is that behavioral health is essential to the health of any individual.

The Division of Behavioral Health reviewed thousands of comments, documents, ideas, and concerns from across Nebraska and the nation concerning behavioral health, most from those who have interest in the topic because of painful personal experiences. In the end we propose this plan to encourage sound behavioral health practices for all, to provide treatment when necessary, and to celebrate recovery when achieved.

I wish to thank the many individuals who have made this plan possible, and whose lives have demonstrated the reality that recovery is real. The Division of Behavioral Health dedicates itself to implementing the ideas and goals of this plan with our partners to improve the possibility of recovery for all Nebraskans.

Scot L. Adams, Ph.D.
Director, Division of Behavioral Health
December, 2010

Glossary

Behavioral health – This includes Mental Health, Substance Abuse, and Problem Gambling.

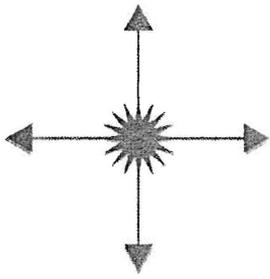
Community-based care – This refers to care provided in the community, not at a State Regional Center (LB1083/2004).

Empirically supported practice – Services and supports that have been shown by research to be effective, sometimes called evidenced based or evidence-informed practices.

Person-centered care - Services and supports designed around the needs, preferences and strengths of individuals.

Recovery-oriented system of care (ROSC) – A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life.

Self-directed approach – Approach to care that encourages and supports individuals in exercising the greatest level of choice possible over their service and support options and taking responsibility for their recovery.



HELPING PEOPLE LIVE BETTER LIVES

A History of Nebraska's Behavioral Health System

1867: Nebraska achieved statehood and thus began the creation of state provided provisions.

1870: The Legislature created the Nebraska Asylum for the Insane in Lincoln.

1885: The Legislature created the Insane Asylum in Norfolk.

1887: The Legislature created the Asylum for the Incurably Insane at Ingleside (Hastings).

1920:

- » A constitutional amendment changed the name of the Board of Commissioners of State Institutions to the Board of Control.
- » The names of the three Insane Asylums were changed to the Lincoln State Hospital, Hastings State Hospital and Norfolk State Hospital.

1946:

- » The Legislature changed the name of the Boards of Insanity to Boards of Mental Health.
- » The Legislature passed a Voluntary Admissions Law, allowing persons needing psychiatric treatment to voluntarily enter a state hospital without being committed.

1947: The Legislature created the Nebraska Psychiatric Institute as an alternative to a fourth state hospital.

1961: The name of the Board of Control was changed to the Department of Public Institutions. This department was given control of 13 Nebraska institutions. The department began operating on

Jan. 1, 1962.

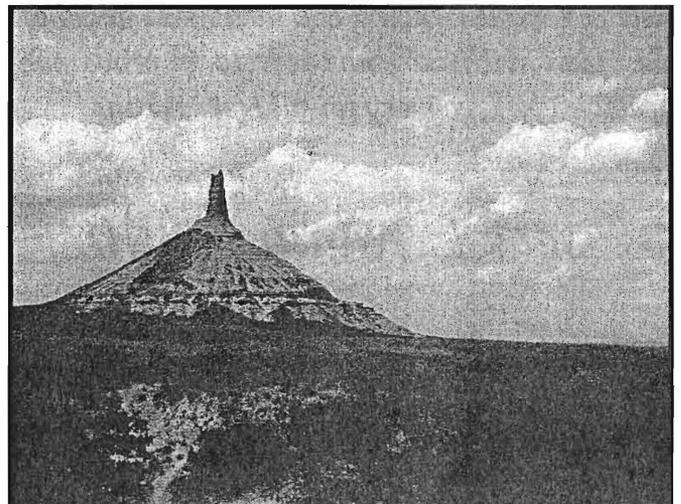
1962: The names of the three state hospitals were changed to Lincoln Regional Center, Hastings Regional Center and Norfolk Regional Center.

1967: The Legislature created the Division of Alcoholism in the Department of Public Institutions. The governor appointed the director of the division.

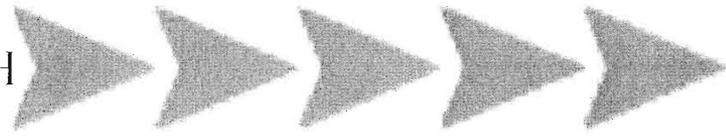
1973: The director of the Department of Public Institutions established the Community Mental Health Division.

1974: Regions are established to develop and coordinate mental health services.

1975: The Nebraska Psychiatric Institute was transferred from dual operation by the University of Nebraska Medical Center and the Department of Public Institutions to sole operation by UNMC.



APPENDIX A: HISTORY OF NEBRASKA'S BEHAVIORAL HEALTH SERVICES



1976: Regions are charged with developing and coordinating substance abuse services.

1988: No longer possible to hold a person with a mental illness in a jail if no crime had been committed.

1991: First Consumer Liaison is hired.

1992: The Gambler's Assistance Program (GAP) was formed as part of the Nebraska Lottery Act, administered by the Department of Revenue. The Nebraska Advisory Commission on Compulsive Gambling was created.

1994: The Office of Consumer Affairs hosts its first Statewide Consumer Conference.

1995: Administration of the Gambler's Assistance Program was transferred from the Department of Revenue to the Division of Alcoholism, Drug Abuse and Addiction Services in the Department of Public Institutions.

1996: The Nebraska Partnership for Health and Human Services Act combined the Departments of Health, Aging, Social Services, and Public Institutions and the Office of Juvenile Services and reorganized them into three Departments: HHS Finance and Support, HHS Regulation and Licensure, and Health and Human Services. These three state agencies formed the Nebraska Health and Human Services System.

1997: The Health and Human Services System was implemented on January 1.

1998: A Legislative Task Force examined delivery and financing of services for adults with mental illnesses or addictions (LB 1354).

2000: Rate increases for BH providers, DDHH and Region VI develop plan for emergency psychiatric services, six additional sex offender beds at LRC.

2001: \$8M was appropriated annually in new funding for community-based behavioral health services. (LB 692)

» Changed disbursement of documentary stamp tax funds to the Affordable Housing Trust Fund and Homeless Shelter Assistance Trust Fund; transferred administration of Homeless Shelter Assistance Trust Fund from the Department of Economic Development to the Health and Human Services System.

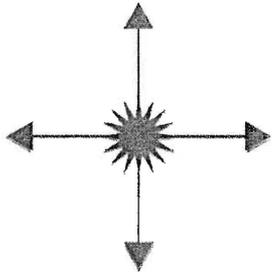
» \$1.3 million appropriated to the HHS System for additional sex offender beds at LRC.

» \$50,000 from Charitable Gaming Operations Fund transferred to Compulsive Gamblers Assistance Fund by November 1st of each year, unless the fund contains less than \$50,000.

» Nebraska Health Care Cash Funds distributed in FY 01/02 and FY 02/03 (LB 692):

- \$7.5 M to increase rates paid to providers of MH/SA services.
- \$6.5 M for community-based MH/SA services including intermediate-level residential care.
- \$1.5M for maintenance and treatment of MH patients under emergency protective custody.

DRAFT



HELPING PEOPLE LIVE BETTER LIVES

2003: Legislation created a 'road map' to reform behavioral health services (LB 724).

2004:

- » The Nebraska Behavioral Health Reform Act was implemented (LB 1083).
- » Closed adult acute hospital services at the Hastings Regional Center (March).
- » Consumer Liaison Introduces Vision of National Memorial to the National Consumer Survivor Mental Health Administrators.

2005:

- » Stopped adult mental health admissions to Norfolk Regional Center (November).
- » Appropriated \$500,000 from NE Health Care Cash Fund for FY 05-06 for compulsive gamblers assistance programs.
- » Transfer from Affordable Housing Trust Fund to the BH Services Fund, to be used for housing-related assistance for very low-income adults with serious mental illness (LB 100).
- » Allows disclosure of info on Sex Offender Registration Act to governmental agencies conducting confidential checks for employment, volunteer, licensure or certification purposes.
- » Changed training requirements related to alcohol and drug counselor trainings supervisors, changes provisions on the Compulsive Gamblers Assistance Fund; requires the Division of BH to maintain data/information system for all people receiving state-funded BH services; changes members for State BH Council, Advisory Committee on Substance Abuse and State Advisory Committee on Problem Gambling/Addiction Services.

2006:

- » Moved adolescent acute hospital services from

Lincoln Regional Center to Hastings Regional Center (January).

- » Standards/procedures for rehabilitation of clandestine drug lab sites.
- » Civil commitment and community supervision for sex offenders, changed Sex Offender Registration Act, adopted the Sexual Predator Residency Restriction Act, established a work group to study sex offender treatment and management services (LB 1199).
- » Converted mission of Norfolk Regional Center to a state sex offender facility and began joint program with Lincoln Regional Center (July).

2007:

- » The Division of Behavioral Health funds Consumer Specialists in all Regions.
- » Closed adolescent acute hospital services at Hastings Regional Center (January).
- » Closed adult residential services at Hastings Regional Center (April).
- » Created a new licensure category of independent mental health practice.
- » Reorganized the Health and Human Services System into a single state agency known as the Department of Health and Human Services (LB 296).
- » Required DHHS to develop policies/rules and regulations on transfer and discharge of sex offenders treated in DHHS program.
- » Created the Children's BH Task Force and required submission of a children's behavioral health plan (LB 542).

2008:

- » Changed membership on Children's BH Task Force.
- » Revised the definition of consultation to include consultation between a licensed

APPENDIX A: HISTORY OF NEBRASKA'S BEHAVIORAL HEALTH SERVICES

MH practitioner and an independent MH practitioner. Clarified when someone can use the titles of independent clinical worker, independent professional counselor and independent marriage and family therapist.

- » Expanded duties of State Committee on Problem Gambling and changed name from former State Advisory Committee on Problem Gambling and Addiction Services.
- » Deficit appropriations included:
 - \$900,000 state and \$1,350,000 federal funds for 1.5% rate increase for providers.
 - Unexpended behavioral health aid funds distributed for one-time payments to regions for development of community BH services.
 - Regional funds to be appropriated to regions for development of community BH services.
- » Expanded the authority of the Ombudsman to all mental health institutions operated by DHHS, all regions and all community-based BH service providers that contract with the Regions.

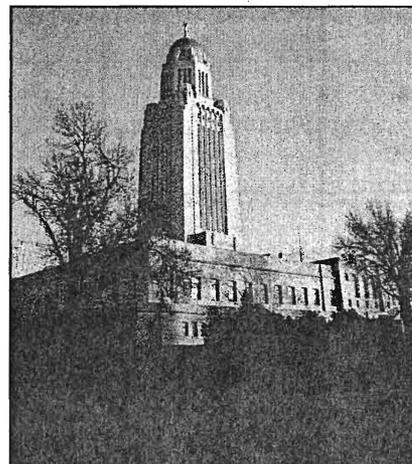
2009:

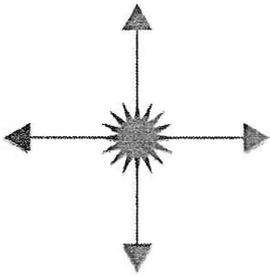
- » Amended Sex Offender Registration Act to bring Nebraska into compliance with federal guidelines so that length of registration is based solely on the convicted offense; expanded list of registry offenses; expanded registration information that is collected.
- » Reduced rate increase for MH/SA providers from 1.5% to .5%.
- » Changed terminology relating to problem gambling services, eliminating 'addiction services' and replacing 'compulsive' with 'problem' gambling.

- » Required establishment of a children and family support hotline; a family navigator program to respond to children's BH needs; post-adoption and post-guardianship care management services for adoptive families/guardians of former state wards; submission of a state Medicaid plan waiver to CMS for community-based secure residential and sub-acute BH services whether committed by a MH Board or not; provided DHHS \$500,000 for FY 09-10 and \$1 million for FY 10-11 for children's BH services; created a legislative Children's Oversight Committee; established the Behavioral Health Education Center (BHECN) to recruit and train more psychiatry residents (LB 603).
- » Merged financial operations at Regional Center (July).
- » Omaha, NE hosts the national Alternatives Conference.

2010:

- » The Office of Consumer Affairs Peer Support Hosts its first Peer Support Training and forms a Facilitator's Circle .
- » Completed Substance Abuse Block Grant technical review resulting in Technology Transfer recognition.





HELPING PEOPLE LIVE BETTER LIVES

BEHAVIORAL HEALTH SERVICES: RECENT DEVELOPMENT & EXPANSION BY FISCAL YEAR

FY96 - FY04 SERVICES

Day Treatment	Halfway House-Men	Home-Based
Partial Care in 96/97	Halfway House-Women	Respite Care
Day Rehabilitation	Crisis Assessment (23/59)	Therapeutic Consultation
Outpatient Therapy (Ind/Fm/Grp)	Crisis Assessment (CADAC)	Therapeutic Community
Outpatient Therapy (ind)	Emerg Shelter-Psych Respite	Partial Care
Medication Management	Emerg Shelter-Social Detox	OP Therapy - Ind/Fm/Grp
Med Maintenance-Methodone	Emerg Comm Support	Med Management
Psychological Testing	Emerg Protective Custody Crisis	Intensive Outpatient
Voc Support	Civil Protective Custody	Death Assessment
Day Support	Community Support-Lv 2	Community Support
Intermediate Res	Assertive Community Treatment	
Psych Res Rehab	Prevention	
Dual Disorder Res	Professional Partner	
Short Term Res		
Short Term Res-Native Americans		
Therapeutic Comm		

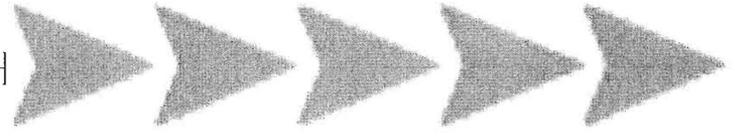
FY05 NEW SERVICES

Inpatient Acute
Inpatient Subacute
Emergency - Crisis Response Teams
Emergency - Urgent Crisis Treatment
Emergency - Urgent Outpatient
Emergency - Urgent Med Management
Emergency - Stab/Treatment (Vol)

FY06 - FY08 NEW SERVICES

FY06 Services	FY07 Services	FY08 Services
Post Commit Days	Intensive Case Mgmt	Secure Res
Urgent Assessment	Supported Employment	
Nurse-Day Rehab	Short Term Res LMHP/RN	
Telemedicine		
Adolescent IOP		

APPENDIX A: HISTORY OF NEBRASKA'S BEHAVIORAL HEALTH SERVICES



FY09 - FY10 NEW SERVICES

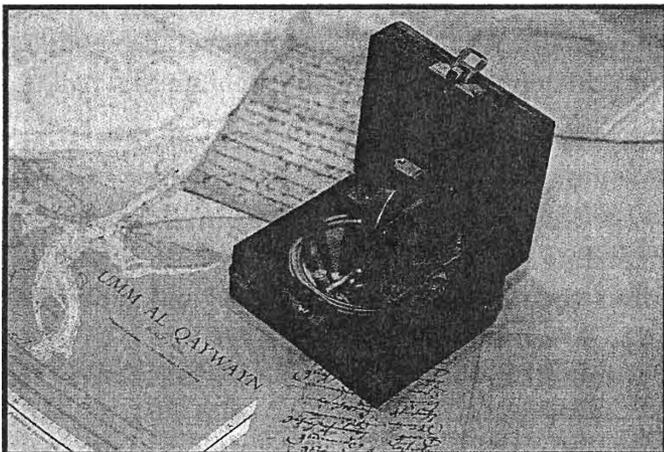
FY09 Services	FY10 Services
Voucher Program	Housing-Related Assistance
Supported Living	Services Evaluation/ Med Support
Bi-Lingual/Bi-Cultural OP	Hospital Diversion
ERCS Youth Transition	Recovery Support
Comm Support - Spec Pops	BH Integation with Primary care
Peer Support	Homeless Support
Geriatric Therapeutic Consultation	Underserved Populations
Network of Care	Family Support - SA
	Youth Special Services

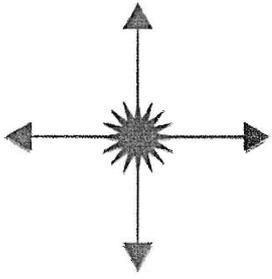
Notes to Appendix A:

Appendix A includes references to a number of significant dates in the development of the Nebraska Behavioral Health System. It is not all-inclusive.

In addition to services listed, DBH works with Nursing Facilities and Assisted Living Facilities to provide consultation and supplemental services when appropriate. (8/21/2009)

DRAFT





HELPING PEOPLE LIVE BETTER LIVES

Behavioral Health Oversight Commission II Vision/Values

The Nebraska Department of Health and Human Services, Division of Behavioral Health Strategic Plan is indebted to and begins with a vision and core values/guiding principles crafted by the Behavioral Health Oversight Commission II – a group established by the Nebraska Legislature (LB928 – 2008). The full report is available at: http://www.hhs.state.ne.us/Behavioral_Health/BHCommission/BHOC-FinalReport-06-25-09.pdf.

Vision: Share a cooperative and common vision among DHHS divisions regarding recovery, best practice, access to care, and funding.

The Public Behavioral Health System in Nebraska will...

- » Promote wellness, recovery, resiliency, and self-determination in a consumer/family-driven system.
- » Focus on positive outcomes and continuous quality improvement by the Division, Behavioral Health Authorities, providers and recipients of services.
- » Provide inclusive, transparent planning through genuine partnership with diverse stakeholders, including meaningful participation by consumers.
- » Focus on prevention/early intervention.
- » Share a cooperative and common vision among DHHS divisions regarding recovery, best practice, access to care, and funding.
- » Encourage public/private partnerships.
- » Maximize available revenue sources, including Federal grants and maximization and capture of Federal Medicaid match dollars, and new revenue sources will be reinvested in the behavioral health system.

Values & Principles

The following core values and guiding principles resulted from the work in June 2009 of Nebraska's Behavioral Health Oversight Commission. They are meant to guide work within the public behavioral health system but are also applicable to Nebraska's mental health, substance abuse and problem gambling services.

Self-Direction:

Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control over resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path toward those goals.

Individualized and Person Centered:

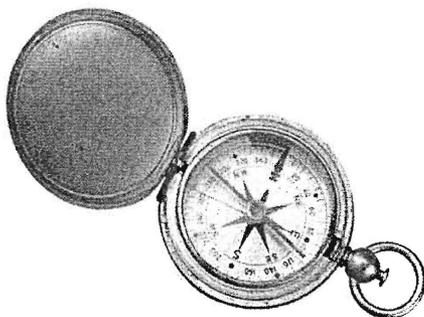
There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment:

Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual

APPENDIX B: BEHAVIORAL HEALTH OVERSIGHT COMMISSION II VISION / VALUES

gains control of his or her own destiny and influences the organizational and societal structures in his or her life.



Holistic:

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic medicine, addiction treatment, spirituality, creative social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear:

Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths Based:

Recovery focuses on valuing and building on the

multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer support:

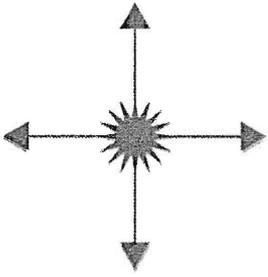
Mutual support—including the sharing of experience, knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect:

Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility:

Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

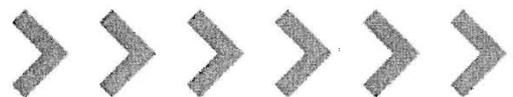


HELPING PEOPLE LIVE BETTER LIVES

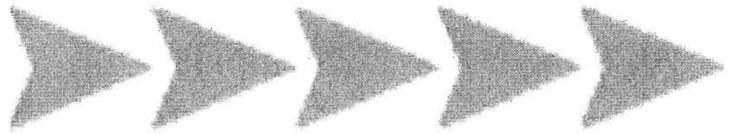
Hope:

Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation (U.S. Department of Health and Human Services, 2005).

DRAFT



APPENDIX C: NATIONAL OUTCOME MEASURES (NOM)



National Outcome Measures (Substance Abuse and Mental Health Services Administration)

Accessibility

National Outcome Measure for Mental Health (NOM-MH) and Prevention (NOM-PR) (Access/Capacity): Number of persons served by age, race, ethnicity, gender.

Substance Abuse

NOM – SA (Substance Abuse & Access/Capacity): Unduplicated count of persons served; penetration rate – numbers served compared to those in need.

Quality

NOM – MH (Perception of Care): Clients reporting positively about outcomes.

NOM – MH (Social Connectedness): Clients reporting positively about social connectedness.

NOM – PR (Social Connectedness): Family communication around drug use.

Cost Efficiency

NOM – PR (Cost Effectiveness): Services provided within cost bands.

Effectiveness

NOM – SA (Reduced Morbidity): Reduction in/no change in frequency of use at date of last service compared to first service.

NOM – PR (Reduced Morbidity): 30 day substance use (non-use/reduction in use).

NOM – PR (Reduced Morbidity): Perceived risk/harm of use.

NOM – PR (Reduced Morbidity): Age of first use.

NOM – PR (Reduced Morbidity): Perception of disapproval/attitude.

NOM – SA (Crime and Criminal Justice): Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service.

NOM – PR (Crime and Criminal Justice): Alcohol related car crashes and drug related crime.

NOM – MH (Retention): Decrease rate of readmission to State psychiatric hospitals within 30 and 180 days.

NOM – SA (Retention): Length of stay from date of first service to date of last service and unduplicated count of persons served.

NOM – PR (Retention): Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message.

NOM – MH (Stability in Housing): Profile of client's change in living situation (including homeless status).

NOM – SA (Stability in Housing): Increase in/no change in number of clients in stable housing situation from date of first service to date of last services.

NOM – MH (Employment/Education): Profile of adult clients by employment status and of children by increased school attendance.

NOM – SA (Employment/Education): Increase/no change in number of employed or in school at date of last service compared to first service.

NOM – PR (Employment/Education): Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment.

Retrieved October 27, 2010 from: http://www.nationaloutcomemeasures.samhsa.gov/PDF/NOMS/ revised_grid_4_1_08.pdf

APPENDIX D: ACKNOWLEDGEMENTS



Acknowledgements

The work of many Nebraskans participating in planning efforts past and present were used as a basis for this document. Special acknowledgement is made to the Behavioral Health Oversight Commission II members for crafting the vision and values underlying this plan; to the members of the mental health, substance abuse and problem gambling committees; and to the members of the joint strategic planning work group who spent countless hours reading, reviewing, crafting and commenting on plan elements. Additionally, the Division of Behavioral Health would like to recognize the Consensus Panel in Omaha, Nebraska for its ongoing work in development of system measurements.

Joint Strategic Planning Work Group

Members of this group were chosen by the body they represent. The joint strategic planning group was charged with the following:

- » Recommend key areas that require additional stakeholder involvement/input prior to inclusion in a strategic plan.
- » Recommend and prioritize methods for obtaining additional stakeholder involvement in the planning process.
- » Review documents and stakeholder input.
- » Serve as a liaison for their constituencies in the planning process.

Joint Strategic Planning Work Group Members

State Committee on Problem Gambling
Jerry Bauerkemper
John Bekins

State Advisory Committee on Mental Health Services (§ 71-815)
Kasey Moyer
Sharon Detrymple

State Advisory Committee on Substance Abuse Services (§ 71-815)
Dana Wiese
Corey Brockway

Regional Behavioral Health Authorities
C.J. Johnson

Division of Behavioral Health
Vicki Maca
Sheri Dawson

Support for the work of this group was provided by the University of Nebraska Public Policy Center (<http://www.ppc.nebraska.edu>) operating under contract with the Nebraska Department of Health and Human Services.

Photo Credits:

- p.17: "Chimney Rock, Nebraska," <http://www.sxc.hu> - coopreg, Gregory Runyan
- p.20: "State Capitol 3," <http://www.sxc.hu> - jmiller, Jon Miller
- p.22: "Old Maritime Map," <http://www.sxc.hu> - hisks, Kriss Szkurlatowski

DRAFT

DRAFT

Department of Health & Human Services



N E B R A S K A

- Exhibit 2 -

Mr. Chairman, Members of the Committee, my name is Rhonda Hawks, spelled R-H-O-N-D-A H-A-W-K-S. I am Vice President, Secretary and Treasurer for the Behavioral Health Support Foundation, former Chairman of the Behavioral Health Oversight Commission and a Trustee for The Hawks Foundation, testifying today in a supportive capacity of LR 513. Thank you for allowing me to testify.

Before I share my formal remarks, I would like to take a moment to say THANK YOU to each of you for your service to the state. Today's hearing also brings us sadness in that it is the last time we will have an opportunity to present to and thank Chairman Tim Gay. You have been an incredible leader. Your willingness to listen and work through difficult issues has been greatly appreciated. You have been a tremendous supporter and defender of those who suffer with behavioral health issues. We will miss you although we know your impact on our state does not end here. On behalf of the behavioral health community, THANK YOU.

One in four families in Nebraska experience mental illness. You likely know someone who is affected.

We often talk of behavioral health—mental health and substance abuse--- on a system level and don't focus on the "real life" experience of a person suffering a psychiatric crisis. I recently received a phone call from a friend of mine who was desperately seeking services for his daughter, an age 19 college student, for the first time ever. He had no idea how to get services, where to go and at first confided that it was a "friend" and later tearfully admitted it was his daughter. His daughter was subsequently admitted to an acute care facility. He later called me and said "my daughter is safe and getting needed treatment" because of Lasting Hope. He could barely speak because he was sobbing. This speaks to the stigma of admitting a loved one who has a mental illness and the initial feeling of "how do I get help".

My personal experience with this disease is one I've spoken of many times and affects families very broadly. My father was diagnosed with schizophrenia in his early 20's after having three young children and a wife who helped him navigate the myriad of doctor appointments, varying doses and trials on psychotropic drugs, emergency protective custody, frequent and extended hospital stays and self medication with alcohol. This lasted 20 years before dying prematurely at age 49. This is not an unusual story and I remain convinced that my father would have been homeless during times of extreme psychosis without an advocate or a strong family network to keep him connected to the system. Because of his connectedness to the system, he also enjoyed periods of recovery and wellness.

LB 1083, passed in 2004 was a great start at moving away from institutionalization and toward community-based care. We've come a long way in instituting LB 1083. Moving individuals out of Regional Centers and back to their "home base" is very important. Ideally, we'd love to see a huge drop in services for high end services like acute and subacute hospitalization—those provided at Lasting Hope. Realistically, we will always have some level of individuals experiencing a psychiatric crisis. However, we are working hard to concentrate on services that are community based and can reduce our need for acute care beds. Lasting Hope, like all behavioral health institutions, is not a money-maker.

During my one-year tenure as chair of the Behavioral Health Oversight Commission, we issued a strategic vision in our final report. The next step was to come up with a strategic plan. The state of Nebraska has been lacking in a plan of how to move forward effectively in a way that doesn't hurt consumers.

The Behavioral Health Support Foundation, concurrent with the Division of Behavioral Health's work on a vision and objectives for behavioral health that Scot Adams described today, hired a consulting group with multi-state experience on the

behavioral health side. This group is called Open Minds and I'm delighted to have Monica Oss from Open Minds with us today to offer testimony on the Consensus Panel work on a Strategic Plan.

Again, as Scot Adams outlined, the Division of Behavioral Health, has recently come up with a very good strategic vision and objectives. We believe that when combined with the work set forth by a Consensus Panel which Open Minds conducted and that Monica Oss will describe today, we are on the right track.

The Behavioral Health Support Foundation (founded by the Stinson family and the Hawks family) convened a 28 member consensus panel from across Nebraska with the aim of determining areas of strategic focus. The 28 members included: Consumers; Division of Medicaid; Division of Behavioral Health; Regions; Providers from Community Based Agencies; Private Psychiatrist, Educators and Private Sector Involvement. Two major areas of focus were determined during the process: Performance Measurement Initiatives and Regulatory Reform Initiative.

Performance Measurement was targeted to:

- Understand the performance of the behavioral health system – in total and by component
- Provide information needed to make system budgeting decisions
- Identify areas for system performance
- Identify best practices with good outcomes for future system investment
- Improve the return on investment of public dollars by improving the performance of the system for consumers

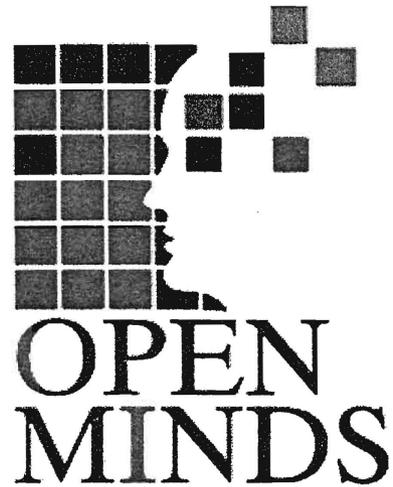
A Regulatory Reform Initiative was chosen to reduce unnecessary administrative costs throughout the state of Nebraska's behavioral health system.

Monica Oss, CEO from Open Minds, is here today to describe these two initiatives in more detail.

I would be remiss if I did not acknowledge that we know you have some very difficult budget decisions before you. Our plea today is to share that great progress is being made in the behavioral health system. Together working as partners, we have navigated through some difficult waters. We will continue to be a strong partner but we must have stability in funding and agreement to move forward on a system that provides measurements and better accountability to taxpayers.

Bottom line: we ask that you do not cut funding for behavioral health. As you can see from our work at Lasting Hope, great things are happening. We also know that in order for this to succeed, we need to continue our plans to address the critical workforce shortage that exists in this arena and again ask that you protect the funding that was allocated in LB 603.

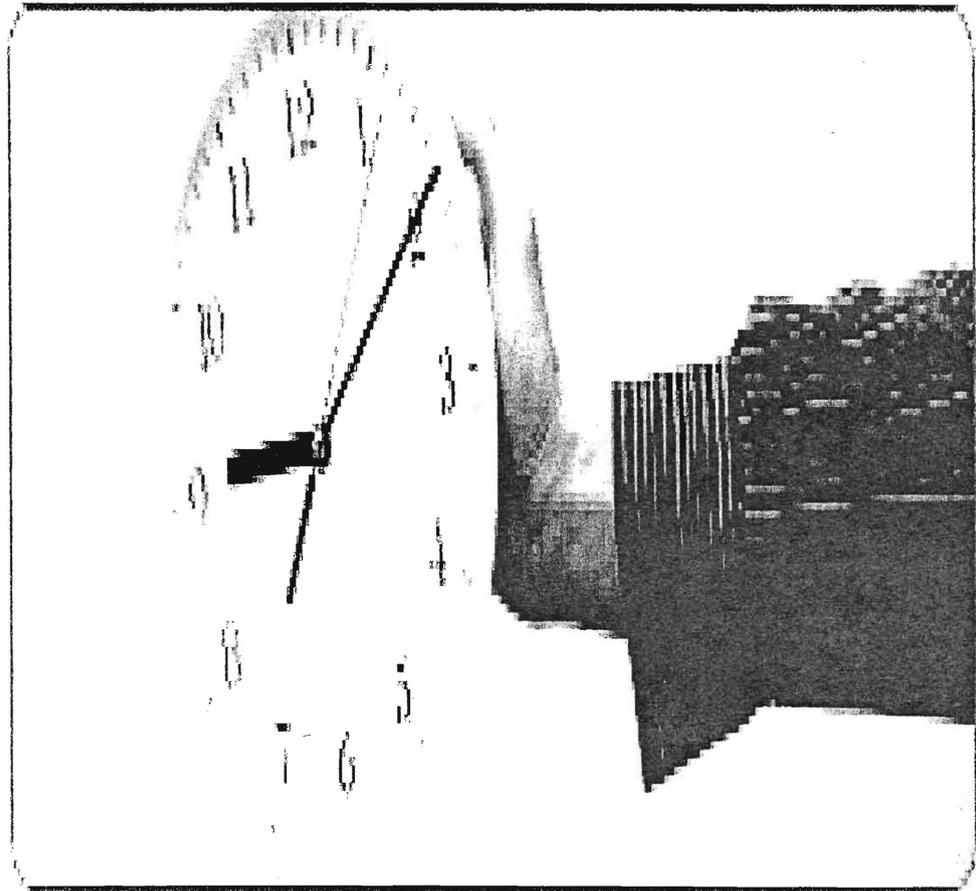
Thank you for the opportunity to testify. I'd be happy to answer any questions and then turn it over to Monica Oss.



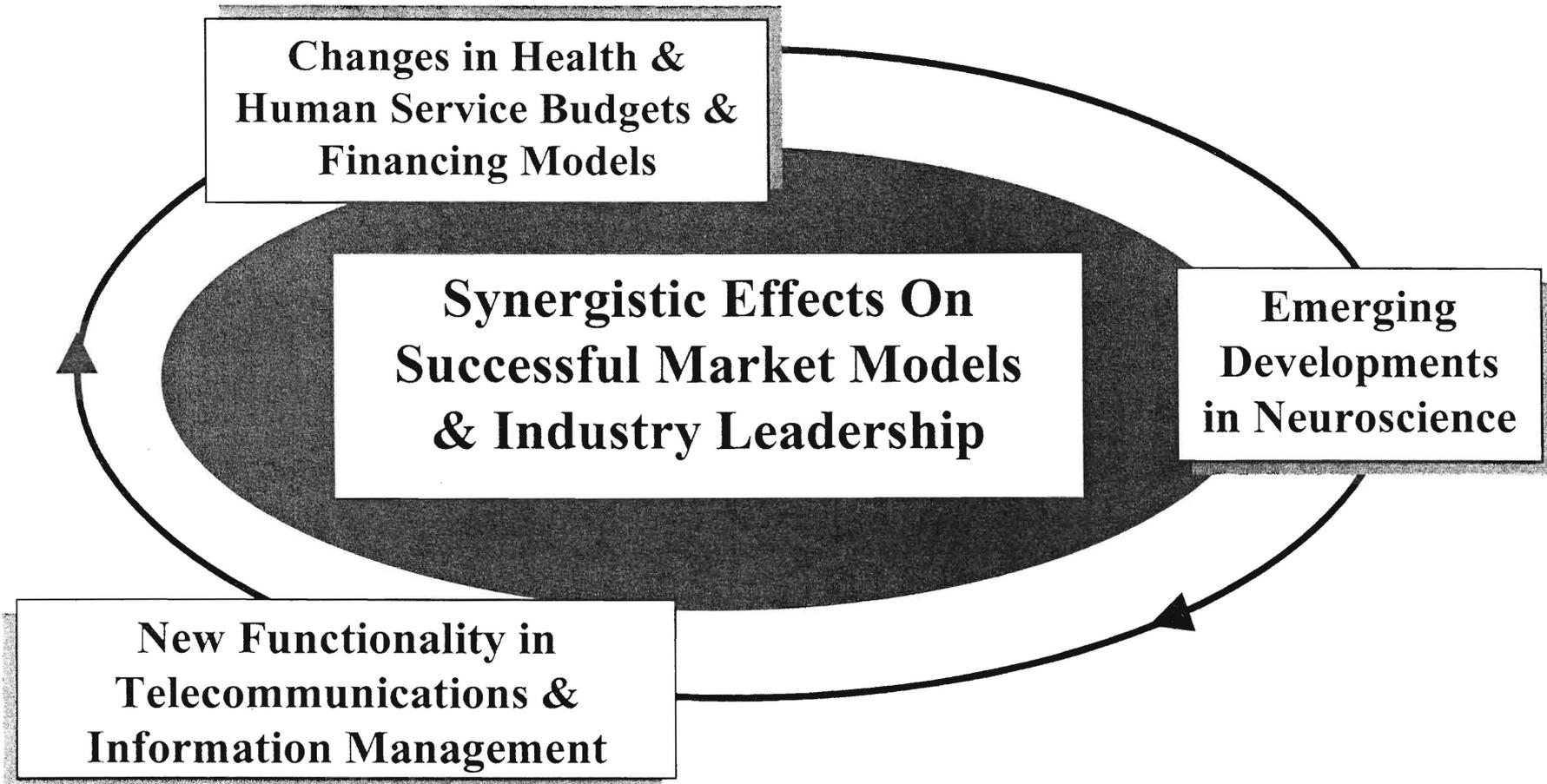
Increasing the Value of Public Investment in Nebraska's Behavioral Health System: A Legislative Update

**Monica Oss, Chief Executive Officer, OPEN MINDS
December 14, 2010**

**Overview Of
National Health
And Human
Service
Developments
& Their
Implications
For Nebraska**



Synergistic & Simultaneous Disruptive Innovations in Health & Human Services



Confluence Of Financial & Legislative Events Shaping National Health & Human Service Policy

- Banking crisis
- TARP (and parity legislation)
- Recession and state/local budget stress
- Stimulus package (ARRA)
- Health care reform legislation

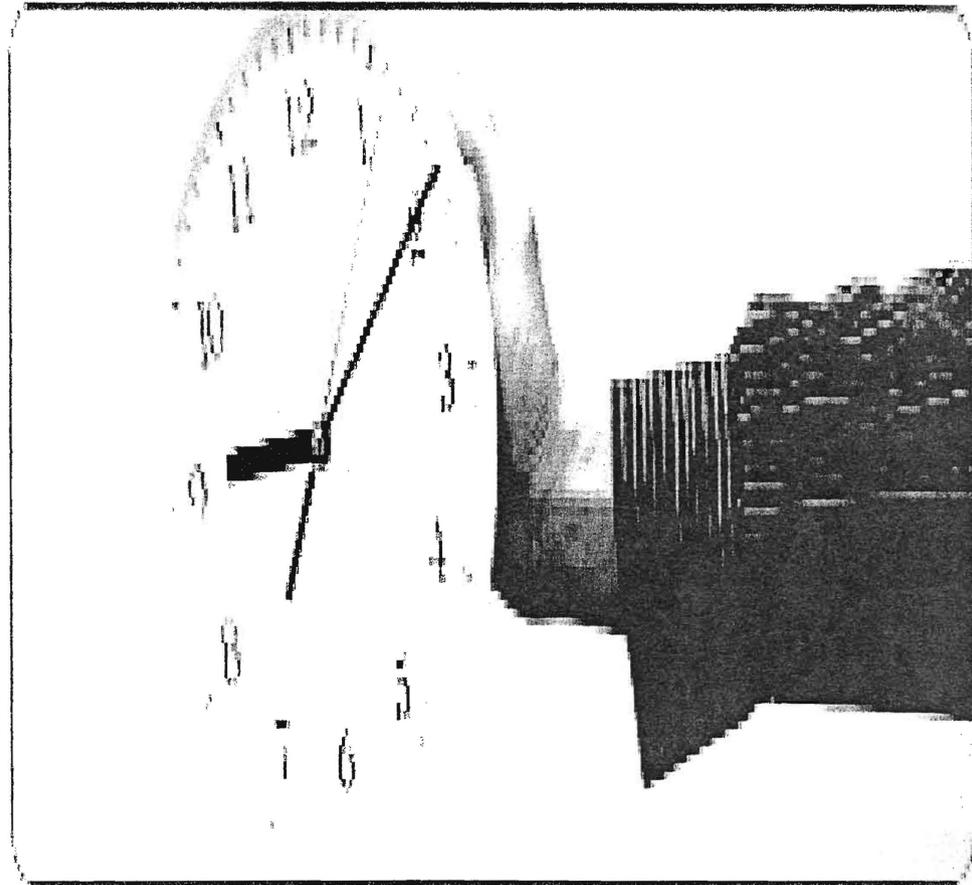
Four Major Strategic Implications Of Parity & Health Care Reform

- Most behavioral health dollars will flow through health plans
- Technology and financing will increase the ‘specialty’ behavioral health services provided via primary care – leaving complex/chronic cases to be provided through disease management models with risk-based financing
- Health plan-based financing will draw clear lines between ‘health’ services and ‘social’ services
- Comparative effectiveness initiatives will increase private pay market – new tech, services not ‘preferred’

Financial Pressure on Government Payers – Federal, State, & Local – Financing Restructuring

- Reduced eligibility for services at state level
 - Reduce coverage of services at state level
 - Reduced fees to provider organizations
 - Risk-based, pay-for-performance, and value-based purchasing initiatives (more managed care)
 - Privatization and outsourcing
-
- This financial pressure is speeding the adoption of disruptive innovations and new programs in government program management. . .

Considerations For Design of Most Cost- Effective, High-Value Behavioral Health Systems



Behavioral Health Spending Is Significant – But Different From General Health Care

- Behavioral health is 7.5% of total U.S. health care spending (\$121 billion in 2003)
- Multiple funding sources are the challenge to effective service system design:
 - ✓ 25% Medicaid
 - ✓ 24% State and local government
 - ✓ 22% Private insurance
 - ✓ 13% Private pay (out-of-pocket)
 - ✓ 7% Medicare
 - ✓ 5% Other federal funding
 - ✓ 4% Other private pay

Hospitalization Is Largest System Expense, But Declining

- Hospitalization is largest behavioral health system expense, but declining:
 - ✓ Inpatient/residential mental health services were 40% of total spending in 2003
 - ✓ 57% in 1991
- Technological substitution reducing inpatient spending is occurring – more community services and access to newer medications decreasing use of inpatient services

Untreated Mental Illness Is Expensive to Taxpayers. . .

- The non-treatment costs of mental illness are 2.4 times the cost of treatment –
 - ✓ Unemployment of patients and their caregivers
 - ✓ Social service support costs
 - ✓ Use of criminal justice resources
- 10% of state and federal adult prisoners are seriously mentally ill
- 22% of population of locals jails are mentally ill
- 46% of homeless individuals report having mental health problem within previous year
- 26% of homeless individuals seriously mentally ill

Challenges To Cost-Effective Behavioral Health Services

- Fragmented funding of treatment (multiple systems and modalities)
- Financially simplistic cost containment decisions increasing (unintended) behavioral health costs in other systems
- Lack of effective “disease management” because of limited consumer options (with fragmented funding and cost containment rules)

Improving The Behavioral Health System -- Element #1: Integrated Funding Models

Funding models that “integrate” financial resources for mental health and addictions treatment:

- At the payer level (Federal, State, local)
- Across systems (health, child welfare, corrections, education, etc.)
- By treatment type (hospital, community-based, medications)

Improving The Behavioral Health System -- Element #2: Educated Consumer Choice

Service delivery models that facilitate consumer choice and are driven by consumers

- Facilitation of individual treatment planning and consumer recovery
- Utilize ‘disease management’ principles and evidence-based practice information
- Transparent performance information for consumer choice

Improving The Behavioral Health System -- Element #3: Stakeholder Performance Metrics

‘Value-based’ purchasing models to assure best use of public funds by State and by consumers

- All stakeholders (counties, care management organizations, provider organizations, professionals, etc.) report standardized cost data and quality and performance information
- Management of ‘outliers’

Model For Best Value Behavioral Health System

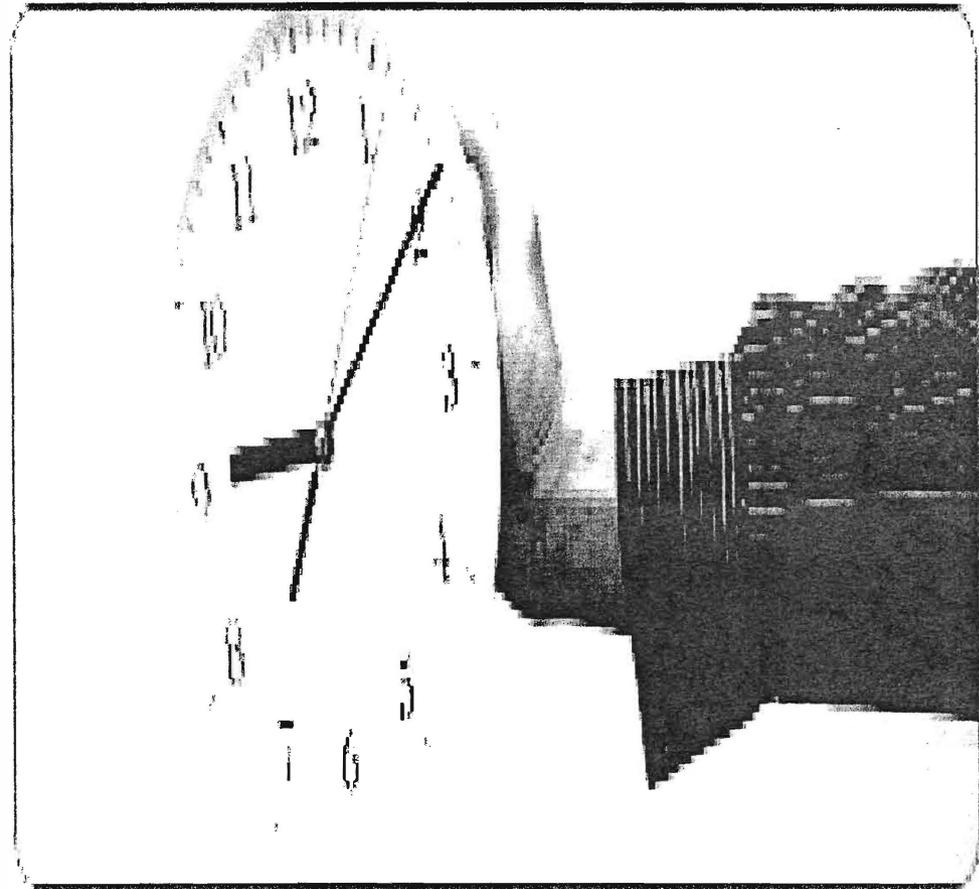
Issues to address:

- Fragmented funding of treatment
- Implications of short-term cost containment decisions that shift/increase costs in other systems
- Lack of effective “disease management”

Elements to improving system:

- Integration of funding
- Consumer-driven care
- Standardized and transparent performance metrics

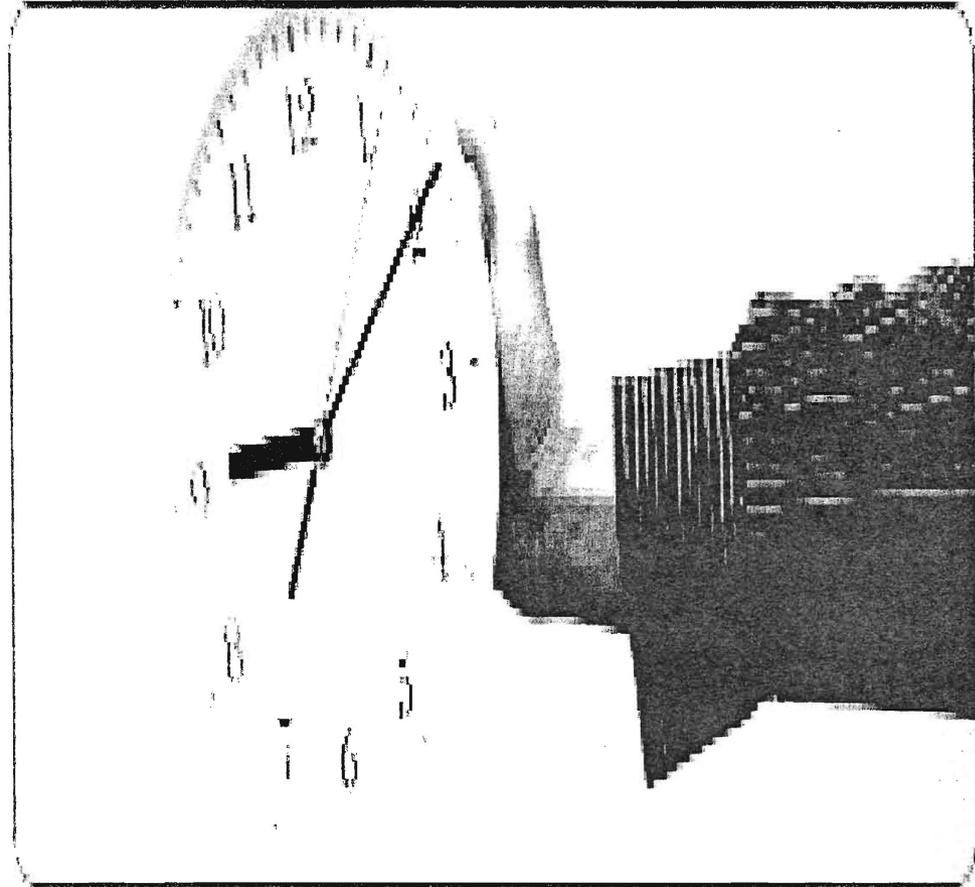
The Elements of Strategic Visions of Nebraska DBS



Nebraska Division of Behavioral Health Strategic Plan 2011-2015: Vision Statement & System Objectives

1. Increase access to appropriate and effective behavioral health services, particularly for underserved or vulnerable populations
2. Improve the quality of behavioral health service for children and adults
3. Improve outcomes for children and adults through the use of effective services
4. Develop flexible and balanced funding to support an efficient and accountable system of services
5. Model and encourage transparent accountable relationships with and among system stakeholders

**Work of
Behavioral
Health Support
Foundation to
Support Best-
Value System
Development**



Participation in Strategic Oversight Commission

- LB 928 created the Behavioral Health Oversight Commission July, 1, 2008
- Strategic focus:
 - ✓ Moving behavioral health forward
 - ✓ Behavioral health workforce shortage
 - ✓ Enhanced communication and partnering

Moving Behavioral Health Forward: Commission Recommendation

DBH will seek out people with objectivity and expertise in strategic planning who are familiar with behavioral health transformation activities elsewhere to facilitate the planning process and lead stakeholders in discussion of what we have and what we need.

Creation of Nebraska Consensus Panel On Adult Behavioral Health

- 25 members of the Consensus Panel
- The Consensus Panel consisted of representatives from the following:
 - ✓ Consumers
 - ✓ Consumer advocates
 - ✓ Division of Behavioral Health
 - ✓ Division of Medicaid and Long-Term Care
 - ✓ Provider organizations
 - ✓ Regional Behavioral Health Authorities
 - ✓ Psychiatrists
- Consensus Panel met during January and February 2010

Objectives of the Nebraska Consensus Panel on Adult Behavioral Health

- Develop a strategic plan to create a high-performing Nebraska behavioral health system
- Establish a clear vision for the future
- Analyze the role of the public behavioral health stakeholders
- Establish specific objectives with clear outcomes for system improvement

Work Product of Nebraska Consensus Panel On Adult Behavioral Health

- The Nebraska Behavioral Health Strategic System Improvement Plan
- The Consensus Panel selected three high priority issues for implementation to improve system value:
 - ✓ Develop an enhanced performance measurement system of the service delivery system
 - ✓ Set standards for access and measure consumer access to services and use that evaluation to identify service capacity issues and efficiencies
 - ✓ Initiate a regulatory reform initiative to reduce redundant costs in the delivery system

Focus on Performance Measures: Reconvening the Nebraska Consensus Panel On Adult Behavioral Health

- Nebraska behavioral health system regulatory reform initiative to reduce duplicative administrative costs
- Enhanced performance measurement initiative for the Nebraska behavioral health system



Consensus Panel met three times from
August through November 2010

Objectives of the Regulatory Reform Initiative

- Develop regulatory reforms to reduce unnecessary costs throughout the behavioral health system
- Focus reforms on reduction of duplicative and conflicting administrative rules to reduce cost and improve system efficiency

Recommendations of the Regulatory Reform Initiative

1. Establish deemed status for nationally-accredited programs
2. Conduct cost analyses prior to administrative rule changes
3. Create licensure for rehabilitation professionals
4. Establish a transparent process for the allocation of behavioral health services funds to the Medicaid program
5. Remove barriers to e-health

Objectives of the Behavioral Health System Performance Measurement Initiative

1. Develop a performance measurement system to assist Nebraska in making decisions within and about the behavioral health system
2. Assess performance and access to care measures in Nebraska
3. Identify and prioritize measures to be used to address system quality, access, and service capacity issues
4. Design the Nebraska Behavioral Health System Performance Dashboard
5. Define the data collection and reporting process

Performance Measurement System Design Process

- Broad stakeholder input via Consensus Panel – with wide range of options offered by *OPEN MINDS* consulting team
- For most measures, Consensus Panel selected data elements measured by State or Magellan – to initiate the process
- This system performance dashboard content and design can be readily applied to other areas HHS – children, developmental disabilities, etc.

Performance Measurement Domains Selected by the Consensus Panel in the Enhanced Performance Measurement Initiative

1. Consumer outcomes
2. Consumer perception of service and recovery
3. Consumer continuity of care and access to care
4. Cost effectiveness and efficient use of system

Domains One & Two: Consumer Outcomes & Consumer Perception Of Service & Recovery

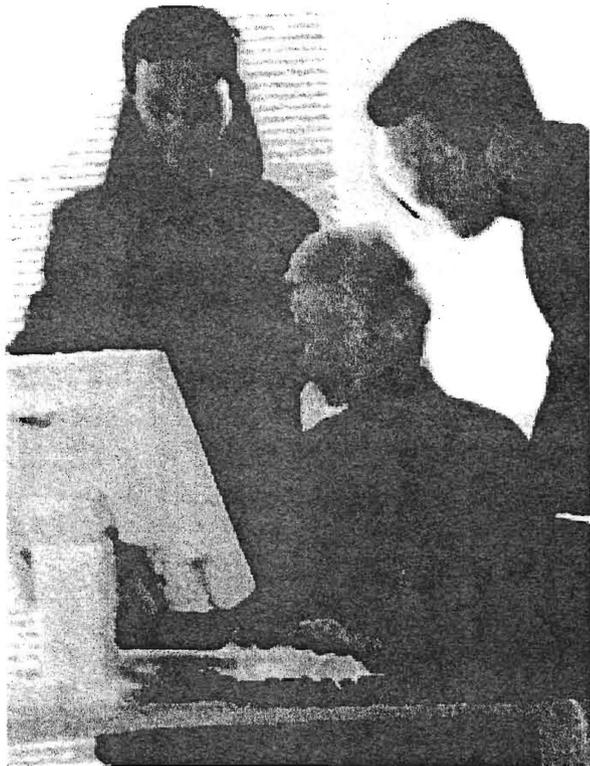
1. Profile of adult clients by employment status
2. Profile of adult consumers living in a private residence at time of admission
3. Consumers arrested and booked by local law enforcement
4. Consumer satisfaction with system and their own outcomes

Domain Three: Consumer Continuity Of Care & Access To Care

1. Number of adults served by the Nebraska Behavioral Health System
2. Access and penetration rate to behavioral health services, including focus on rural/frontier populations
3. Percent of discharges, where treatment team recommended community services are available, when patient is discharge ready
4. System service utilization

Domain Four: Cost Effectiveness & Efficient Use Of System

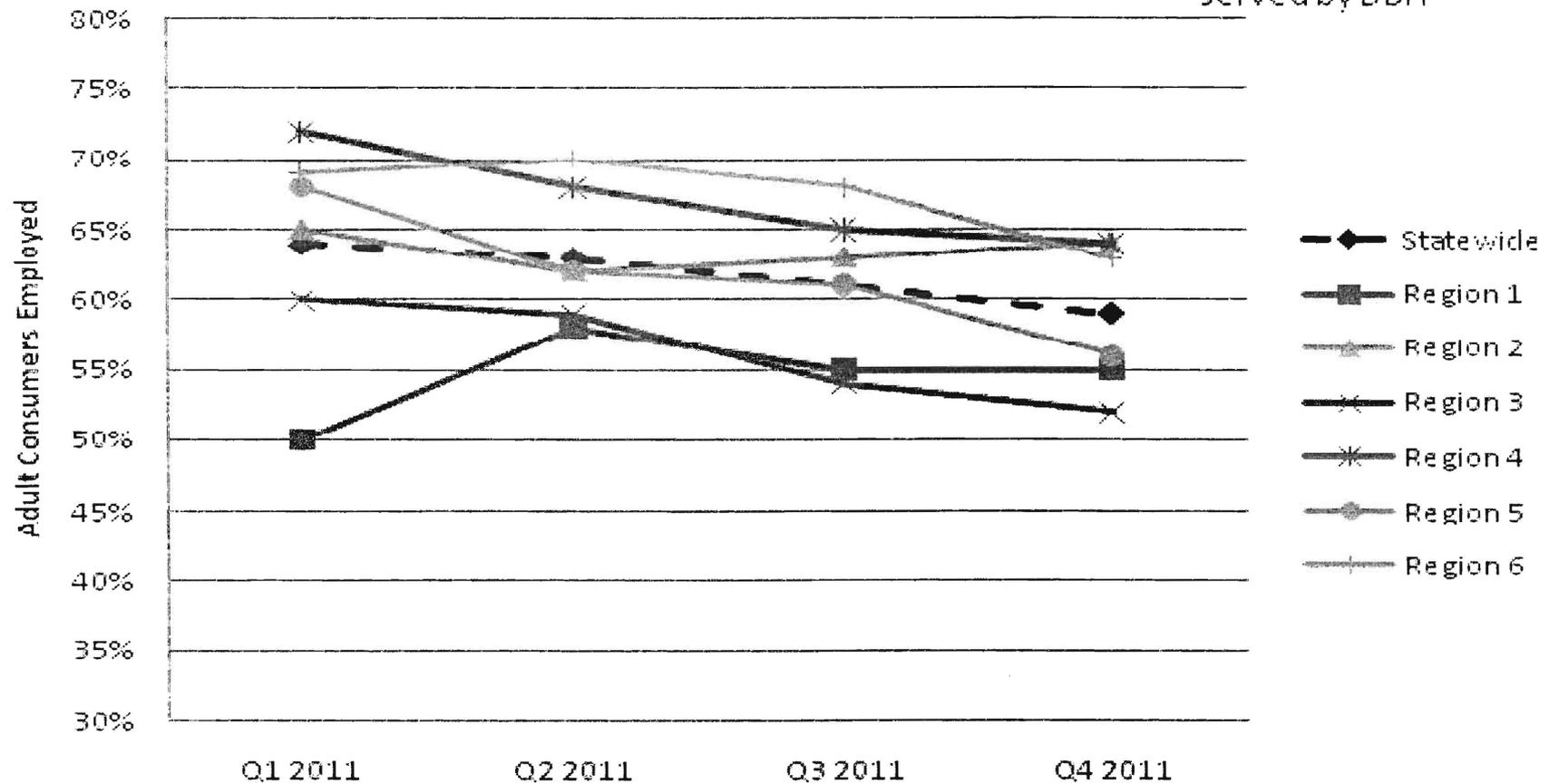
1. Per user expenditures for behavioral health services
2. Ratio of administrative cost to service cost and administrative cost versus service spending
3. Consumer admissions into inpatient behavioral health services in a year
4. Consumers using outpatient behavioral health services in a year
5. Consumer average length of stay
6. Decreased rate of readmission to psychiatric hospitals/psychiatric units within 30-days
7. 180 day readmission rate/community tenure



Nebraska Behavioral Health System Performance Measurement System: Dashboard Design

Measure 1:1 Percentage of Adult Consumers Employed at time of Admission to Services by Region

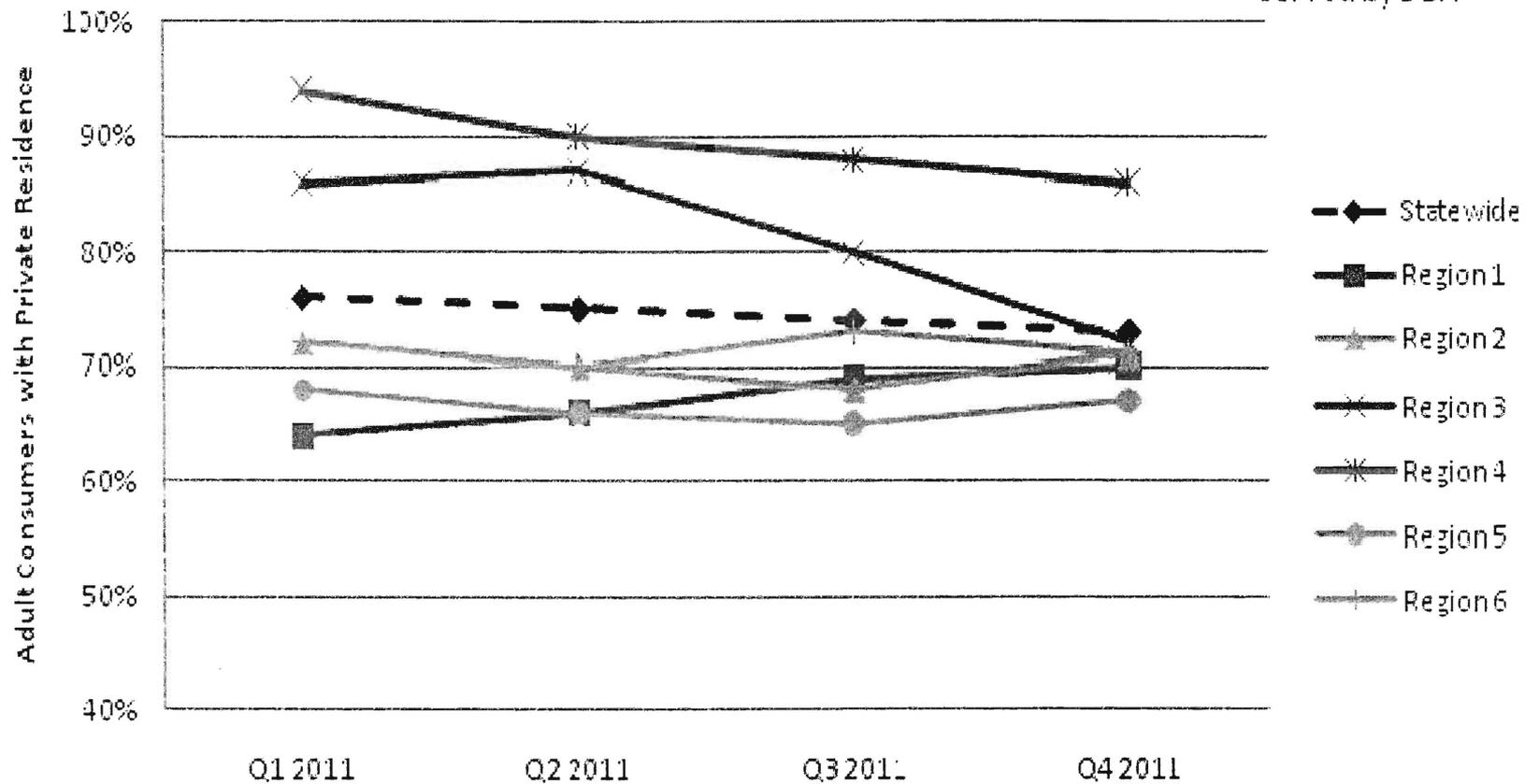
Clients funded and served by DBH



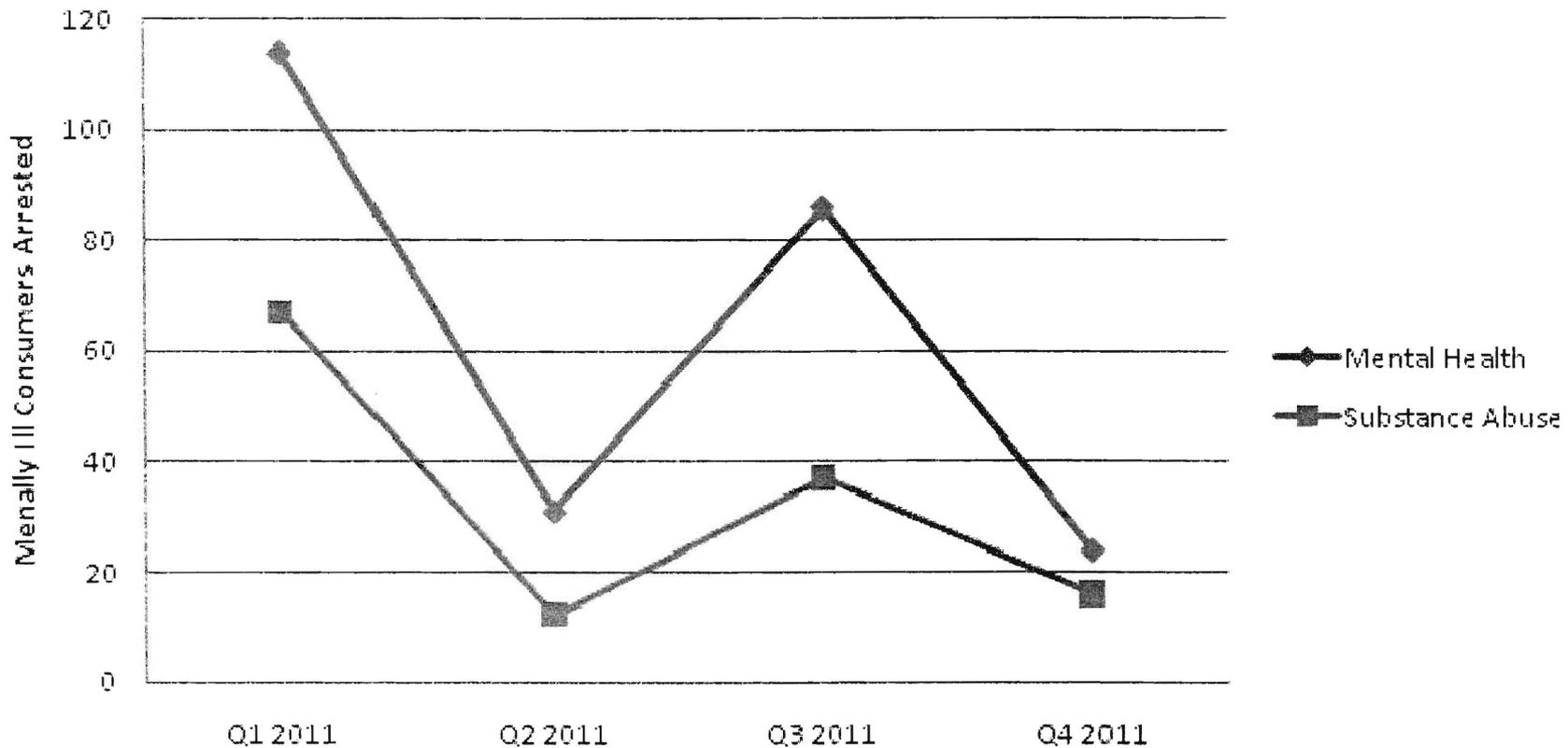
Measure 1:2 Percentage of Adult Consumers Living in a Private Residence at Time of Admission to Services

by Region

Clients funded and served by DBH

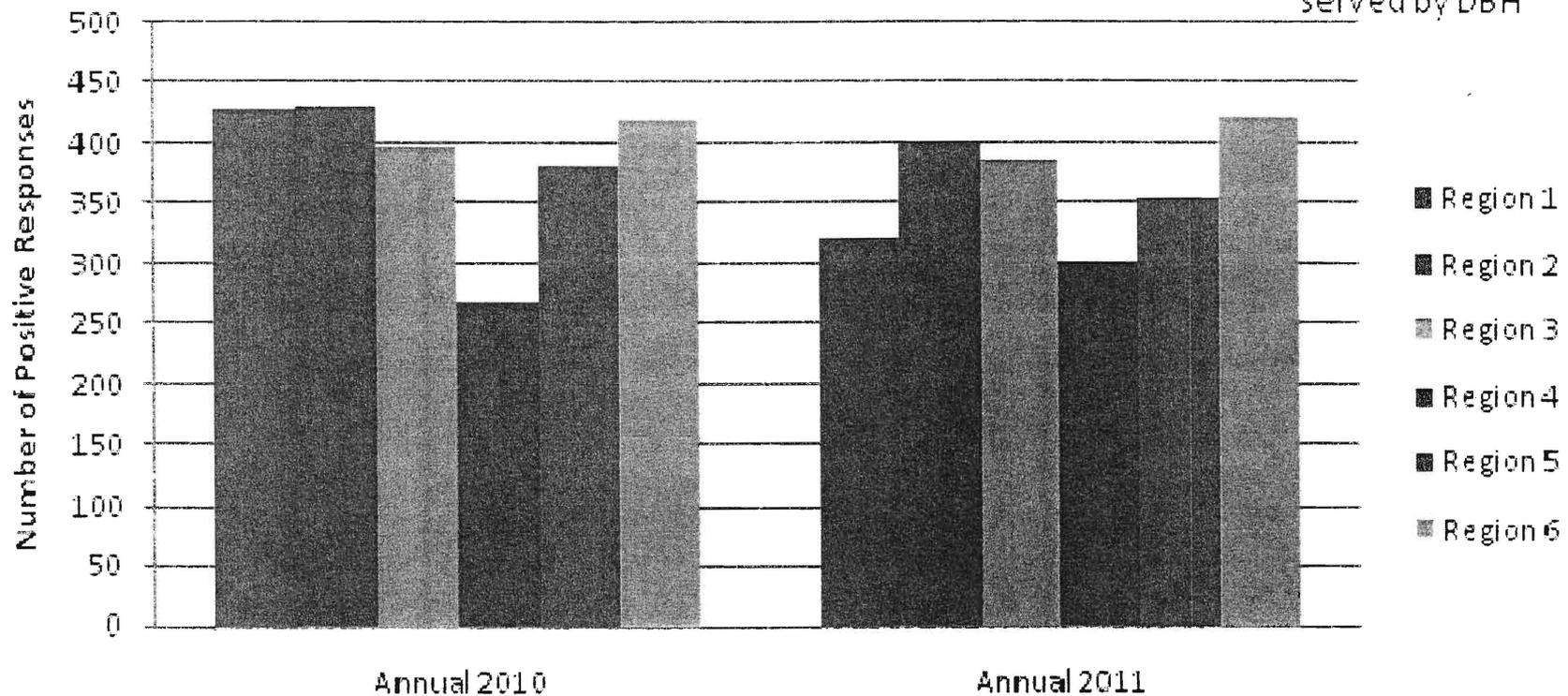


Measure 1:3 Number of Mentally Ill Consumers Arrested and Booked by Law Enforcement by Diagnostic Group

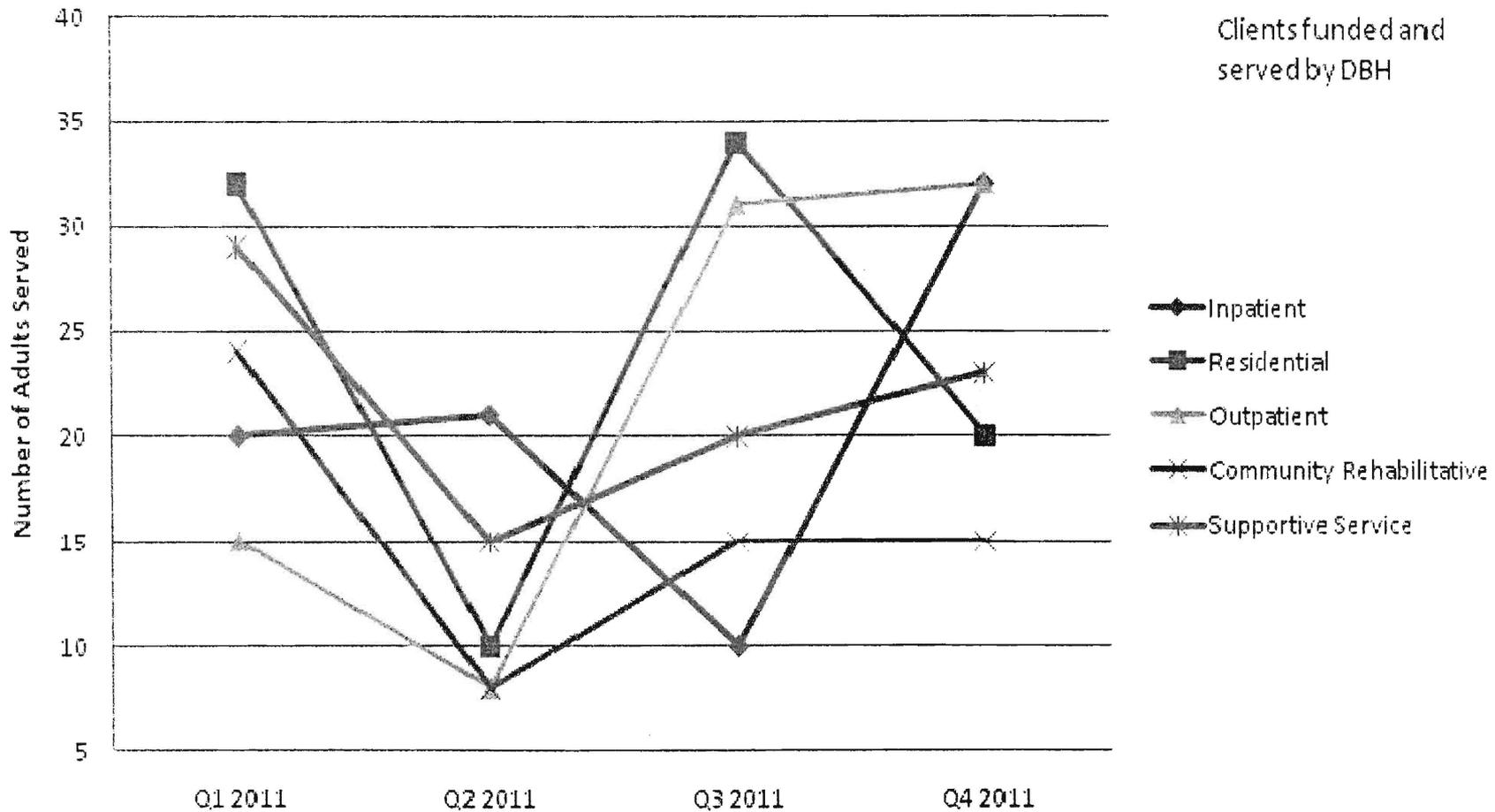


Measure 2:1 Number of Positive Responses to Survey Question #1 "I deal more effectively with daily problems" by Region

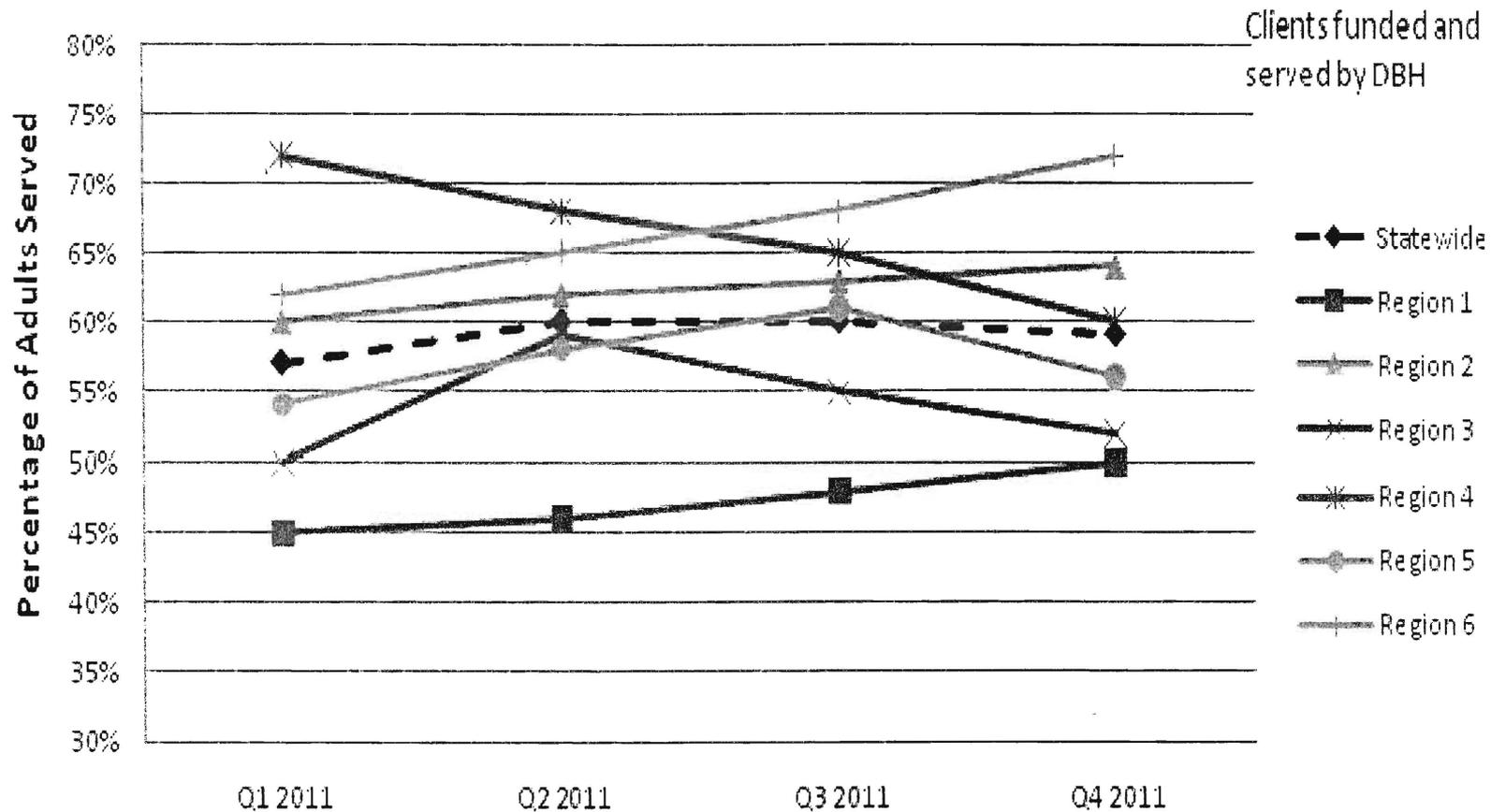
Clients funded and served by DBH



Measure 3:1 Number of Adults Served in the Nebraska Public Behavioral Health System by Service Type

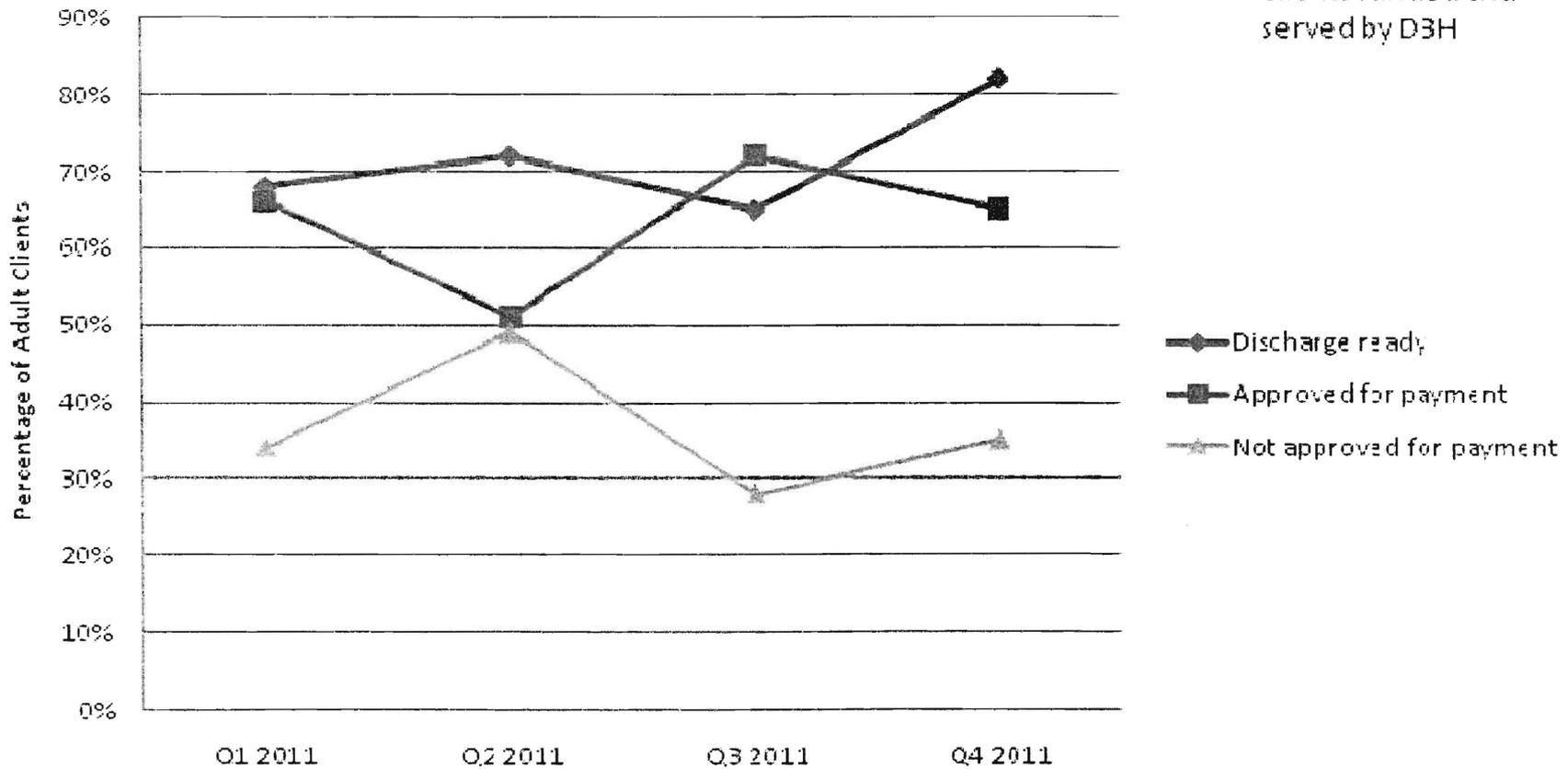


Measure 3:2 Percentage of Adults Living in Rural/Frontier Areas Receiving Behavioral Health Services by Region



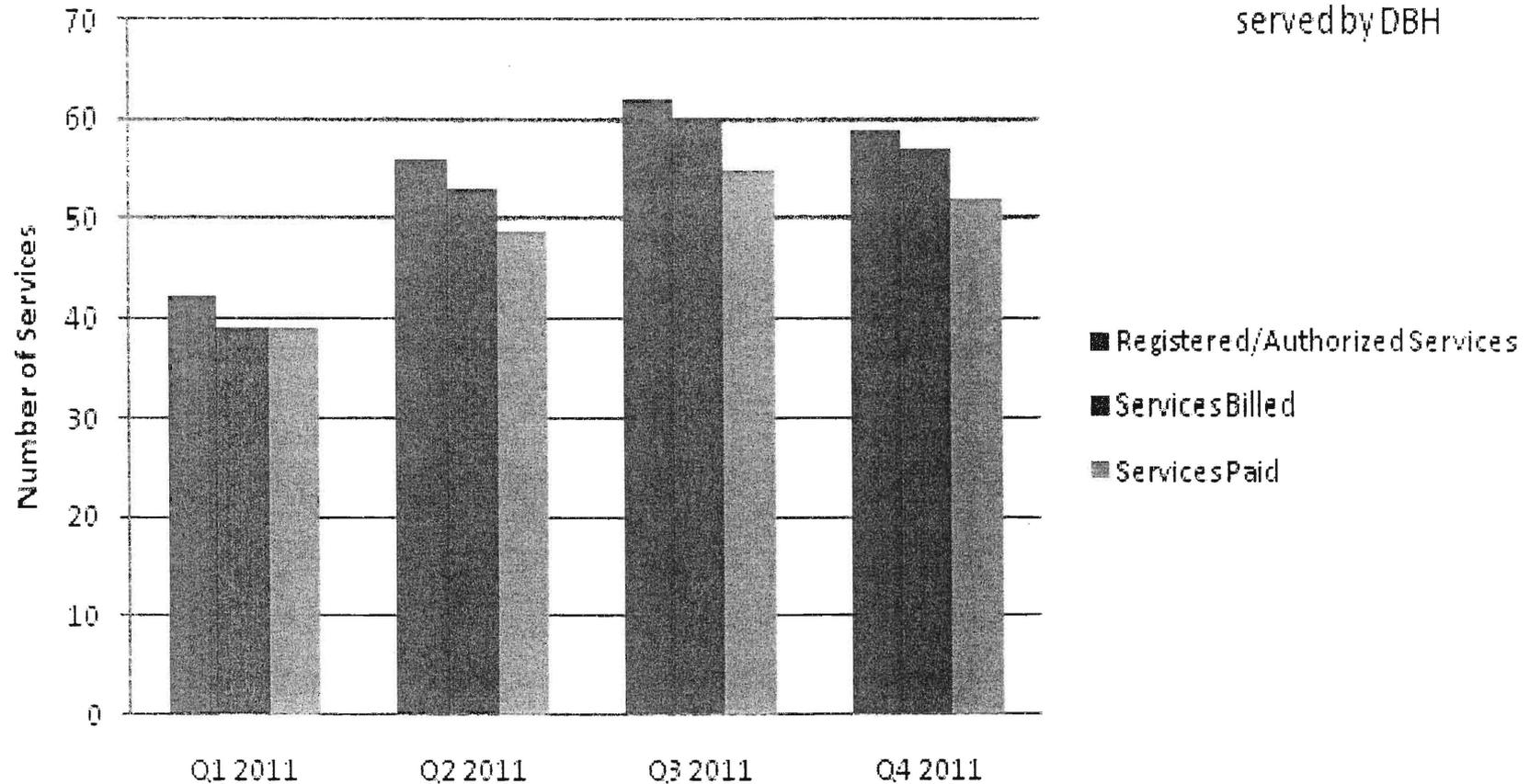
Measure 3:3 Percentage of Discharges from Hospital, Where Treatment Team Recommended Community Services are Available, When Patient is Discharge Ready

Clients funded and served by DBH



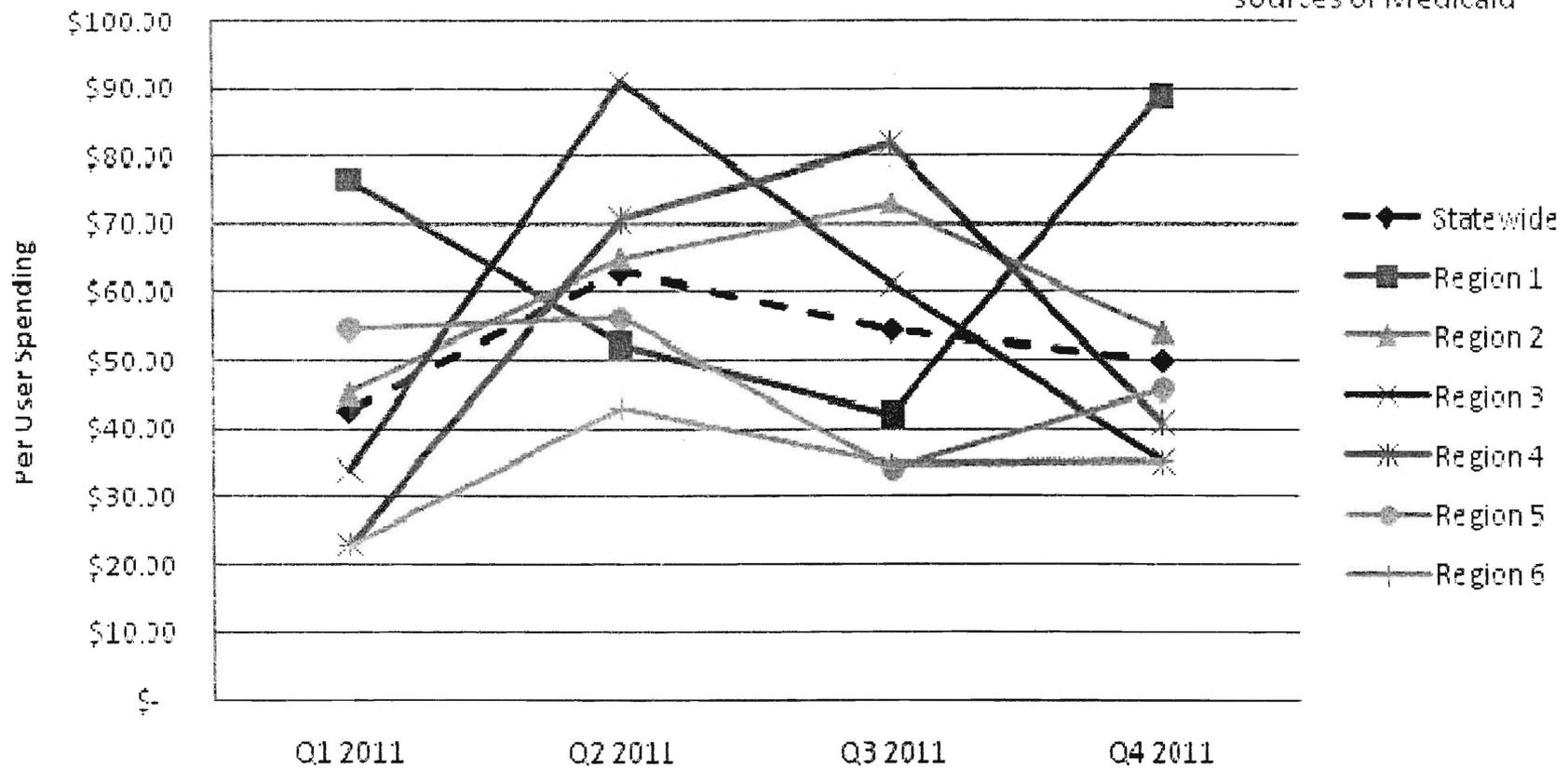
Measure 3:5 System Service Utilization by Service Type - Inpatient

Clients funded and served by DBH

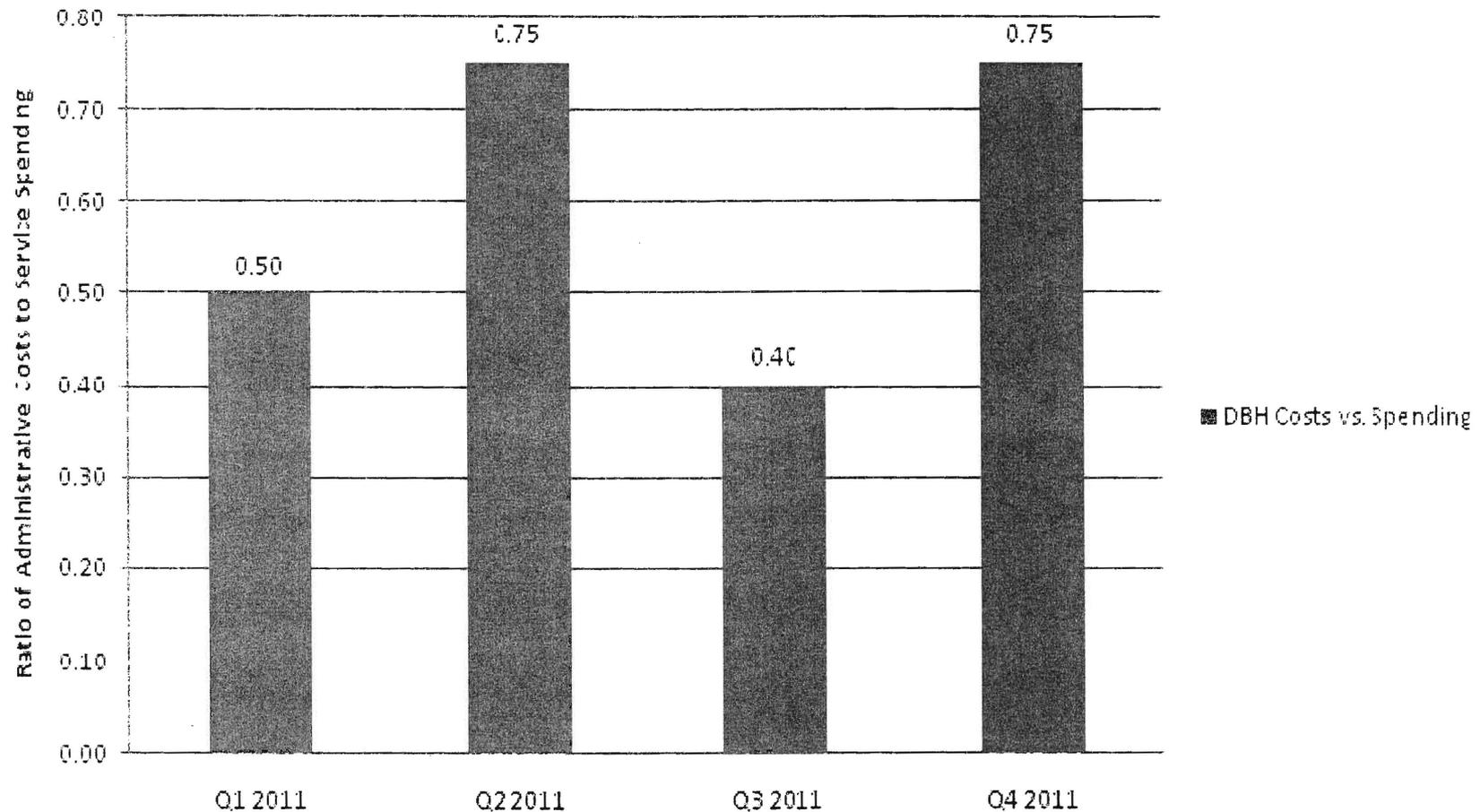


Measure 4:1 Per User Expenditures for Behavioral Health Services by Region

Clients funded by all sources of Medicaid

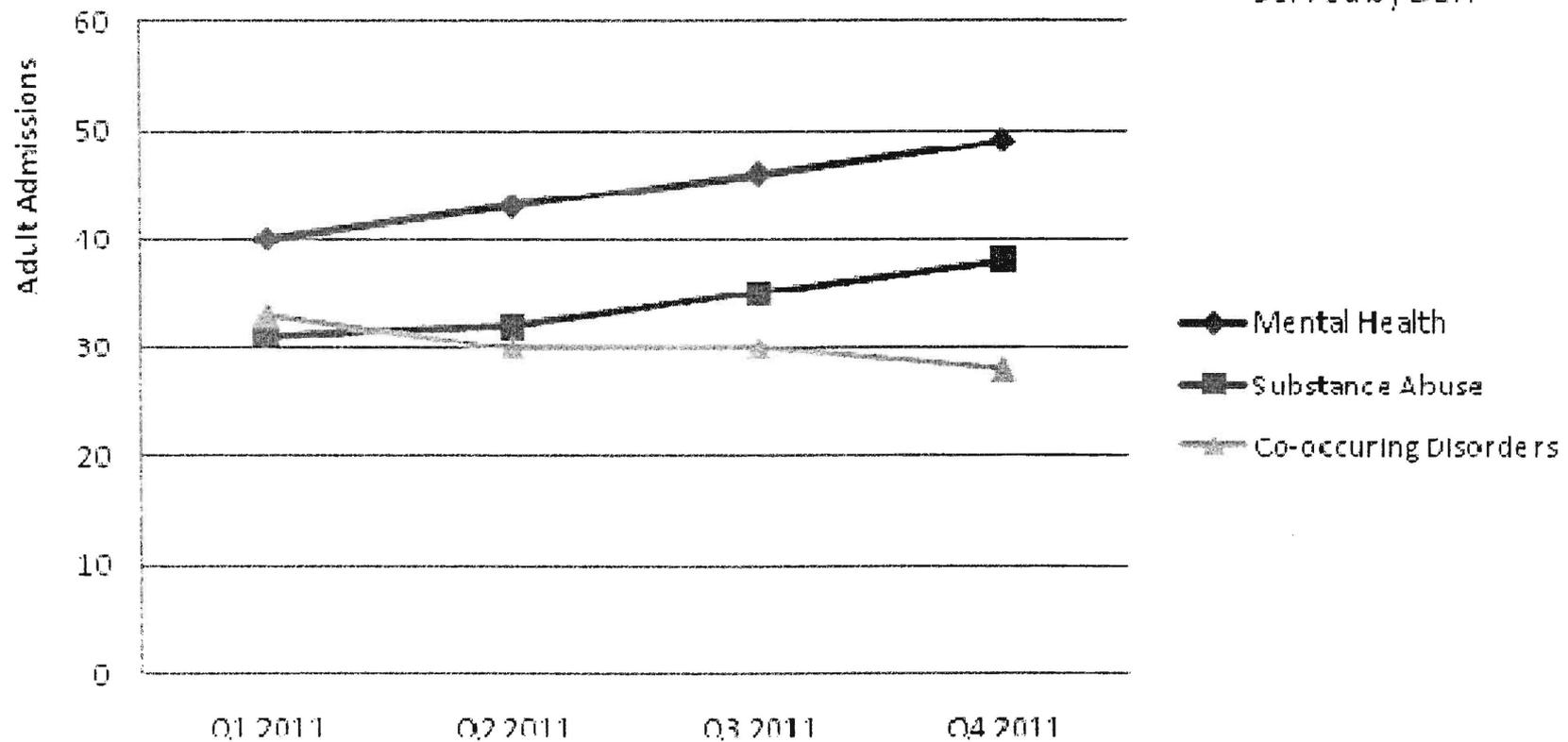


Measure 4:2 Ratio fo Administrative Cost to Service Cost for Nebraska Department of Behavioral Health (DBH)



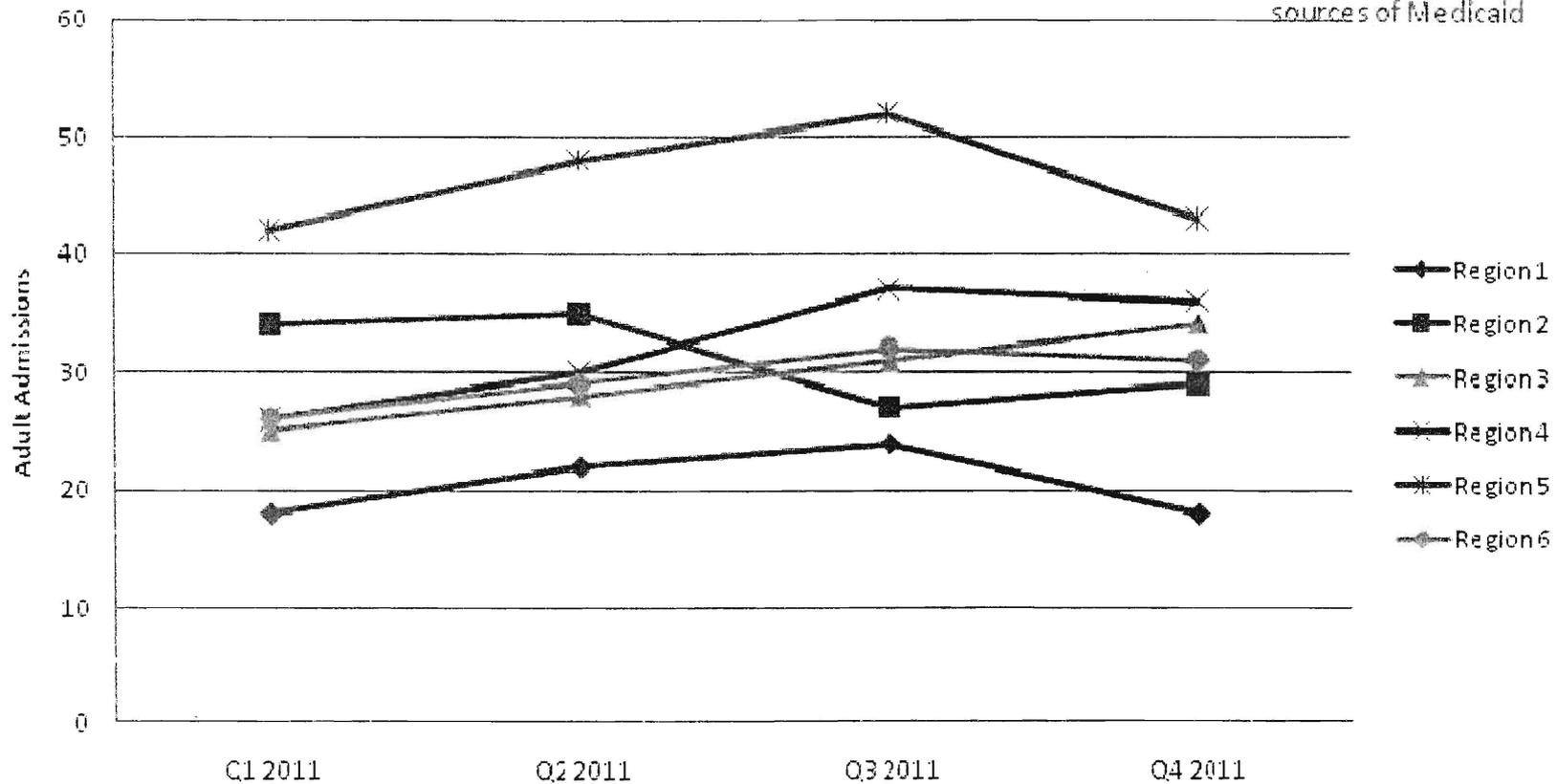
Measure 4:3 Number of Adult Admissions into Inpatient Behavioral Health Services by Diagnostic Group

Clients funded and served by DBH

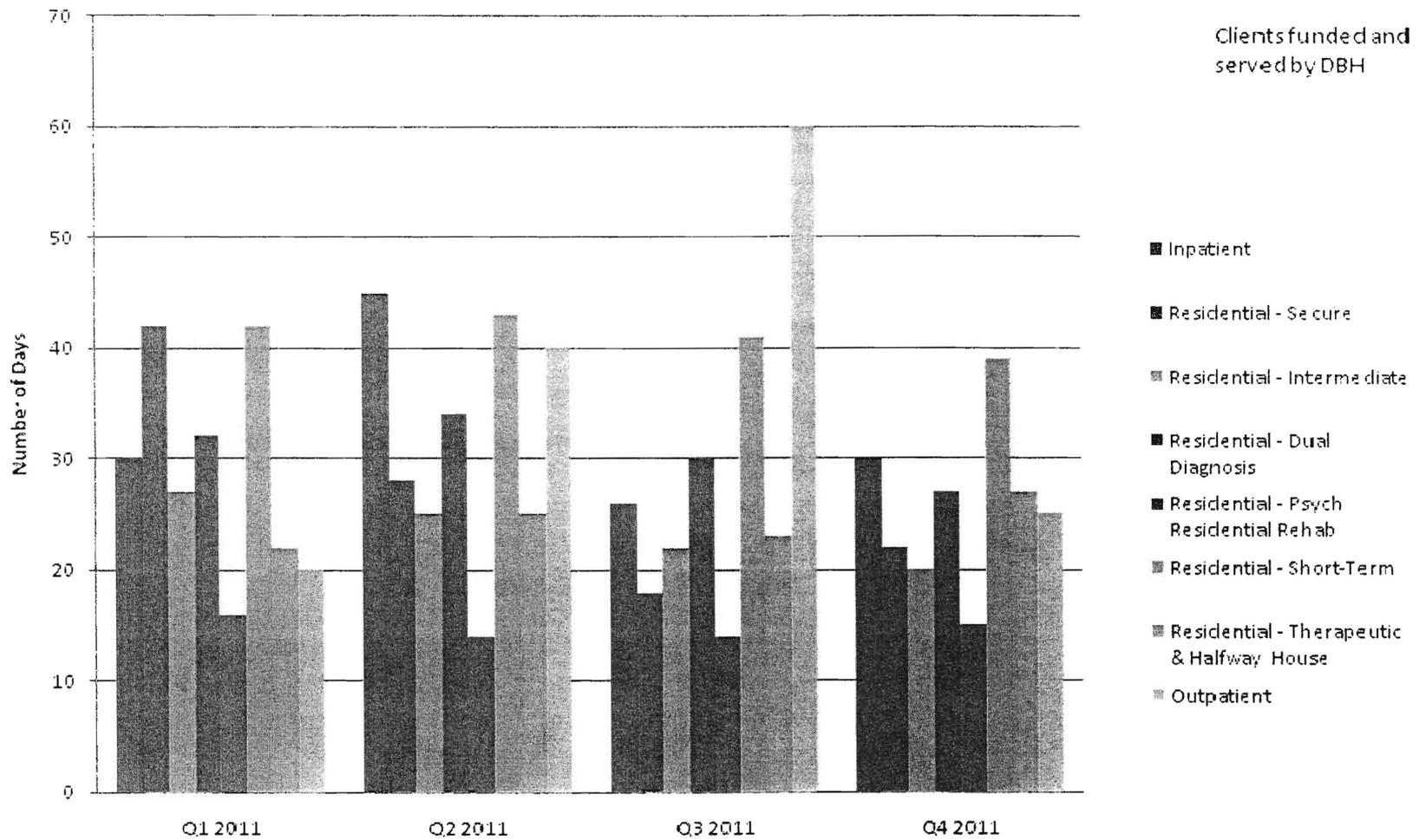


Measure 4:4 Number of Adult Consumers Using Residential Community Based and Non-Residential Community Based Behavioral Health Services by Region

Clients funded by all sources of Medicaid

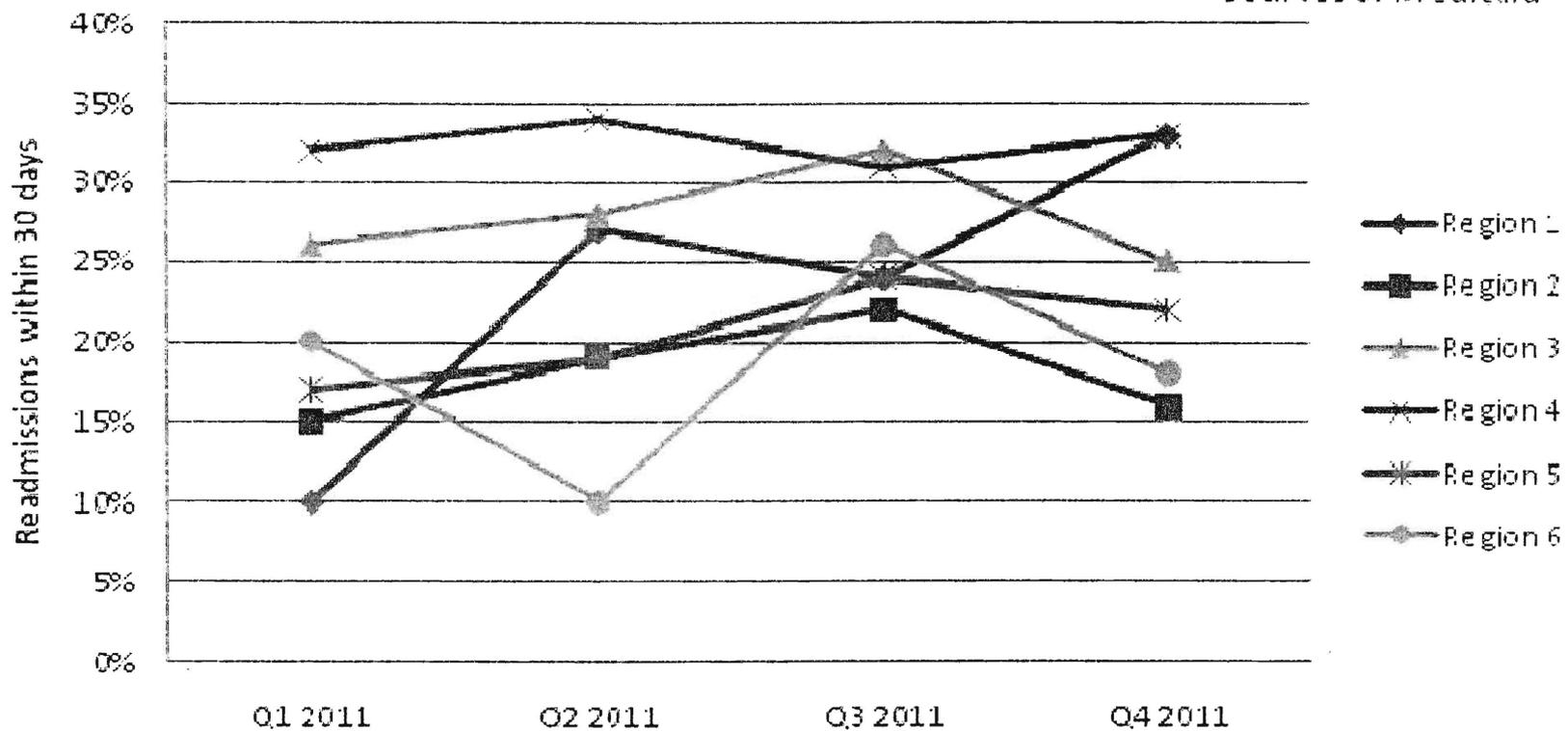


Measure 4:5 Consumer Average Length of Stay for Region 1

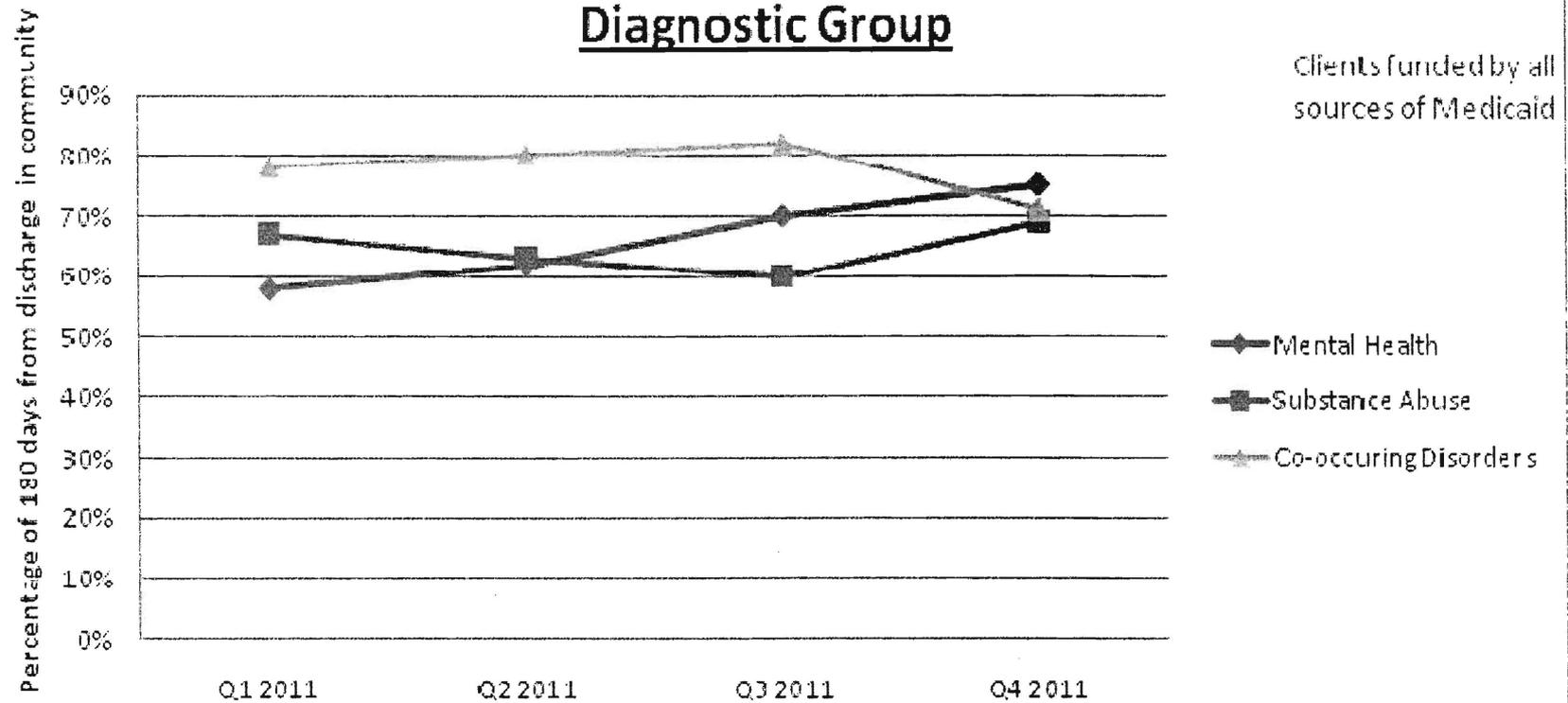


Measure 4:6 Percentage of Readmissions to Pyschiatric Units/Hospital within 30 Days of Discharge by Region

Clients funded by all sources of Medicaid

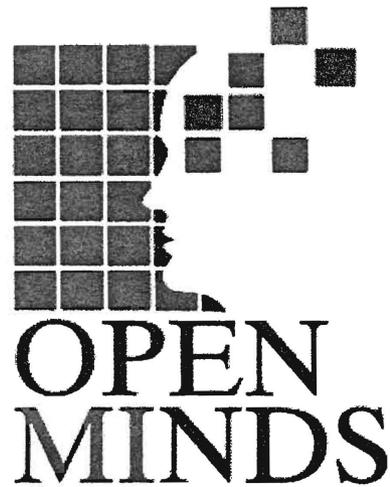


Measure 4:7 Percentage of Days Consumers are in the Community and not in an Inpatient Setting 180 days after Discharge from Inpatient Psychiatric Hospital by Diagnostic Group



Proposed Next Steps in Public/Private Partnership Work of the Nebraska Behavioral Health Support Foundation

- “Beta test” of performance measurement system
- Discussion of and plan for implementation of regulatory reform initiative recommendations to reduce system costs
- Facilitation of planning to encourage better integration and coordination of services in behavioral health system



The market intelligence to navigate.

The management expertise to succeed.

www.openminds.com

163 York Street, Gettysburg, Pennsylvania 17325

openminds@openminds.com

717-334-1329

December 14, 2010

TO: Health and Human Services Committee

FROM: Jonah Deppe, Executive Director
NAMI Nebraska

RE: Public Hearing LR513 – Interim Study to review implementation of the Nebraska Behavioral Health Services Act by the Division of Behavioral Health of the Department of Health and Human Services.

NAMI is the nation's largest grassroots mental health organization representing consumers and family members. NAMI Nebraska represents consumers and family members across the State of Nebraska.

During the past several years, NAMI has participated in several strategic planning sessions for the Division of Behavior Health. NAMI members – both consumers and family members – served on the LB1083 Advisory Committee. To date, with other planning activities we have not seen the expected participation of consumers and family members in developing plans and services. More recently, representatives of NAMI consumer and family members reviewed the Division of Behavioral Health's Draft Strategic Plan for 2011-2015 and have noted several concerns.

The Draft 2011-2015 Strategic Plan Goals seem to address special populations without an overall priority for all persons experiencing a behavioral health episode in their lives – mental illness, substance abuse and gambling. NAMI and its members certainly support effective prevention and treatment for co-occurring disorders and appropriate services for sex offenders. Goals 1-3-4.

The outcomes seem to be focused on the development of reports and documents. NAMI members would like to see outcomes related to the services provided through the Division of Behavioral Health. NAMI members found it somewhat difficult to see how the Strategies addressed the 2011-2015 goals. There are areas where this looks like this could happen such as in Initiatives for Strategy 2: Improve the Quality of Behavioral Health Services for children and adults. Although we would hope it would not take four years to develop the quality improvement system measuring outcomes and workforce development plan.

Access to services in the community is important to both children and adults. Home and community based services need to be accessible and available. Moving from residential care to home and community based services will not be successful unless those services are available in the community. Developing standards and publication of standards for access to care will not be successful if the services are not available. Lack of availability and access is what consumers and families are presently experiencing as service providers are closing services due to lack of authorization for these services.

Partnership initiatives with state agencies including those outside of the Department of Health and Human Services are important for a recovery-oriented system of care. Persons receiving services should be involved in monitoring the quality and availability of services. This is not a new concept and can be most helpful to the Division of Behavioral Health. The Office of Consumer Affairs is one avenue for partnering with people with a lived experience but should not be the only avenue.

Yesterday, there was a Children's Health Summit in Omaha sponsored by the Omaha Bright Futures Program where the importance of education and health working together to improve the lives of

children and their families was discussed. A medical home including behavioral health services along with physical health services was part of the discussion by persons working in both the health field and education fields. Especially for children – the Department of Education and school districts working with health resources available can often obtain services for children earlier and therefore prevent the need for higher levels of care when they become adults. NAMI would encourage the Division of Behavioral Health to develop a closer relationship with the Department of Education.

NAMI is particularly pleased to see children mentioned in the Strategic Plan and would like to see monitoring that includes services for children and youth. Children were mentioned in LB1083 and that was all they received was a mention. The Medicaid Division received a SIG for developing an infrastructure for children and adolescent services – the results of that planning process led by the Division of Behavioral Health was disappointing to say the least – the state received \$750,000 for several years. Other efforts by the Division have still not identified a system of care for children and youth infrastructure so appropriate and timely services are delivered to children and youth. One population in desperate need of services is the 19 year olds aging out of the children's services and needing services in the adult service system. Many of these youths are now in jails, etc and not receiving adequate behavioral health services.

NAMI supports the concept of person-centered care and a recovery-oriented system of care and would very much like to see these concepts implemented by the Division of Behavioral Health, the Regional Behavioral Health Programs and service providers. We believe effective services include the implementation of these practices in evidence based programs. Monitoring should include fidelity to evidence based practices being implemented. Person centered care including self-directed care could impact the cost effectiveness of providing behavioral health services.

We recognize the funding issues being faced by the State and Nation and support the movement towards home and community based care as potentially being cost effective once the services are in place. Building the capacity for cost-benefit and cost-effective services offered as person-centered and recovery oriented could provide for the availability of funds for needed services.

NAMI fully supports the Division of Behavioral Health's Vision that the Nebraska public behavioral health system promotes wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family driven system. NAMI supports the inclusion of services for children and youth in planning as more recent efforts to develop plans have not included children and youth. NAMI members are concerned that while these planning efforts are being implemented – services will be reduced more than they presently are. We recommend that persons affected by a behavioral health and their families from across the state participate in all the planning involved with the Divisions Strategic Plan.

NAMI NEBRASKA CONSUMER AND FAMILY MEMBER
RESPONSE TO NEBRASKA DIVISION OF BEHAVIORAL HEALTH STRATEGIC PLAN 2011-2015

NAMI Nebraska consumer and family members reviewed the Draft Strategic Plan for the Nebraska Division of Behavioral Health and provide the following comments:

2011-2015 Goals

1. Why are only co-occurring disorders targeted for effective prevention and treatment in recovery-oriented systems of care by a public behavioral health workforce? We would like to see this goal for all people with a behavioral health disorder.
2. Regional Centers will be used for court ordered and sex offender care by 2014. We see this goal as too limiting with the lack of space in community hospitals available for treatment. There are people in acute and long-term secure facilities who can not be managed at that level of care. What services will be available for this population once LRC is not an option.
3. Concern that an effective system to safely manage sex offenders in outpatient settings will be ready for implementation by 2015. Concern that this would be implemented in much the same way as closing the regional centers and the goal to provide community-base services was never fully achieved due to in-adequate funding for community-based programs.

We fully support the Vision for the Division of Behavioral Health – the Nebraska public behavioral health system promotes wellness, recovery, resilience and self determination in a coordinated, accessible consumer and family driven system. The Mission for the Division of Behavioral Health to provide leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

We found it somewhat difficult to determine how the five strategies addressed the four 2011-2015 Goals. We found it interesting that partnership initiatives were all within the Department of Health and Human Services. It would seem that partnerships with other entities such as the Department of Rehabilitation, the Department of Education , the Department of Labor/Workforce Development , and the Attorney General would be two additional partnerships that would be helpful in implementing the strategies.

It seemed to the consumers and family members reviewing this document that outcomes tended to be the development of publications and indirect outcome measures. We found it interesting that two of the goals addressed sex offenders yet only strategy 3 mentioned measuring the effectiveness of public safety driven services like court ordered and sex offender care in a footnote. In addition, Strategy 4 mentioned sex offenders in the partnership initiatives promoting credentials for professional specialties including sex offender care.

In addition, we were concerned regarding the lack of focus on children and especially youth in transition. We did not note a recognition that services for children and youth require programs

different than those for adults. Families play a major part in the development of services for children and youth and an acknowledgement of this factor is not clearly defined.

We have an overall concern that this will be another example of time spent developing guidelines and publications which gather dust on a shelf or are tucked away on a website.

COMMENTS RELATED TO STRATEGIES:

Strategy 1: Insist on accessibility – increase access to appropriate and effective integrated behavioral health services, particularly for underserved or vulnerable populations.

- Increase home and community-based services for accessibility.
- Recovery oriented needs to be responsive to individual and family.
- Need to partner with education and health to provide access for children/youth.
- Surveys should include issues/service accessibility determined by families especially for transition youth.
- Accessibility depends on the capacity of existing services which need to be adequately funded to be available and accessible.

Strategy 2: Demand Quality - Improve the quality of public behavioral health services for children and adults.

- Expand to persons with lived experience outside the OCA to identify measurable, meaningful quality indicators. By only using the OCA to identify persons – limited to same few consumers providing input – HHS/BH's recommending consumer involvement through OCA needs updating lists on their website as staff persons listed are no longer working with OCA.
- Expand to include families with children/youth. Also persons with gambling and dual diagnosis – not likely to find through OCA.
- Include consumers and family members in monitoring programs and evaluate the quality of services provided.
- State's annual survey is limited in questions and persons who respond. Work with organizations like NAMI with consumer partners to involve more consumers and family members.
- Does OCA include gambling, addiction, substance abuse – in addition to mental illness.
- Need to do better at including peer specialists in developing quality services

Strategy 3: Require effectiveness – improve outcomes for children and adults through the use of effective services.

- Include consumers, children/youth and family members in determining effectiveness of services being provided –
- Effectiveness prepares adults, children/youth for living in the real world outside of a controlled environment – i.e., when they return home from hospital or residential care.
- Effectiveness relates to transition services when moving from one service delivery system to another – input from children and youth experiencing the transition.

- Definition of effectiveness – defined by each individual and the impact of the service on their lives.
- Extent of child/youth/adult in determining treatment as it relates to effectiveness should be considered.
- Concern Leadership Initiative 6 – who determines effectiveness – is input from adult – child/youth and family considered in determining effectiveness.
- Definition of court ordered services – not clear what is intended – how does this relate to public safety driven services including sex offender care.
- Listen to recipient of care description of what happened to them and what do they feel they need for services – give consideration in determining effectiveness – who determines effectiveness? Provider or recipient ??
- Understandable description of evidenced-based and empirically-based – helpful to better understanding of these terms and what they mean.

Strategy 4: Promote cost efficiency – develop flexible and balanced funding to support an efficient and accountable person-centered, recovery oriented system of services.

- Does this lead to privatizing the behavioral health services as we see happening with child welfare services?
- Integrated behavioral health professional credential could lead to cost efficiency if it was not at the cost of effectiveness.
- Parity issues and health care reform issues could impact the cost of services provided.
- Self-directed care could be a cost efficient and accountable person-centered, recovery oriented service delivery model implemented with peer specialists supervised by case managers.

Strategy 5: Create accountable relationships – Encourage transparent, accountable relationships with and among system stakeholders.

- Include adults/youths/families in developing measures of accountability.
- Ensure that stakeholders include persons from provider agencies, rehabilitation and education.
- OCA is not the only source for identifying people who have lived experience with a mental illness nor are the Regional Behavioral Health Authorities – there are many people with lived experience living every day lives whose experiences could bring another aspect to accountable relationships.
- Inclusion of those most effected in developing relationships should be identified.

Testimony, LR 513, 17 December 2010
J. Rock Johnson JD
1243 S. 11th Street
Lincoln, NE 68503
402-474-0202

Thank you Senator Gay and members of the Health and Human Services for this important hearing.

The purpose of this interim study is to review and assess the implementation of the Nebraska Behavioral Health Services Act.

It is now six years since this reform legislation was passed.

The concepts of inclusion, a purpose of the Nebraska public behavioral health service system, and recovery in the Behavioral Health Service Act requires the Behavioral Health Division to do business differently. We are not seeing this expressed appropriately in the draft rules and regulations currently in the final stages of approval. Nor do there seem to be "policies" that can be accessed to further understand the viewpoint of the Division.

The Division is to be commended on undertaking a strategic planning process that has never been done here before.

Consumer-run and peer-run services are also included in the Behavioral Health Services Act.

An important inclusion/recovery implementation is the adoption of evidence-based practices. These are practices proven empiracally to be effective. In a multi-state, multi-site \$20 million dollar research study, consumer run services functioning as adjunct to traditional mental health services were found to be an evidence based practice. "

Peer-provided services is the work of the Mental Health Association of Nebraska. Keya House is an informal , recovery-based, four bedroom house in a residential neighborhood that has been operating for a year. People have been trained as

Peer Companions, available 24/7, to talk with during guest's five day stay. People come to Keya house before a crisis. They come when they need time and supports to avoid a crisis.

Preliminary data on early guests shows a dramatic decrease in their use of traditional mental health services.

In this first year 78 guests, unduplicated count, stayed a total of 550+ days at 1/3 the cost of the Lincoln/Lancaster Crisis Center. Medicaid data shows two out of three guests stay out of high cost services after using the House.

The Mental Health Association also administers Project Hope, supported employment to assist people who are ready to enter into competitive employment. There have been good results. For example, a client early in the program has been continuously employed for four years.

Supported employment is an evidence-based practice. It isn't enough for any agency to just start up supported employment. "Fidelity to the model" compares how closely a program is following supported employment.

The Division is to be commended for having chosen to implement and purchase supported services from ten providers in the state over the last several years. The one provider with fidelity to the model was the Mental Health Association.

Implementation of consumer inclusion needs to be addressed. It is a purpose of this statute and critical to developing a recovery in the system and the individual.

To this end, and simply good practice, consumers must actively be involved in the quality, efficiency and effectiveness of the services they received. This means something completely different than the Division sending out a satisfaction survey once a year as it has done for many, many years in order to meet the requirements of the mental health block grant.

Just a few of the states with substantive involvement of the people who use the services are PA, MA, GA and SC. Often consumer organizations contract with the State to involve consumers in quality assessments. There are face-to-face interviews. A complaint resolution mechanism can become a part of this activity.

This could be a helpful direction for several reasons, as Nebraska does not have a functional or substantive complaint/grievance mechanism and the proposed rules and regulations do not change this unfortunate circumstance.

Consumer substantive involvement can be extremely efficient and effective. Both are component parts of quality. With consumers working close to service delivery and outcomes, a great deal of useful information can be processed at very little cost. This does require authentic, trained involvement which would need to be developed.

Several years ago Nebraska had a Medicaid Infrastructure Grant. One part of it was to develop "Consumer-Directed Guiding Principles". Under the heading "responsibility", it stated "Consumers have the responsibility to monitor and evaluate the quality of their services."

Nebraska needs to acknowledge the new measures, such as "Recovery, What Hinders, What Hurts". All aspects of data have been problematic for at least twenty years. Nebraska must develop measures that speak to the new approaches and services. For all practical purposes, approaches that do not treat recovery in a meaningful way will not be helpful in even the short run.

Many are very concerned that formerly state funded services continue to be funded by the state but use the strict medical Medicaid requirements. These can be interpreted rather stringently at our State level and have been done so in at least this instance. The State is losing the flexibility of state funds that can support the recovery based services we know, here and other places, keep people out of the system and living lives integrated in the community.

It took an act of the Legislature in the mid-90s to require application for the Medicaid Rehabilitation Option. Perhaps more legislation could be necessary to implement the inclusion and recovery provisions of the Behavioral Health Services Act.

- Exhibit 6

Epworth Village

a change for the better

Box 503, 2119 Division Avenue • York, Nebraska 68467-0503 • (402) 362-3353 • Fax (402) 362-3248 • epworthvillage.org

December 16, 2010

Senator Tim Gay, Chair
Health and Human Services Committee
Nebraska Legislature
P.O. Box 94604
Lincoln, NE 68509

REF: Testimony related to LR 513

Dear Senators:

Thank you for this opportunity to address some comments related to the public hearing held on December 13, 2010 for LR 513. I did attend the meeting and found the oral testimonies to be very informative and interesting. I am representing the Children And Family Coalition Of Nebraska (CAFCON). I hope my comments in this letter are also as engaging.

LB 1083 as it was written and intended did not limit the Act to addressing services only to adults. The language includes children, but the focus and most of the action and funding was generated towards adults and adult services. It must be remembered that as much as this legislation relegated work to and with the Behavioral Health Regions, those Region staff will admit their work to be generally focused on adult services and issues. It was not until the passage of LB 542 in 2007 creating the Children's Behavioral Health Task Force was there focus on systems issues specifically for youth. The 542 Task Force advanced 17 Recommendations to the Department of Health and Human Services (DHHS) as ways to improve access and quality of care to children under age 21 in Nebraska.

I believe it would be a good idea to revisit those recommendations and ask for specific measurements as to how or if those recommendations have been or are being addressed. As we look at the desire of the Behavioral Health Division to implement a Strategic Plan from 2011 to 2015, I believe these efforts should be cautiously applauded. I need to say that I believe in goal setting and creating functional measurements of how those goals were or were not attained. My hesitancy as it relates to the announced plan comes from experience. I have been involved in human services work for over 30 years. Twenty-four of these years have been most specifically with youth. Going back to a group empanelled by then Governor Johannes to examine DHHS and identify significant problems inherent in the department and the system one of the items they noted specifically was the lack of Vision and Continuity in the Department. I looked in my twenty-four year history and identified nine (9) Directors or CEOs of that Department responsible for establishing and identifying the direction of the department. As stakeholders we have addressed issues with at least 9 different Directors or CEOs of DHHS, and found 9 different directions, philosophies, vision and plans.



Accredited by The Joint Commission

"A project related to the General Board of Global Ministries
of The United Methodist Church"



While I have enjoyed my interactions with Dr. Scot Adams over many years and respect him greatly, this planning process could change with a new CEO or if something happened and he was unable to resume his position. Of the countless hours of visioning, planning and identifying a direction over the years, none of them have been sustained. Does anyone remember or can identify the goals established by the Nebraska Family Portrait or even its philosophy? My point is not to degrade the need for planning, but to point out the poor historical performance in this area.

As planning to reform, alter or change our system occurs we must keep in mind the recent reform efforts and our experience thus far. The remaining service provider groups or agencies are really bruised and battered right now. At the same time the Child Welfare reform process is not over, we are already in the throes of Medicaid Reform which will have absolutely huge impacts on providers. Within the past year we can identify 13 agencies that have either had to close completely, reduce staff, or shut down entire program areas within their treatment programs. Many providers are very fragile and additional major changes that are simply thrust their way could prove devastating not only to the provider but especially to those receiving services. Further losses to providers and programs will definitely have a negative impact on the access of care to those in need.

I listened to and agreed with virtually all the testimony by Monica Oss of Open Minds. I would, however, offer a caveat as it relates to some 'Best Practice' and 'Performance Measures' identifying which practice or provider is better than the other. Best Practice offerings while being established, studied and validated in the instance that it exists in does not mean that same practice will offer the same degree of benefit if applied over the entire scope of services. While some tenants of a Best Practice might relate, adhering to fidelity to the model might render it useless if not harmful applied elsewhere. Provider programs need the flexibility of offering Best Practice models associated to the unique population that program serves.

Performance Measures are something that every Accredited agency must have already established and been demonstrating. The purpose of the measures must be articulated and in what fashion will they be used. Early on when No Child Left Behind was beginning it was required that each state and each school district will have measureable standards in certain core subjects. Over and over it was stated that these measures were only established so that individual schools could see where they needed to improve. One of the very first things to happen when the aggregate data was released was that School District 'A' looked to see how School District 'B and C' looked in relation to the test scores. Those test scores have now morphed into how deciding how much education aid is distributed to the District. However, this was not the original intent.

A cookie-cutter approach to Performance Measurements alone has inherent problems. I have not seen the process or measures that Open Minds has created and I am very interested in studying those. On the surface, comparing agency data looks wonderful; while in its practical application it can become problematic. First of all, there needs to be 'common definition' of terms and understandings, and how each measureable item has the data collected and analyzed. It must be recognized that each provider serves a distinct population that may be very unique and expectations for 'success' will differ. As an example it would be very difficult to utilize the same criteria determining effectiveness when comparing a program that has girls aged 14 to 19 with only 1 Axis diagnosis and each girl having an IQ over 90, to a program serving boys ages 8 to 19 and each boy has multiple Axis I diagnosis and IQs that could go as low as 64.

Currently each agency which holds accreditation by a national accrediting body, has many different data sets from 'average age upon admission' to 'percent enrolled and attending school at 3,6 and 12 months post discharge', as an example. For many years, as the state has talked about Performance Based Contracting, many of us have indicated our willingness to move in that direction. Another item Ms. Oss touched on, was that in areas where economics of scale really come into play, it would be fair to expect that services in rural areas have a higher rate of compensation.

There must be a greater level of communication and coordination between the Divisions of Behavioral Health, Children and Families and Medicaid and Long Term Care, than currently exists. No Child Caring Agency exists in a vacuum associated with only one of these Divisions in their work with children and families. The reorganization of DHHS in 2007 was touted as being the start of transparency, collaboration and reduction of the 'silo-ing' effect. It continues to appear that while some discussion takes place between Divisions little collaboration actually is in evidence. An example is that years ago agencies used several different kinds of instruments for measuring behavioral severity. The state then began telling agencies that the CAFAS (Child and Adolescent Functional Assessment Scale) instrument would be used in determining placements. Most agencies then also switched to the CAFAS. Now we have been told that Magellan will be using the CANS (Child and Adolescent Needs and Strengths) assessment tool and providers had to send staff to training and begin using the CANS tool. When asked if the Children and Family Division would also be moving to this tool we were told by administrative staff that they did not have any plan to do that. Thus, we are currently using two different instruments and often times two instruments on the same child to satisfy both requirements.

I apologize for the length and diverse issues addressed in this testimony. It was not my intent to write *War and Peace*. It seems that when we identify a plan to right the wrongs, and inject exciting new potential we want to celebrate and dive right into the change. What we don't often take the time to realize is how when we squeeze the balloon in one place that same balloon bulges out and acts differently in another place and it might not have even been our intention. I greatly appreciate Dr. Adams planning to make a difference in Behavioral Health but as it impacts children the change has to be orchestrated in an incremental, studied process with the involvement of those who will be greatly impacted. To that end I also appreciate the Strategic Plan being identified as a four year process. Honestly, our ecosystem of care for children can not tolerate much more change at this point. That system of care for children already is tremendously impacted by change within Child Welfare and Medicaid and right now needs some rest and stability.

Thank you.

Respectfully,

A handwritten signature in black ink, appearing to read 'T. G. McBride', with a long horizontal line extending to the right.

Thomas G. McBride, M.S.
President/CEO

Nebraska Behavioral Health System Strategic Planning Report

**Commissioned By
Behavioral Health Support Foundation
Rhonda Hawks and Ken Stinson, Principals**

Prepared By



**163 York Street
Gettysburg, Pennsylvania 17325-1933
717-334-1329
<http://www.openminds.com>**

March 15, 2010

Table of Contents

I.	Executive Summary.....	3
II.	Nebraska Behavioral Health System Development Priorities	5
III.	History of Oversight Commission & Resulting Vision	14
IV.	Summary of System Structure.....	16
V.	Summary of System Funding	19
VI.	Nebraska Behavioral Health System Limited Performance Measurement Data.	28
VII.	Gap Analysis of Current Nebraska Behavioral Health System & System Vision	30
Appendix A:	Consensus Panel and Planning Group Members	34
Appendix B:	Prioritization of Legislative Initiatives & Regulation	35
Appendix C:	Effect of Parity Legislation on Nebraska Medicaid Managed Care.....	37
Appendix D:	New State Regulations Regarding Medicaid Rehabilitation Facilities ..	42
Appendix E:	Magellan Performance Reporting.....	44
Appendix F:	New Rulings on IMD Funding and Relevance to Nebraska Facilities...	46
Appendix G:	Nebraska BH Service Funding by Payer	49
Appendix H:	Behavioral Health System Provider Rates & Reimbursement.....	51
Appendix I:	Medicaid Rates	54
Appendix J:	Nebraska Division of Behavioral Health Goals (2010 MHBG Application)	57
Appendix K:	National Trends Overview	58
Endnotes		68

I. Executive Summary

OPEN MINDS is pleased to present to the Behavioral Health Support Foundation (BHSF) and other Nebraska stakeholders this Nebraska Behavioral Health System Strategic Planning Report. The focus for this initiative was to define an ideal Behavioral Health System for Nebraska and set forth specific, prioritized strategies by which to move toward this ideal.

The *OPEN MINDS* team approach included working closely with the Nebraska behavioral health system Planning Group and Consensus Panel, an ex officio community coalition of stakeholders representing the range of state and local government, professionals, provider organizations, consumers, and consumer advocates (See Appendix A for a list of participants). The Planning Group and the Consensus Panel were engaged to provide:

- Information about the current behavioral health system
- Feedback on the findings of the research and analysis of the Nebraska behavioral health system
- Priorities to move toward the envisioned behavioral health system

The *OPEN MINDS* team conducted a gap analysis comparing the current Nebraska behavioral health system with the system vision identified in the BHOC 2009 report. The following gaps were identified:

1. The current behavioral health system is not a system that has a unified and fully developed performance measurement process or outcomes that support decision-making.
2. The Consensus Panel members identified a continued concern over the lack of continuity and inclusion in a meaningful planning process with the Division of Behavioral Health as evidenced by:
 - ✓ No current transparent communication process between DBH, Division of Medicaid, RBHAs, providers, and consumers
3. The current system lacks a collaborative model for establishing new initiatives such as integrating physical health and behavioral health needs for consumers.
4. No state effort has been initiated to develop a common or cooperative strategic plan to achieve the goal
 - ✓ Without a targeted set of objectives and accompanying timeline, progress cannot be monitored and success cannot be measured or assured

As a result of this analysis, the *OPEN MINDS* team, the Planning Group, and the Consensus Panel members identified three critical priorities that must be addressed to achieve a strategic vision for the envisioned behavioral health system. These priorities are listed below and are expanded upon in more detail in later sections of this report.

- Priority One: Assure accountability of behavioral health system by developing performance measurements for best use of funding
- Priority Two: Develop standards for timely access to behavioral health services for all Nebraskans
- Priority Three: Optimize the use of available funding for behavioral health services by initiating regulatory reform to reduce redundant costs and burdens in the delivery system

The remainder of the report provides: a history of the behavioral health system development; overview of the system structure, financing and performance measurement initiatives; a gap analysis; and additional information and analysis leading to the development of the three priorities. We look forward to further discussion of these issues.

II. Nebraska Behavioral Health System Development Priorities

The Behavioral Health Support Foundation (BHSF) was instrumental in the development of a Plan Development Work Group (Planning Group) to work collaboratively with the Consensus Panel members in meetings held on January 21 – 22, 2010 and again on February 17, 2010. The purpose of the meetings was to develop a behavioral health system strategic plan that could be operationalized by the system stakeholders, and that included recommendations to the executives at the Department of Health and Human Services (DHHS) including Behavioral Health and Medicaid, Legislators, and the Governor. The collaborative vision statement identified by the Planning Group and the Consensus Panel members for operationalizing the Nebraska behavioral health system vision is to “provide universal access to behavioral health service to all Nebraskans with support of services for persons impacted by serious mental illness that focus on recovery and wellness that are cost effective with demonstrated value.”

Building on the established vision, the Consensus Panel members identified the system goals, elements considered in Nebraska behavioral health system planning, Consensus Panel priority issues, and the development of a preliminary system plan based on recommendations from Consensus Panel meetings. Four system goals were identified:

1. Universal and timely access to all behavioral health services for all Nebraskans
2. System design that supports recognition of and early intervention in behavioral disorders
3. System focus on consumer recovery and wellness
4. Funding of cost effective services with demonstrated value

The elements of the Nebraska behavioral health system were differentiated between primary and secondary stakeholders. The primary stakeholders are identified in Figure One and represent those stakeholders who impact directly the service delivery system. Table One represents the secondary system stakeholders who in one way or another may be involved in system funding, shared service delivery, or connected to a consumer receiving behavioral health services.

Figure One. Nebraska Behavioral Health Core System Elements

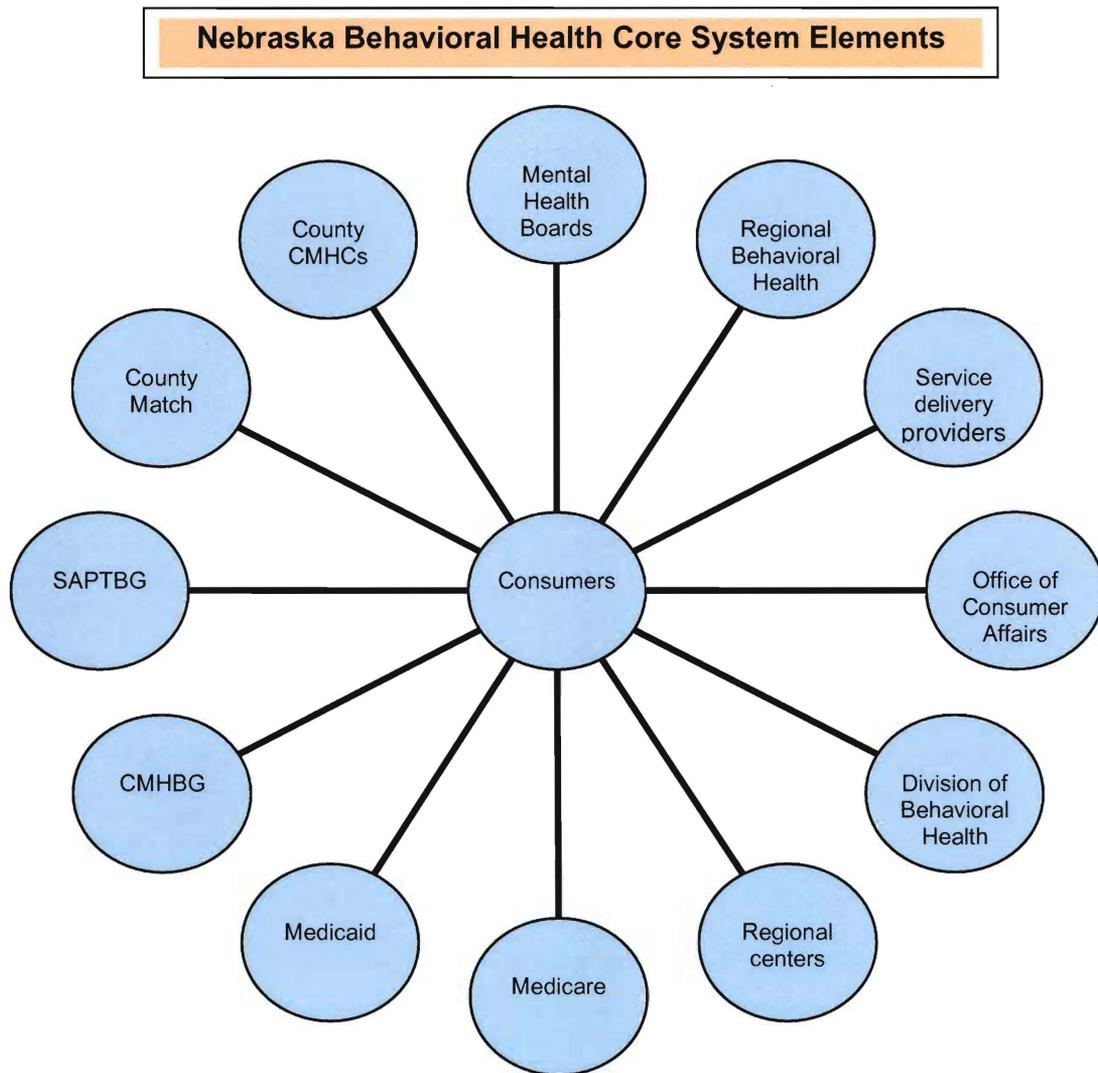


Table One. Additional Behavioral Health System Stakeholders

Additional Behavioral Health System Stakeholders		
Law enforcement	Education	Labor
Developmental disabilities system	Child welfare	Housing
General assistance	Social Services	Transportation
Corrections	Tribes	City/County
Courts (Local, District, State, or Federal)	Indian Health Services	Primary Care Providers
Probation	Veterans	Private Sector Donors

The Planning Group and Consensus Panel members developed a list of priority issues that acted as impediments to the envisioned behavioral health system:

1. Need for an enhanced performance measurement system
2. Limited flexibility for consumer-centric case planning and resource matching
3. Prioritization of use of behavioral health system dollars
4. Benefits of parity for mental health and addictions within Medicaid
5. Potential lack of service capacity and timely access to services
6. Lack of continuity of care
7. Better interface between corrections and behavioral health
8. Regulatory reform (relief and cost effectiveness)

The Consensus Panel members reviewed each of the priority issues, using the following process:

1. Defined the priority issue
 - Where one is in the system changes that person's view of whether system is "working".
 - Consumer
 - Family Member
 - Advocate
 - Mental Health Professional
 - Provider Organization Executive
 - County Government
 - State Government
 - Taxpayer
2. Discussed the options to address the priority issue
3. Reviewed examples of what other states are doing to address the priority issue
4. Identified key issues, preferred options, and other relevant information available or needed

The Consensus Panel narrowed the priority list from eight priorities to three priorities through the use of a nominal voting process. Each member was given three votes to identify the three most significant impediments and in addition, was asked to offer the best option to address the priority issue impediment. The following three priorities were ultimately selected by the Consensus Panel members.

- Priority One: Assure accountability of behavioral health system by developing performance measurements for best use of funding

- Priority Two: Develop standards for timely access to behavioral health services for all Nebraskans
- Priority Three: Optimize the use of available funding for behavioral health services by initiating regulatory reform to reduce redundant costs and burdens in the delivery system

The three priorities and the solutions offered by the Consensus Panel members are described in detail below, including a discussion of each priority, recommended steps to address each priority, and a proposed timeline to provide a “road map” of how to move forward.

Priority One: Assure accountability of behavioral health system by developing performance measurements for best use of funding The Consensus Panel members identified this priority as the most important given the need for good data to evaluate and prioritize the delivery system investments. These measures will facilitate assessment of the clinical and cost effectiveness of programming, and ultimately guide decision-making about funding priorities.

The Consensus Panel identified the following critical components in the development of the performance measures:

- An enhanced performance measurement system includes the adoption and use of one or more standard performance measurement instruments such as the Substance Abuse Mental Health Services Administration (SAMHSA) National Outcomes Measures (NOMs), which Nebraska currently completes annually as part of the Mental Health Block Grant criteria. Consensus
- Panel member discussion identified the need for adoption of a consumer assessment tool that looked more specifically at the outcomes associated with evidence based practices (EBPs).
- Performance measure initiatives would need to be coordinated with Magellan or another ASO, in addition to being an administratively simple system for provider organizations and consumers that would reduce other data collection efforts.

The action plan for the development of a performance measurement system for the Nebraska behavioral health system will begin with research and evaluation of the use of standard performance measurement instruments being utilized in other states, such as the National Outcomes Measurement (NOMs) tool, a consumer satisfaction assessment tool, and a tool that can measure system-wide cost of services and systems, both service costs, and indirect/administrative costs. The research will establish a list of the measures to offer choices to the system stakeholders in the development of the Nebraska performance measures.

The second complementary step involves research on what the Department of Health and Human Services (DHHS) and provider organizations are mandated to measure and

report on to various funding and regulatory sources. This will include current provider benchmark data sets, the regional center performance data, the RBHAs performance data, and the new outcomes report data from DBH. This research on other state performance measures and the DHHS and provider measures will be consolidated into a summary power-point document for presentation to the 'performance measurement' work group, made up of Consensus Panel members.

The summary power-point presentation to the performance measurement work group meeting will be used to review the measures gathered in the research and prioritize those measures to include in a Nebraska Behavioral Health System Performance Dashboard, which will be posted on the state Department of Health and Human Services (DHHS) website to ensure transparency for all stakeholders. A draft of the Nebraska Behavioral Health System Performance Dashboard will then be developed, along with a detailed plan and specifications for the process to import the identified data into the dashboard.

This will be followed by a meeting of the Consensus Panel to review and modify as needed the draft Nebraska Behavioral Health System Performance Dashboard and the detailed plan and specifications for the process to import the identified data into the dashboard. A beta test of dashboard will then be conducted, including the data collection process, website development, and the process for importing the data to the website. The Consensus Panel will then meet to review the first quarterly Nebraska Behavioral Health System Performance Dashboard, and recommend any needed modifications.

Each quarter thereafter, the Consensus Panel will be convened to review the quarterly Nebraska behavioral health system performance report.

Following is a suggested timeline for the implementation steps for Priority One.

Task	Date
1. Conduct research on other state behavioral health system performance measures	5/10/10
2. Conduct research on what DHHS and provider organizations are mandated to measure and report on to various funding and regulatory sources	5/24/10
3. Develop a summary of the research, including an inventory of measures from the current system and other state systems	6/8/10
4. Convene a Performance Measurement Consensus Panel to review available performance measures and prioritize measures for inclusion in the Nebraska Behavioral Health System Performance Dashboard	6/17/10
5. Based on the Consensus Panel prioritization, create an initial design of a Performance Dashboard and preliminary specifications for importing existing data in the Performance Dashboard; reconvene the Consensus Panel to review and finalize	6/28/10
6. Finalize the design of the Performance Dashboard along with the specifications for importing data into the Dashboard and any related data collection tools; Create a web site for participating stakeholders to input/download any data that is not available through existing sources	7/21/10
7. Manage a beta test of the Performance Dashboard – data collection; production of Dashboard; creation of web pages for public viewing of dashboard data; reconvene Consensus Panel to debrief on beta test and refine the Dashboard and reporting process based on Consensus Panel feedback.	8/4/10
8. Produce a quarterly Nebraska Behavioral Health System Performance Dashboard	Quarterly

Priority Two: Develop standards for timely access to behavioral health services for all Nebraskans Ensuring timely access to needed services is a critical component of an effective system of care. The first step in ensuring timely access to services and acceptable wait-times is to establish standards for access to care. Once these standards are established, actual access rates can be measured comparison with the standards, the root causes of access issues for specific services by region can identified, and action plans can be developed to address any identified gaps in service capacity.

The action plan for the development of access standards will begin with research to determine any established standards for consumer access to services both within Nebraska and in other states. The results of the research will be summarized in a power-point document for presentation to the Consensus Panel members.

A meeting of the Consensus Panel will be convened to review the summary power-point document and to identify quarterly access to care standards for the Nebraska behavioral health system by region. A draft of an Access to Services Report will then be developed, along with a detailed plan and specifications for the process to import the identified data into the report. The report will be posted on the state Department of Health and Human Services (DHHS) website to ensure transparency for all stakeholders.

A beta test of the access to services report will then be conducted, including the data collection process, website development, and the process for importing the data to the



website. The Consensus Panel will then meet to review the first quarterly access to services report, and recommend any needed modifications.

Each quarter thereafter, a quarterly access to care report will be developed. The Consensus Panel will be convened to review the quarterly Nebraska behavioral health system access to care report and identify system capacity issues based on the report.

Following is a suggested timeline for the implementation steps for Priority Two.

Task	Date
1. Conduct research on existing access to care standards from payers, including DHHS, other state systems, grants, and professional associations; develop recommendations for consumer access to care.	5/17/10
2. Convene a stakeholder meeting (and web site for posting) to review the recommended standards for consumer access to care	6/7/10
3. Finalize the Nebraska Behavioral Health System Access Standards and develop a set of procedures and specifications to both measure and report the consumer access data	6/14/10
4. Convene a stakeholder meeting (and web site for posting) to review the final standards, procedures and specifications for measuring and reporting consumer access data; finalize the standards, specifications, and procedures	7/5/10
5. Manage a beta test of the Nebraska Behavioral Health System Access measurement system – data collection; production of access to care report; creation of web pages for public viewing of dashboard data	7/22/10
6. Reconvene stakeholder group to debrief on beta test and review the initial data; refine the access measures, measurement process, and reporting format based on the stakeholder input.	8/5/10
7. Manage a second quarter of data collection and reporting for the Nebraska Behavioral Health System Access measurement system	Quarterly
8. Reconvene stakeholder group to review the second quarter of consumer access data; discuss possible solutions for services/ geographies where consumer access is below standard	Quarterly

Priority Three: Optimize the use of available funding for behavioral health services by initiating regulatory reform to reduce redundant costs and burdens in the delivery system This priority identifies a need to establish a regulatory reform initiative to reduce redundant costs in the delivery system.. Examples of regulatory reform that may reduce redundant costs include:

- Updating and amending Medicaid rules
- Eliminating audit duplication
- Initiating a one year moratorium on new regulatory requirements impacting the behavioral health industry for purposes of completing a cost analysis and amend



state law to require a cost analysis prior to public hearing as part of the state regulation and rule-making process

- Expanding state licensing of professionals to include rehabilitation professions and others

A full list of legislative and administrative rule changes that impact regulatory reform can be found in Appendix B.

The first two steps in addressing priority number three involves gathering feedback from behavioral health system stakeholders on regulatory reform that would specifically result in system savings and efficiencies. The first is to establish a website on the DHHS website for stakeholder public comment on regulatory reform. The public comment website not only gathers information but also ensures transparency. The second step is to conduct a survey across the behavioral health stakeholders to identify regulatory reform that would specifically result in system savings and efficiencies.

The results from both the regulatory reform website and stakeholder survey will be summarized and presented to a regulatory reform work group made up of Consensus Panel members. The group will review the summary of findings and prioritize regulatory reform recommendations. The recommendations will address Medicaid regulatory changes that enhance the behavioral health system, DBH regulatory administrative rule changes, and the development of Legislative initiatives requiring statutory changes.

A summary statement of regulatory reform in each of these three areas will be developed, along with a plan for dissemination and implementation, and then presented to a meeting of the regulatory reform work group for approval. . |

Following is a suggested timeline for the implementation steps for Priority Three.

Task	Date
1. Develop a web site for stakeholder public comment on regulatory reforms that would specifically result in system savings and efficiencies	5/28/10
2. Conduct a survey across behavioral health system stakeholders on regulatory reforms that would specifically result in system savings and efficiencies	6/4/10
3. Develop a summary of the findings of the web site comments and stakeholder survey	6/28/10
4. Convene a regulatory reform work group to review the summary of findings and prioritize regulatory reform recommendations	7/14/10
5. Develop a summary statement of regulatory reform in each of these three areas: <ul style="list-style-type: none"> • Medicaid regulatory changes • Division of Behavioral Health regulatory administrative rule changes • Legislative initiatives requiring statutory changes 	7/28/10

III. History of Oversight Commission & Resulting Vision

The State of Nebraska, like many states, is at a crossroads in system financing and planning. State budget challenges, combined with historical system design and emerging consumer needs, are creating stresses on both system policy and planning. In response to the changing environment, the 2004 Legislature passed the Nebraska Behavioral Health Services (NBHS) Act which established a revised framework for the provision of behavioral health services in Nebraska. The NBHS Act established the Division of Behavioral Health Services and defined a behavioral health disorder as “mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder.” The single most important event of the 2004 legislation was to move funding from the regional center hospitals to community-based services through Legislative Bill 1083.

That same year, the Legislature established the Behavioral Health Oversight Commission (BHOC), to oversee and support implementation of NBHS Act. The Nebraska BHOC completed an analysis in 2008 which culminated in a 2008 BHOC report to the Legislature and others and a subsequent 2009 BHOC issued another report. Both reports detailed the impacts of LB1083 and offered a number of recommendations for the development and implementation of a more effective behavioral health system aided by a strategic vision.

In addition to the above reports, a continuum of care study commissioned by the Behavioral Health Support Foundation (BHSF) and completed by HDR Consulting resulted in the design and development of the Lasting Hope Recovery Center (LHRC) as an additional and essential element in the behavioral health service continuum in Nebraska Region 6, as well as, providing capital funding for other community-based services in the Region 6 area. LHRC is operated by Alegen Health system and was funded by generous private sector contributions and is supplemented by state fundingⁱ for operating support. Lastly, a study commissioned by the Behavioral Health Support Foundation, is being conducted by The Gallup Organization to solicit public and stakeholder perceptions of continuity of care needs within the behavioral health system in Region 6. This study is in progress with an outcome expected in March of 2010.

The 2009 BHOC developed a strategic vision and recommendations for the continuing reform and transformation of the Nebraska behavioral health system. The following statements comprised the BHOC’s strategic visionⁱⁱ:

1. Promote wellness, recovery, resilience, and self determination for adults and children and such system will be consumer and family driven
2. Focus on and create positive outcomes coupled with a performance evaluation process that supports continuous quality improvement for the division as well as the Regional Behavioral Health Authorities, providers and recipients of services
3. Provide inclusive and transparent planning through genuine partnership and collaboration with a diverse group of stakeholders, including meaningful participation

by consumers, to promote a rational, strategic decision-making environment and process

4. Focus on prevention and early intervention
5. Share a cooperative and common vision among DHHS divisions regarding recovery, best practice, access to care, and funding
6. Encourage public/private partnerships
7. Pursue every opportunity to maximize available revenue sources, including but not limited to Federal grants and maximization and capture of Federal Medicaid match dollars, and these new revenue sources will be reinvested in the behavioral health system
8. Implement a process that expands the above seven strategic vision statements into specific processes, activities and objectives to be accomplished and provide progress and accomplishment measurements to ensure the above strategic vision statements are effectively implemented

The Behavioral Health Support Foundation brought together stakeholders from all parts of the State of Nebraska and throughout the behavioral health system of care to engage in a system planning initiative. The perceived need for a system planning initiative is driven by: the results of the analyses cited above; recent budget and regulatory changes at both the Federal and the state level; and the perception of Nebraska thought leaders that the implementation of the BHOC's recommendations may be hindered by competing and unprioritized stakeholder demands. Any planning for Nebraska's behavioral health system is also complicated by a 'crisis response' mentality in Nebraska. The unintended consequences of recent 'child safe haven' legislation and turmoil at Beatrice Developmental Center have occupied the attention of both the executive and legislative branches of government. These issues have kept the focus on the 'urgent' and detracted from more systematic and strategic planning.

Nebraska stakeholders agree that there is a need to move forward the planning process and establish priorities for the Nebraska behavioral health system. Some, but certainly not all, of the elements to be considered in the planning process are state-of-the-art contracting and purchasing practices; the role of the six regional behavioral health authorities (RBHAs) including regional needs and regional resources; the role of the state regional center system; and the role of public/private partnerships in system operation.

IV. Summary of System Structure

A unique feature in Nebraska behavioral health system is the state's regional structure. Nebraska's non-Medicaid public behavioral health services for children and adults are managed directly by six Regional Behavioral Health Authorities (RBHAs). Two of the regions include urban areas – Omaha and Lincoln. The other four regions are rural or frontier. The RBHAs provide behavioral health services and also contract with providers for inpatient, outpatient, emergency, and community-based services within the regions. Funding, oversight, and technical assistance to the RBHAs is provided by the Division of Behavioral Health (DBH). Each RBHA is governed by a Regional Governing Board and has a regional advisory committee consisting of consumers, providers, and other interested parties.

The RBHAs are considered local units of governments which partner with the state DBH to do planning and service implementation. Each county taking part in a region appoints one county commissioner to sit on a regional board. The county commissioner represents that county, speaks to specific region needs, and participates in the decision making of the board. Each of the RBHAs is staffed by an administrator who in turn hires additional personnel. Each RBHA purchases services from providers in that region. If necessary, services are purchased from other service providers across the state.

The map below shows Nebraska Behavioral Health Regionsⁱⁱⁱ.

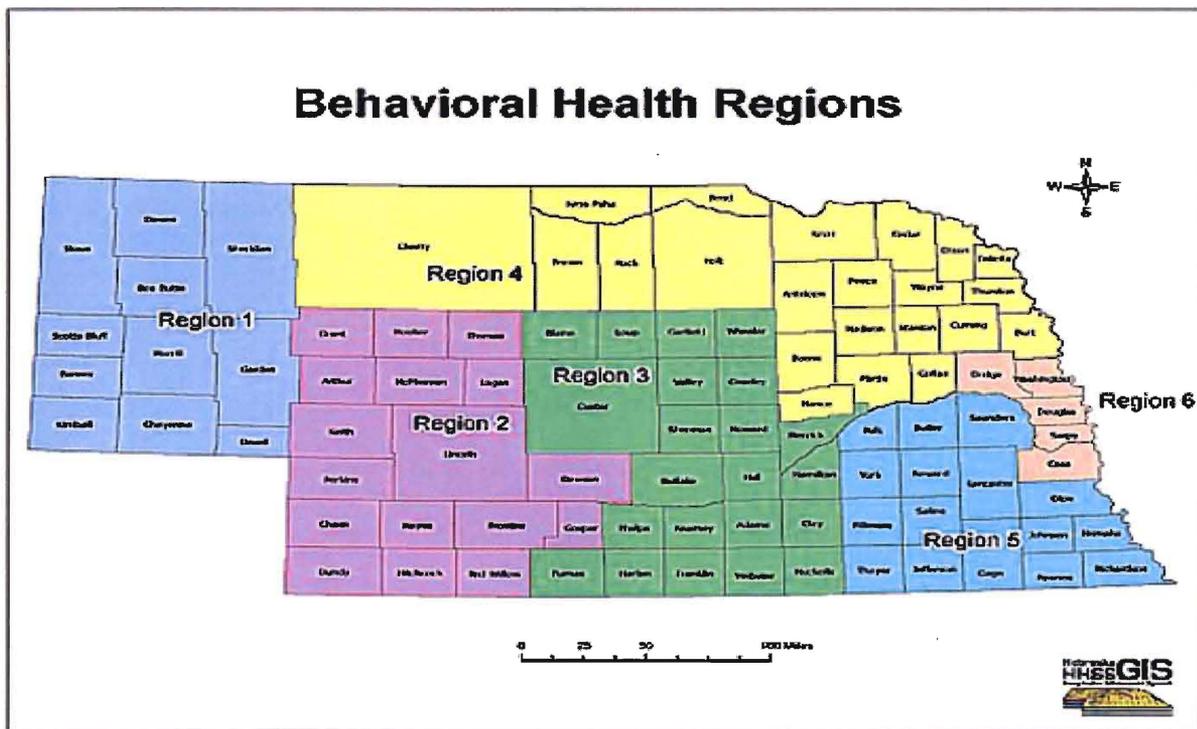


Table Two below details the population base of each region in 2000 and 2007.

Table Two. Population Base by Region^{iv}

Region	Regional Office	Counties	Population (2000)	% of State Population (2000)	Population (2007)	% of Population (2007)
1 (Panhandle)	Scottsbluff	11	90,410	5.3%	85,859	4.85%
2 (West Central)	North Platte	17	102,311	6.0%	99,368	5.63%
3 (South Central)	Kearney	22	223,143	13%	222,169	12.56%
4 (Northeast & North Central)	Norfolk	22	216,338	12.6%	205,386	11.62%
5 (Southeast)	Lincoln	16	413,557	24.2%	433,114	24.45%
6 (Eastern)	Omaha	5	665,454	38.9%	723,577	40.89%
Totals		93	1,711,213	100.0%	1,769,473	100.0%

The Division of Behavioral Health is made up of two departments, the Community Based Services Department and the Regional Centers Services Department. The budgets for each department are separate line item appropriations and are not intermingled. The Regional Centers care for persons, among others, committed by mental health boards or the courts. Lincoln Regional Center, a 250-bed, Joint Commission-accredited state psychiatric hospital, provides 95 beds for general psychiatric services, with the remainder of the beds dedicated to forensics and sex offender residential services. Norfolk Regional Center is a 120-bed facility now intended to provide only sex offender services. As of this report, there remain approximately 11 behavioral health residents, many of whom are difficult to place in community hospitals due to violent behavior for which the state has targeted placement in community-based settings by March 2010. Hastings Regional Center provides adolescent residential mental health and substance abuse treatment for boys and girls. The Hastings Regional Center is licensed for 40 beds, accredited by the Joint Commission and services must be pre-authorized through Magellan Behavioral Services^v.

DBH is the manager of the behavioral health system through the use of both state general funds and Medicaid funds to pay for services. The 2007 federal estimate of Nebraskan adults with serious mental illness in Nebraska is 71,351.^{vi} The Nebraska behavioral health system using both state general funds and Medicaid served 48,949 persons with serious mental illness in 2009. Nebraska state general funding in 2009 served 32,082, while the number of adults served by Nebraska Medicaid behavioral health funding was 16,867. The combined state general fund and Medicaid resulted in

a penetration rate of 69% of the 71,351 persons identified with a serious mental illness in Nebraska.

Another feature of importance in the Nebraska behavioral health delivery system is the changing dynamics of the behavioral health professionals working in the system. The Nebraska Center for Rural Health Research completed a workforce planning project in September 2009 titled, "A Critical Match" and it offers an in-depth review of the work force issues.^{vii} The purpose of this project was to develop a strategy for meeting the health care workforce needs of Nebraska. Three significant factors were identified for behavioral health providers.

1. 36.7% of the psychiatrists in the workforce are now in the pre-retirement age group, i.e., 55 years and older. Additionally a number of retired psychiatrists retain their license offering a disparity in the actual number of practicing psychiatrists in Nebraska.
2. 33.3% of the physician assistants in the workforce are now in the pre-retirement age group, i.e., 55 years and older.
3. 50% of APRN's work in a primary care environment and their psychiatric practice is less than 40% of their time.

The Nebraska behavioral health system uniqueness is in the rural/frontier nature of the state, the demographics and penetration rate of services to the target population, the evolution to move to a recovery oriented system, and the structure of the delivery system. The challenges identified are not unique to Nebraska and can be found in similar states with geographical and population similarities.

V. Summary of System Funding

Behavioral health funding in Nebraska comes from a variety of sources ranging from the Federal government to local counties. The total state of Nebraska public behavioral health funding is approximately \$275,013,522, and does not include commercial insurance, private grant funding or out-of-pocket costs by consumers. The Division has redirected \$30 million in funding from the state regional centers to community-based services since July 2004, making it possible to close 232 adult beds and 16 adolescent mental health beds at the Regional Centers and leveraged additional Medicaid dollars^{viii}. These funds are now being used to purchase community-based services through the Regional Behavioral Health Authorities (RBHAs). Norfolk Regional Center is funded through LB1099 funds so does not come out DBH state general funds. Figure Two below represents the total funding for behavioral health services with the exceptions noted above. Table Three below represents the total behavioral health system expenditure by percentage in FY09.

Figure Two. Total Behavioral Health System Funding for FY09^{ix}

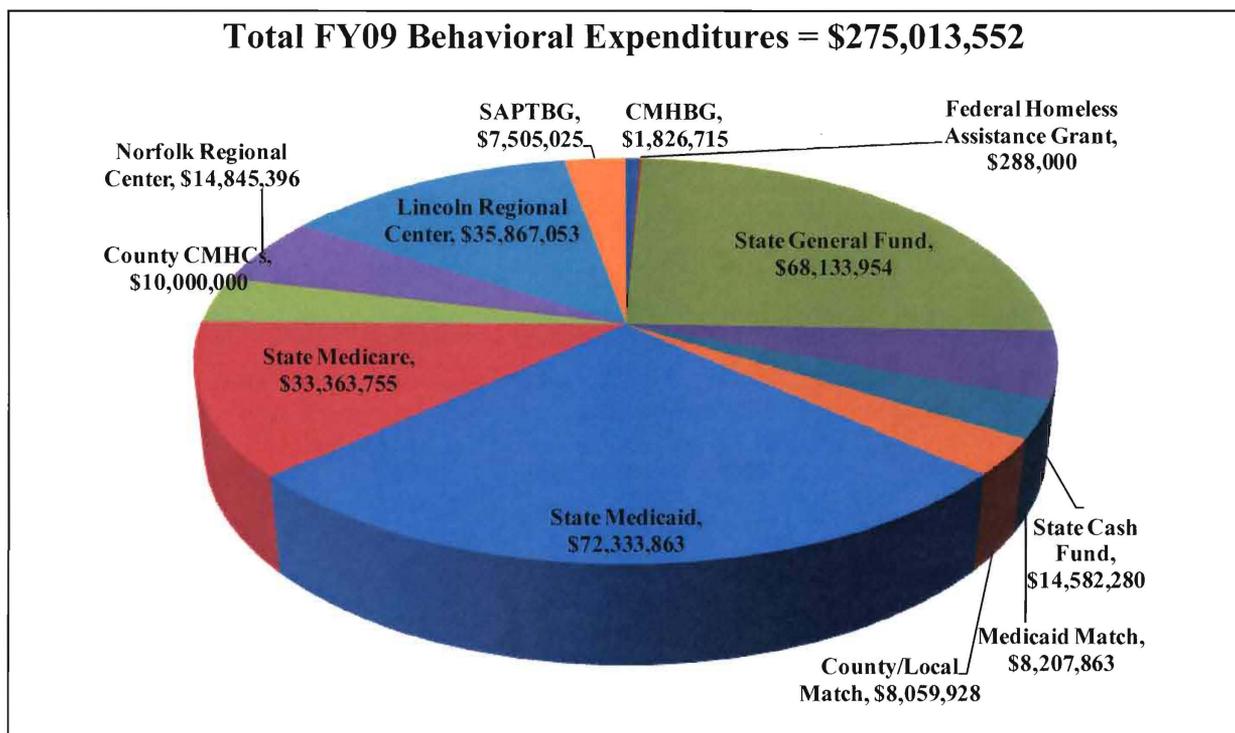


Table Three. Total Nebraska Behavioral Health System Funding by Percentage in FY09

	Expenditures	Percentage of Total
State Medicaid	\$72,333,863	26.3%
State General Fund	\$68,133,954	25%
Lincoln Regional Center	\$35,867,053	13%
State Medicare	\$33,363,755	12%
Norfolk Regional Center	\$14,845,396	5.3%
State Cash Fund	\$14,582,280	5.3%
County-funded community mental health services	\$10,000,000	4%
Medicaid Match	\$8,207,863	3%
County/Local Match	\$8,059,928	3%
SAPT Block Grants	\$7,505,025	2.7%
CMH Block Grants	\$1,826,715	.07%
Federal Homeless Assistance Grant	\$288,000	.001%
Total	\$275,013,552	

The Division of Behavioral Health Community Services contracted \$75,967,094 in Fiscal Year 2009 (FY09) to the six RBHAs. The Medicaid behavioral health expenditures for FY09 were \$72,333,863. By statute each county in a behavioral health region additionally provides funding as a match against specific state general funds at an approximate ratio of \$1.00 of County funds for every \$7.00 of State funds for the administration of the behavioral health authority and for the provision of behavioral health services in the region. Lancaster and Douglas Counties are unique in the state as each county funds a community mental health center to meet the behavioral health needs of the county. Figure Three below is a breakdown of the Medicaid behavioral health expenditures of \$72,333,863 in FY09. The breakdown of Medicaid behavioral health outpatient services in FY 2009 is represented in Figure Four.

Figure Three. Total FY09 Medicaid Behavioral Health Spending^x



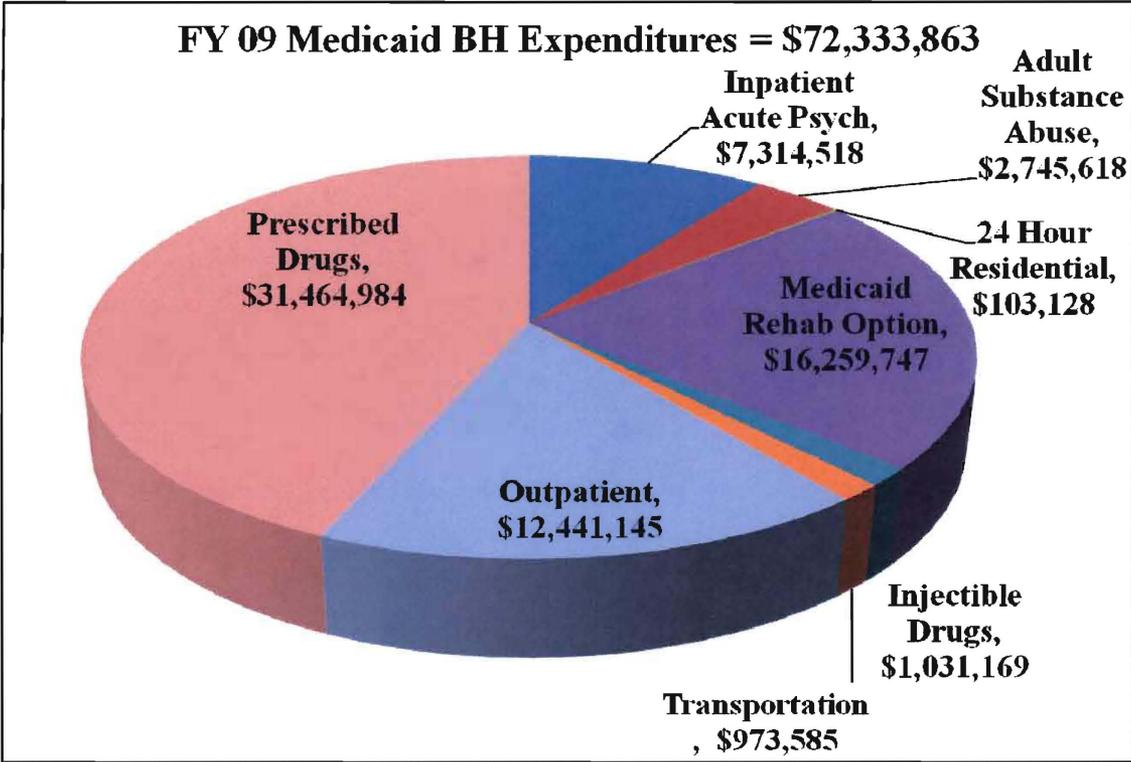
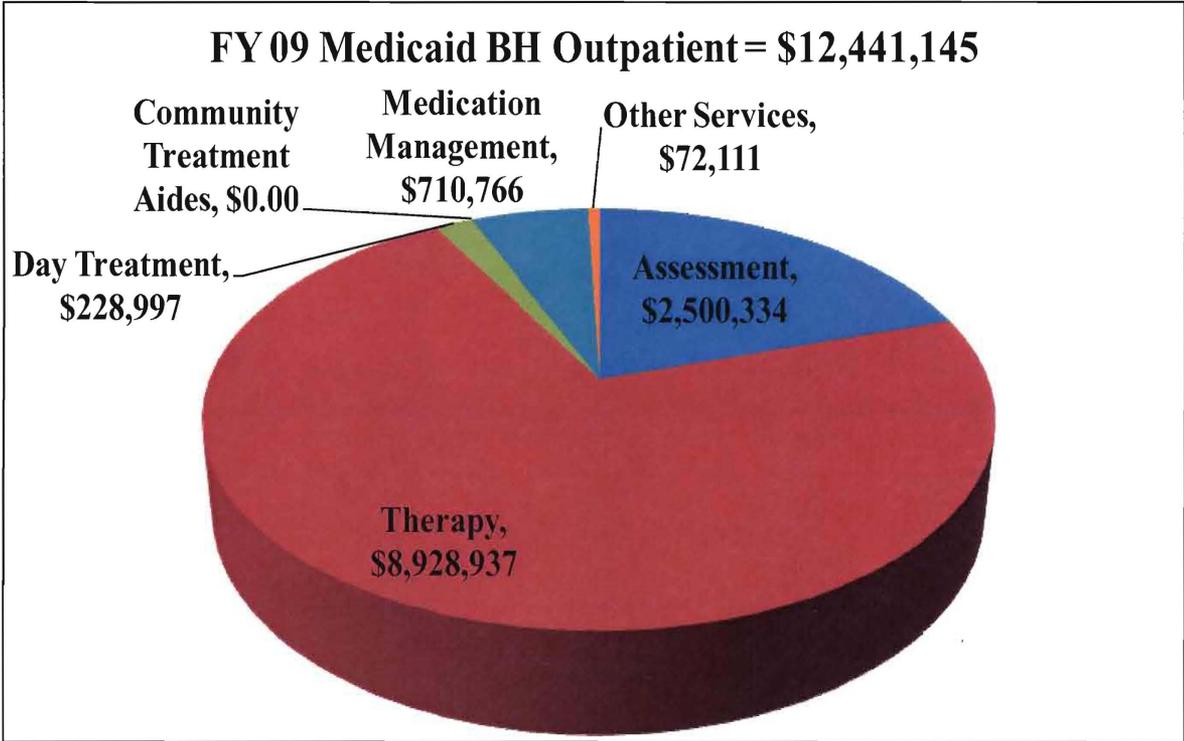


Figure Four. FY09 Medicaid Outpatient Behavioral Services Health Spending^{xi}



Medicaid reform was mandated by the Nebraska Legislature in LB 709 (2005) through the Medicaid Reform Act. The Act mandated "fundamental reform" of the state's Medicaid program and a significant rewriting of Medicaid-related statutes. On April 16, 2008, Magellan Behavioral Health was selected as the Administrative Service Organization contractor for Medicaid and Division of Behavioral Health state funds. The contract began on May 1, 2008 and ends on June 30, 2010. The contract allows for three one-year extensions to allow for continuity in management of Medicaid funds.

A Magellan Partnership Quality Improvement Team (MQIT) was established in October of 2008 by the Nebraska DHHS to work on building effective working relationships with all contract and DHHS partners and obtain data to manage the Behavioral Health system in order to achieve positive consumer outcomes^{xii}.

The goals of the MQIT initiative included the following:

- Improving communication and coordination between the three Divisions, Regions, Providers, Consumers, Families and Magellan.
- Developing an understanding of the work flow, systems and processes related to data and making recommendations for improvement.
- Establishing a mechanism for the identification, review and resolution of issues.
- Reviewing reports and recommending content and format improvements to ensure the presentation of meaningful data.

The Nebraska Division of Behavioral Health is responsible for the both the non-Medicaid and Medicaid service delivery system. The Regional Behavioral Health Authorities act as agents to ensure the service components meet the distinct needs of the respective regions. While the total spending for the Nebraska behavioral health system in FY09 was \$275,013,552, the administrative costs involved were at a rate of 15.8%. Table Four below details the expenditure by category with assumptions of percent to administration and estimates of direct care funding.

Table Four. Total DBH Spending – Administrative vs. Direct Care

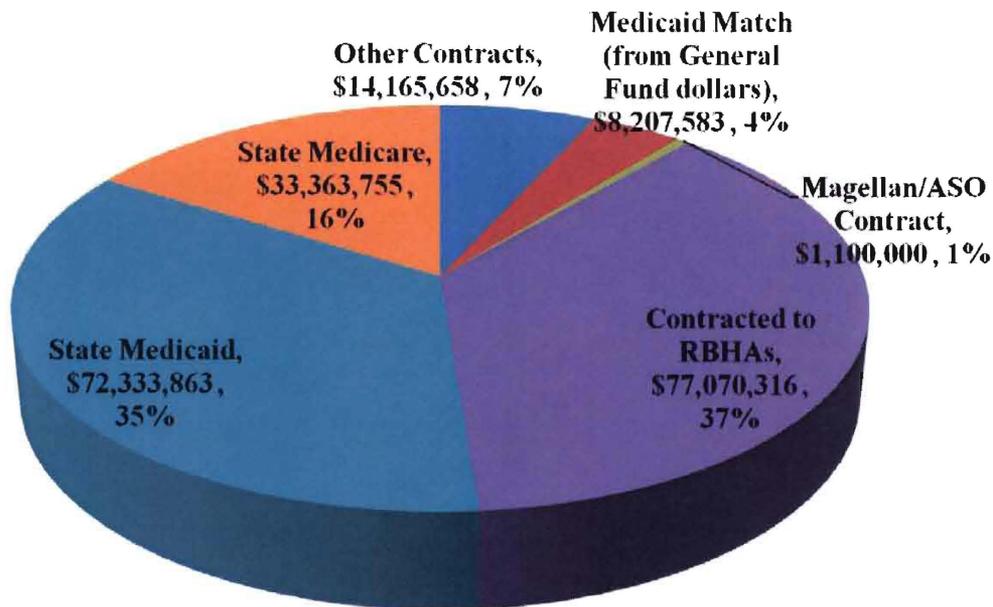


DBH Spending	Expenditures	Estimated Direct Care Funding	Estimated Administrative Costs	Assumption
Contracted to RBHAs	\$75,967,094	\$72,900,831	\$3,106,293	Assume 4% regional coordination administration costs
Region 1	\$5,487,862	\$5,113,774	\$374,118	Assume 6.8% admin costs
Region 2	\$5,481,659	\$5,274,731	\$206,928	Assume 3.7% admin costs
Region 3	\$12,255,963	\$11,662,340	\$593,623	Assume 4.8% admin costs
Region 4	\$10,184,894	\$9,621,624	\$563,270	Assume 5.5% admin costs
Region 5	\$17,928,348	\$17,090,395	\$877,953	Assume 4.9% admin costs
Region 6	\$24,628,368	\$24,137,967	\$490,401	Assume 2.0% admin costs
County/Local Match for RBHAs	\$8,059,928	\$0	\$8,059,928	Assume 100% admin costs
Magellan ASO Contract	\$1,100,000	\$0	\$1,100,000	Assume 100% admin costs
Medicaid Match	\$8,207,863	\$8,207,863	\$0	Assume direct claims \$ 8,207,863
DBH Administration	\$3,858,778	\$0	\$3,858,778	Assume 100% admin costs
Other Contracts	\$14,165,658	\$12,749,092	\$1,416,566	Assume 10% admin costs
Total	\$111,359,321	\$93,857,786	\$17,541,565	Assume 15.8% admin costs

The total Nebraska behavioral health community-based spending in FY09 was \$100,543,557. Figure Five below identifies each of the community-based spending components as identified by DBH in the biennial budgeting process. These essentially are the expenditures in the communities and not in institutions. They include assessment, outpatient therapy, pharmaceutical, medication management, day treatment, and other supportive community-based options.

Figure Five. Nebraska Behavioral Health Community Based Spending = \$100,543,557





The contracted funding to the RBHAs is made up of state general funds, Community Mental Health Block Grant (CMHBG), Substance Abuse Prevention and Treatment Block Grant (SAPTBG), and local county match. The formula for distribution to the RBHAs is based on population of the counties within each of the RBHAs. Tables Five and Six provide a breakdown of the RBHA expenditures and population changes from 2000 to 2007.

Table Five. RBHA Expenditures and Population Changes from 2000 to 2007

RBHA Region	State Funding	Percent of Region	Percent of RBHA Total
Region 1	\$5,487,862		7.2% of RBHA Total
Mental Health	\$3,069,847	56% of Region 1 Total	4.0% of RBHA Total
Substance Abuse	\$2,043,896	37% of Region 1 Total	2.7% of RBHA Total
Regional Coordination	\$374,118	7% of Region 1 Total	.5% of RBHA Total
Region 2	\$5,481,659		7.2% of RBHA Total
Mental Health	\$3,323,141	61% of Region 2 Total	4.3% of RBHA Total
Substance Abuse	\$1,951,589	36% of Region 2 Total	2.6% of RBHA Total
Regional Coordination	\$206,928	4% of Region 2 Total	.3% of RBHA Total
Region 3	\$12,255,963		16.2% of RBHA Total
Mental Health	\$7,482,151	61% of Region 3 Total	10% of RBHA Total
Substance Abuse	\$4,180,162	35% of Region 3 Total	5.5% of RBHA Total
Regional Coordination	\$593,623	5% of Region 3 Total	.7% of RBHA Total

Table Six. RBHA Expenditures and Population Changes from 2000 to 2007

RBHA Region	State Funding	Percent of Region	Percent of RBHA Total
Region 4	\$10,184,894		13.3% of RBHA Total
Mental Health	\$5,735,223	56% of Region 4 Total	7.5% of RBHA Total
Substance Abuse	\$3,886,400	38% of Region 4 Total	5.1% of RBHA Total
Regional Coordination	\$563,270	6% of Region 4 Total	.7% of RBHA Total
Region 5	\$17,928,348		23.6% of RBHA Total
Mental Health	\$9,169,713	51% of Region 5 Total	12.1% of RBHA Total
Substance Abuse	\$7,880,682	44% of Region 5 Total	10.4% of RBHA Total
Regional Coordination	\$877,953	5% of Region 5 Total	1.1% of RBHA Total
Region 6	\$24,628,368		32.5% of RBHA Total
Mental Health	\$15,944,976	65% of Region 6 Total	21% of RBHA Total
Substance Abuse	\$8,192,991	33% of Region 6 Total	10.8% of RBHA Total
Regional Coordination	\$490,401	2% of Region 6 Total	.7% of RBHA Total

The RBHAs are responsible for serving persons with a serious mental illness with the contracted state general funds and any additional funds gathered from commercial insurance, Medicaid, Medicare, program grants, and self-pay fees from consumers. Table Seven below offers a snapshot of the unduplicated count of person's receiving behavioral health services by region.

Table Seven. DBH System Utilization by Region

Regions	One		Two		Three		Four		Five		Six	
	MH	SA	MH	SA	MH	SA	MH	SA	MH	SA	MH	SA
Total Number	1,050	432	1,340	712	2,806	1,930	1,579	1,000	6,121	5,246	5,602	4,495
Percent	71%	29%	65%	35%	59%	41%	61%	39%	54%	46%	55%	45%

The Nebraska utilization review of services (URS) for FY09 provided by Magellan through the ASO contract offers an additional snapshot of persons served in community mental health centers (CMHCs), State psychiatric hospitals, & other settings with DBH funding. Table Eight below details the setting of the service, age groups, and percent of utilization in the different settings.

Table Eight. Persons Served in CMHCs, State Psychiatric Hospitals, & Other Settings With DBH Funding (Duplicated Numbers)

Service Setting	Age 18 – 20		Age 21 – 64		Age 65+		Percent
	Female	Male	Female	Male	Female	Male	
Community Providers	690	992	9533	10387	277	166	83%
State Psychiatric Hospitals	8	25	99	370	5	9	2%
Other Psychiatric Inpatient	126	164	1657	1975	37	41	15%
Subtotal	824	1181	11289	12732	319	216	100%
Total							26,561

The behavioral health funding in Nebraska generates from a variety of sources and an estimated 84% goes to delivery of direct care to consumers. What is not captured in the information throughout this section is the self-pay from consumers, commercial insurance, and grant funding captured by the RBHAs or the contracted providers of the RBHAs.



VI. Nebraska Behavioral Health System Limited Performance Measurement Data

The Nebraska behavioral health system has some limited performance measurement initiatives in place but the data is not aggregated to for system-wide use in planning, monitoring performance, and supporting decision-making. Magellan, as the ASO contractor, manages both the Medicaid and State funds for the Division of Behavioral Health (DBH) by contract and is responsible for performance measurement reports (see Appendix C). These reports are provided to DBH, the Medicaid division, the Regional Behavioral Health Authorities (RBHAs), and the system providers. Additionally there are some performance measurement initiatives within the RBHAs and the contracted behavioral health providers.

The regional administrators for the RBHAs and the contract providers in attendance at the Consensus Panel meetings identified a number of performance measurement projects that are customized to meet the needs of each respective organization. However, the data from these initiatives is not aggregated at the system-wide level.

The DBH Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and the Community Mental Health Block Grant (CMHBG) each identify performance measures in the 2010 applications (Appendix H). The outlined performance measures in the CMHBG and SAPTBG applications are missing how the data will be utilized in system development and decision-making. Additionally there is no historical representation of the data to offer a picture of progress over time.

External performance measurement of the behavioral health system is offered by the National Alliance on Mental Illness (NAMI). The 2009 NAMI report card rated Nebraska's behavioral health system as follows:

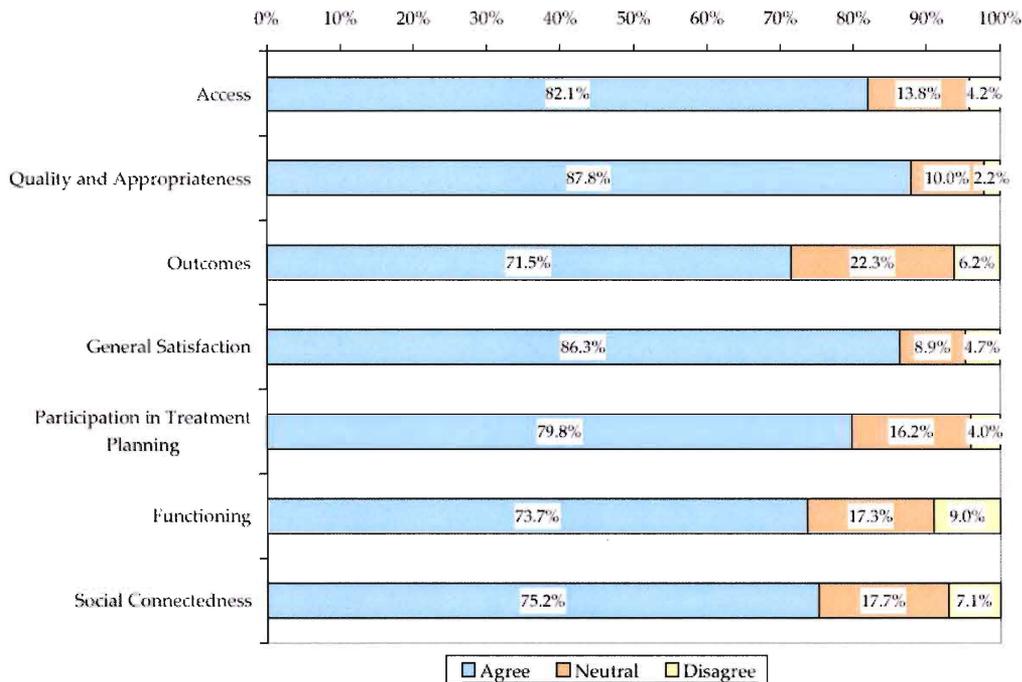
- Health promotion and measurement: F
- Financing and core treatment/recovery services: D
- Consumer and family empowerment: F
- Community integration and social inclusion: F

Suicide is identified as the 10th leading cause of death in Nebraska and Nebraska ranks 38th in the rate of suicide nationally. Annually, DBH in conjunction with the RBHAs conducts a community mental health block grant consumer survey as a part of the MHBG requirement. Table Nine below presents the results of the 2009 survey Mental Health Statistics Improvement Program (MHSIP)^{xiii}. The survey is 28 question consumer satisfaction survey constructed to fit into the seven domains identified below in the 2009

survey. The discussion in the Consumer Panel meeting lead to concern over the low score on outcomes, functioning, and social connectedness.

Table Nine. Annual 2009 Community Mental Health Block Grant Adult Consumer Survey

Statewide Summary – MHSIP Scales – Adults



Overall, while there is some performance measurement initiatives underway in the Nebraska behavioral health system, concerns with some of the data gathered were offered by the Consensus Panel members, and the data is not aggregated for system-wide use in planning, monitoring performance, and supporting decision-making.

VII. Gap Analysis of Current Nebraska Behavioral Health System & System Vision

The *OPEN MINDS* team conducted a gap analysis comparing the current Nebraska behavioral health system with the system vision identified in the BHOC 2009 report. The following summary addresses the eight 2009 BHOC's strategic vision statements and the current gap in achieving the vision.^{xiv}

1. Promote wellness, recovery, resilience, and self determination for adults and children and such system will be consumer and family driven. The Nebraska behavioral health system continues to make progress in meeting this vision. Consumers are increasingly involved in their care as evidenced in three areas. One area is the use of consumer advisory groups at all levels of the system, including the regional and state advisory councils. The consumer advisory groups are joined by advocacy groups such as the National Alliance on Mental Illness (NAMI) and the Mental Health Association of Nebraska. The second area of development has been the addition of Peer Support Specialists who provide training and utilization in the system of care. The third area involves the team decision-making with consumers on the range, level, and choice of available services to meet the consumer's unique needs.
2. Focus on and create positive outcomes coupled with a performance evaluation process that supports continuous quality improvement for the division as well as the Regional Behavioral Health Authorities, providers and recipients of services. The current behavioral health system is not a system that has a unified and fully developed performance measurement process or outcomes that support decision-making. A variety of local providers have some performance measure or outcome measure data that is specific to regulatory mandates, funding requirements, or needs of that provider organization, but this data is not aggregated into overall system performance measures. The lack of a system-wide performance evaluation process makes establishing funding priorities in a challenging economic environment difficult if not impossible.
3. Provide inclusive and transparent planning through genuine partnership and collaboration with a diverse group of stakeholders, including meaningful participation by consumers, to promote a rational, strategic decision-making environment and process. The Consensus Panel members identified a continued concern over the lack of continuity and inclusion in a meaningful planning process with the Division of Behavioral Health. The behavioral health system stakeholders are made up of five major stakeholder groups:
 - o DBH/Medicaid
 - o Regions
 - o Providers

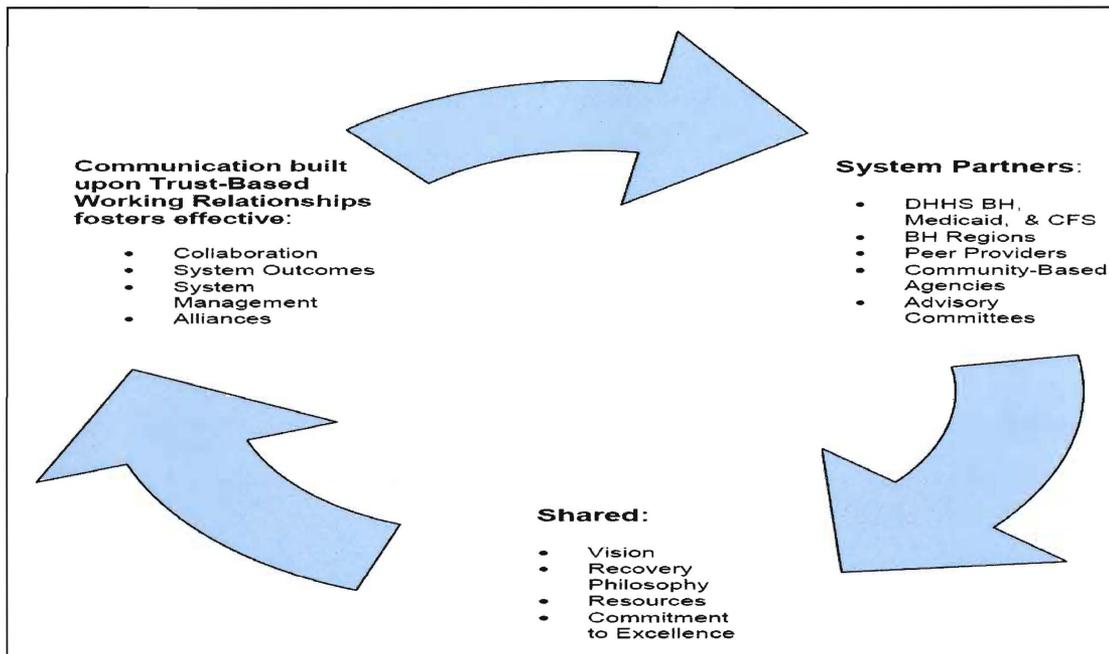
- o Consumers
- o Other key stakeholders

The system stakeholders do not have regular meetings to identify strategic system issues and make plausible plans to reach an improved behavioral health system.

4. Focus on prevention and early intervention. The discussion at the January 21 -22, 2010 behavioral health system planning Consensus Panel meeting indicated that the system is focused heavily on crisis services and the financial resources are being directed to emergent and core service delivery. There is evidence of scattered wellness projects going on in the six RBHAs but no unified or concerted initiatives with the exception of Substance Abuse programs. Substance Abuse has established regional prevention coordinators and a prevention web site. One additional area that could be considered prevention and early intervention is the Network of Care web site, which offers web access by service choice in every region but was also offered as a concern by the Consensus Panel due to their limited involvement and input in the development of the Network of Care information.
5. Share a cooperative and common vision among DHHS divisions regarding recovery, best practice, access to care, and funding. The BHOC adopted a statement about cooperation and a common vision in 2009. The statement is to, “foster, encourage and promote creative ways to develop services and supports that consumers want and need while maximizing existing funding, using open communication and developing trusting relationships”. This is accomplished by promoting partnerships and multi-dimensional communication among consumers, the divisions of the Department of Health and Human Services, the Behavioral Health Regions, Regional Centers, Community-Based Agencies, peer providers, and Behavioral Health Division advisory committees.

System stakeholders have numerous opportunities to connect, and be involved in system development focused on recovery, best practices, access to care, and maximization of funding. Despite the many vehicles for communication and the acceptance of the Behavioral Health Communication System (Figure Five), the behavioral health system remains in debate as to the strategies to reach the envisioned system. Ongoing system issues include the need for behavioral health workforce development, collaboration with the corrections system in the treatment of behavioral health consumers, initiatives to address cultural and linguistic competence of the workforce, and access to medication for the underinsured and uninsured. Figure Six below addresses the communication process that should be in effect among system partners building more effective services for consumers in the behavioral health system, built upon a common vision^{xv}

Figure Six. Behavioral Health Communication System



6. Encourage public/private partnerships. The Nebraska behavioral health system is built on a model which encourages public/private partnerships. Private sector funding is available for capital projects but only if the State can provide operating funding for sustainability. Additionally the model is illustrated by the contractual relationships of the Nebraska DBH, the six RBHAs and the providers within the six regions. The current DBH state funds are only provided to the RBHAs and the contracted providers within each RBHA. This partnership does not include those provider organizations that do not have contracts with the RBHAs. Behavioral health providers not in the contract group do not have access to state DBH funds and have to find other funding sources to serve similar populations.

7. Pursue every opportunity to maximize available revenue sources, including but not limited to Federal grants and maximization and capture of Federal Medicaid match dollars, and these new revenue sources will be reinvested in the behavioral health system. The Nebraska behavioral health system has numerous funding sources that includes Medicaid, Medicare, State general funds, County funds, private funding, and local community grants. The advent of the American Recovery and Reinvestment Act (ARRA) has brought relief in the state Medicaid match formula from essentially a 40% state and 60% federal match to a 30% state and 70% federal match. This has freed up state general funds that would have gone to the Medicaid match to be used more flexibly. Where federal Medicaid funding can be maximized, state funding may be diverted to other operating funding. Where Federal Medicaid match opportunities exist, Nebraska should leverage these federal funds.

8. Implement a process that expands the above seven strategic vision statements into specific processes, activities and objectives to be accomplished and provide progress and accomplishment measurements to ensure the above strategic vision statements are effectively implemented. Without a targeted set of objectives and accompanying timeline, progress cannot be monitored and success cannot be assured. This is critical for a more effective behavioral health system for consumers in Nebraska.

Two additional factors that impact the gap analysis of the current system and system vision are a limited behavioral health workforce and the recent initiation of a separate strategic planning process by DBH. The limited behavioral health workforce was substantiated in the workforce development study commissioned by the 2009 BHOC. The study has resulted in a completed report (A Critical Match) by the Nebraska Center for Rural Health Research which was presented in September 2009^{xvi}. Three significant factors were identified for behavioral health providers.

- 36.7% of the psychiatrists in the workforce are now in the pre-retirement age group, i.e., 55 years and older. Additionally a number of retired psychiatrists retain their license offering a disparity in the actual number of practicing psychiatrists in Nebraska.
- 33.3% of the physician assistants in the workforce are now in the pre-retirement age group, i.e., 55 years and older.
- 50% of APRN's work in a primary care environment and their psychiatric practice is less than 40% of their time.

Pursuant to LB603, the University of Nebraska Medical Center has initiated development of behavioral health learning sites in the six regions. This project is just beginning and is intended to have training that meets the needs of each region and to develop the behavioral health workforce using multi-disciplinary training. In addition, telehealth opportunities will be pursued more aggressively.

The second factor relates to the Division of Behavioral Health (DBH) facilitating a November 2007 strategic partner planning session followed by a November 2008 strategic planning meeting. The planning meeting did involve some behavioral health stakeholders that were engaged in a discussion to develop recommendations. These recommendations can be found on the DBH website.^{xvii} No additional meetings were held as a follow up to implementation.

Appendix A: Consensus Panel and Planning Group Members

Consensus Panel Group	Agency Represented
Connie Barnes	Behavioral Health Specialists
Beth Baxter	Region Program Administrator, Region 3
Mary Barry-Magsamen	St. Monica's (Lincoln)
Susan Boust	University of NE Medical Center
Carole Boye*	Community Alliance
Linda Burkle	The Salvation Army
Roxie Cillissen	Medicaid -- State of Nebraska
Pat Connell*	Boys Town National Research Hospital
Jonah Deppe	NAMI NE
Scott Dugan	Mid Plains Counseling
Shannon Engler	Bryan LGH
Aimee Folker	Consumer
Ingrid Gunsebom	Region Program Administrator, Region 4
Rhonda Hawks**	Behavioral Health Support Foundation
Becky Janulewicz	Goodwill Industries of Greater Nebraska
CJ Johnson	Region Program Administrator, Region 5
Patti Jurjevich*	Region Program Administrator, Region 6
Sheree Keely	Alegent Health
Vicki Maca	BH - State of Nebraska
Donna Polk-Primm	Nebraska Urban Indian Health Coalition
Amy Richardson	Lutheran Family Services
Nancy Rippen	Consumer & Nurse
Jean Sassatelli	Catholic Charities
Kathy Seacrest*	Region Program Administrator, Region 2
Dean Settle	Lancaster Community Mental Health Center
Sharyn Wohlers	Region Program Administrator, Region 1

*Member of Planning Group

**Principal

Appendix B: Prioritization of Legislative Initiatives & Regulation

Several areas of possible legislative action and administrative rule changes were discussed by the Consensus Panel but no consensus was gained in terms of an agreed upon list or the most appropriate action plan. The Consensus Panel members offered the need to develop a behavioral health caucus unifying the behavioral health stakeholders into one clear voice for the Legislators. Any legislative action items will require statutory changes while the administrative rule changes will require policy and practice changes. Priority number three addresses the need to develop a master list of high cost regulations and legal requirements and prioritize that list in terms of system costs. The discussions which took place at the Consensus Panel meetings included the following possible items for the master list:

Legislative items identified by the behavioral health planning Consensus Panel stakeholders include the following but do not represent a consensus vote by the panel members:

1. Update and amend Medicaid and related eligibility rules and plans to provide for presumptive eligibility
2. Legislatively or administratively initiate a one year moratorium on new regulatory requirements impacting the behavioral health industry for purposes of completing a cost analysis and amend state law to require a cost analysis prior to public hearing as part of the state regulation and rule-making process
3. Amend facility licensing statutes and/or regulations to provide for broader recognition of deemed status and cross-over between like services for purposes of reducing redundancy and inefficient use of scarce resources
4. Expand state licensing of professionals to include rehabilitation professionals and other related fields relevant to Medicaid Rehabilitation Option services
5. Directly appropriate State match for all behavioral health services or, in the alternative, legislate a cap on amount of general fund appropriations transferred from Division of Behavioral Health Program 38 to the Medicaid division for purposes of matching Medicaid
6. Merge regional center behavioral health appropriations with RBHA appropriations; provide for RBHA to purchase services from Regional Centers on a fee for service basis based on utilization

Administrative Rule changes identified by the behavioral health planning Consensus Panel stakeholders include:

1. Eliminate audit duplication for organizations and programs

2. Institute Peer Support Specialist Certification consistent with CMS guidance on the inclusion of Peer Support services within the Medicaid plan
3. Evaluate the regulations imposed on organizations reporting to ensure among other things, the coordination of federal and state requirements for service delivery
4. Institute a policy of no new regulations until a cost/benefit analysis has been conducted
5. Define administrative expenses in the behavioral health system to provide equity across system providers in contracting and determining the administrative costs associated to provide behavioral health services
6. Complete a cost rate analysis to identified shared definitions of services, outcome standards, and performance measures
7. Initiate a policy and practice allowing RBHAs to purchase psychiatric beds directly from inpatient settings on a fee for service basis
8. Evaluate the Magellan ASO contract relative to defining and measuring desired outcomes
9. Convene stakeholders and explore “at risk” contracts with DHHS, RBHAs, and providers
10. Streamline the Medicaid eligibility process so it is shorter and doesn't put pressure on the state funded behavioral health system
11. Increase efforts to develop tele-health capacity across the state and across provider types
12. Develop a standard statewide formulary of behavioral health services

Appendix C: Effect of Parity Legislation on Nebraska Medicaid Managed Care

Nebraska's 1999 parity law requires group health insurance plans to provide coverage for treatment of mental health conditions at parity with physical health conditions, including same out-of-pocket limits, lifetime limits, annual payment limits, and inpatient and outpatient services limits, but not including deductibles, copayments, or coinsurance. The 1999 parity statute excluded substance abuse.

A mental health condition is defined as any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Mental Disorders Section of the ICD. Prior to January 1, 2002, "serious mental illness" was defined as "schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression, and obsessive-compulsive disorder." After January 1, 2002, serious mental illness was re-defined as "any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness." There is a small business exemption for groups with 15 or fewer employees.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, signed into law on October 3, 2008 — as part of the Emergency Economic Stabilization Act of 2008 — introduced momentous changes concerning equity in coverage for mental health and addiction treatment services. The 2008 Act amends the 1996 Parity Act (which remains in effect through 2009) to include addictions, and further mandates that applicable plans must provide comparable annual or lifetime dollar limits for mental health and physical health services. Entities covered by the Act comprise group plans sponsored by private-sector employers and unions; church-sponsored plans; Medicaid managed care; some State Children's Health Insurance Plans (SCHIP) plans; and some state and local health plans.

Parity Act Overview

The Parity Act introduces several key provisions that have the potential to greatly transform mental health and addiction treatment services:

- Equity in coverage for mental health and addictions treatment services
- Out-of-network benefits
- Preservation of State law
- Small employer exemption
- Cost exemption

Equity in coverage for mental health and addiction treatment services is applicable to all financial requirements including deductibles, copayments, coinsurance, and out-of-pocket expenses. It also applies to all treatment limitations, including frequency of treatment, number of visits, days of coverage, and other limits on scope and duration.

With regard to out-of-network benefits, any group health plan (or coverage) that provides out-of-network coverage for medical and surgical benefits must also provide coverage, at parity, for mental health (MH) and substance use disorder (SUD) benefits. The issues around comparability of usual and customary fees are not addressed by this provision.

The parity law protects state parity requirements that are more generous to the consumer. Also, small employers with two to fifty employees are exempt from the requirements of the Act. Small employers of 50 or fewer employees are exempt from the requirements of the Act, as State parity laws will continue to pertain to these employers and to individual plans.

Last but not least, the parity legislation provides a limited cost exemption to employers. If a group health plan or coverage experiences an increase in total costs of 1% (or 2% in the first plan year the Act is applicable) — including medical, surgical, and MH/SUD services — the plan can be exempted from the law for one year. Cost exemption eligibility must be determined by a qualified actuary who shall prepare a written report regarding a plan's cost increase after a plan has complied with the Act for the first six months of the plan year involved. Federal and State agencies reserve the right to audit a plan to determine its compliance with the Act when the plan has elected an exemption.

There are some important exclusions in the parity legislation. Although 97% of employer health plans offer some mental health and addiction treatment benefits, the Act does not mandate that covered plans provide such benefits. However, if a plan chooses to offer MH/SUD coverage, costs and limits must be at parity to those of physical health coverage. Moreover, the Act does not mandate that all MH/SUD conditions are covered, as it only requires the coverage of conditions defined under each plan's terms.

Also, the Parity Act does not apply to Medicare or Medicaid fee-for-service plans. However, parity in Medicare will be achieved through the Medicare Improvements for Patients and Providers Act (MIPPA). MIPPA was passed on July 15, 2008, to equalize coverage for outpatient psychiatric care under Medicare. On the Medicaid side, legislation reauthorizing SCHIP now requires parity. The previous provision to allow States to develop "benchmark-equivalent plans" for mental health was eliminated. As of 2008, SCHIP coverage applied to 7.4 million children and it is estimated to reach 11 million children by 2013.

Questions & Issues in Parity Legislation Implementation

While the Parity Act has much to offer, there are several key areas that are not yet resolved:

- Diagnostic exclusions
- Separate (or combined) deductibles and out-of-pocket maximums
- Network adequacy
- Treatment restrictions
- Medical necessity
- Enforcement of fee structure requirement

In the Parity Act, there is little or no mention of what *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) diagnoses need to be covered. Some advocates see this as a key concern. Instead, the Act requires the Government Accountability Office (GAO) to study coverage rates for commonly included and excluded diagnoses, whether parity has affected what plans cover, and the impact of exclusions on enrollees' health.

The language in the Act is not entirely clear on whether insurers can enact “separate but equal” deductibles and out-of-pocket maximums. The question is whether there will be one single limit for deductibles and out-of-pocket maximums or separate limits (one for physical health and one for behavioral health) with two deductibles each year.

While the Act requires payers to reimburse out-of-network behavioral health providers at the same rate as out-of-network medical and surgical providers, the issue of network adequacy remains. If payers have inadequate provider networks, consumers seek more service from out-of-network providers at lower rates of reimbursement. Advocates are looking for a requirement that insurers demonstrate the ‘adequacy’ of their behavioral health networks and, if inadequate, reimburse beneficiaries at the same rate as in-network providers.

Another key advocacy concern is the comparability of treatment services. There are many services that are unique to the treatment of mental illness and addiction — residential treatment, in-home services, wrap around services, etc. It is not clear whether or how these services will be treated.

One area of contention with managed care plans is the disclosure of clinical review criteria. The Act requires that insurers make available their MH/SUD criteria for medical necessity to both beneficiaries and provider organizations. Exactly how the criteria will be made available — and its degree of specificity — are unclear.

Finally, and of great interest to professionals, the Act requires that insurers reimburse providers of mental health and addiction treatment services at rates comparable to those providing medical and surgical benefits. However, the method for establishing ‘rate comparability’ is not clarified.

Looking Forward: Predicted Market Effects & Opportunities



For the past twenty years, there has been great debate (and multiple estimates of) the cost of parity. *OPEN MINDS* estimates 1% to 2% increases in total health plan costs (dependent on the plan and current coverage). The CBO estimates a 0.4% increase in total costs split between payer and consumer. *OPEN MINDS* also estimates a 30% increase in MH/SA spending. However, we believe that this increase will be the result of more accurate coding as opposed to new service delivery.

With more coverage by private sector and covered health plans, Parity Act legislation has the potential to decrease demands on 'safety net' provider organizations. This would require these organizations to become more sophisticated in eligibility determinations and management of 'blended' funding streams. The longer term implications of parity and universal coverage may eventually lead to the end of 'safety net' funding.

It is likely that employer plans and group health insurers will move (in the near-term) to more risk-based financing (more managed care carve-outs) in order to mediate any short-term cost increases. However, with cost offset possibilities in parity, payers will likely develop more longer-term plans for service integration.

The Parity Act should drive a greater 'volume' in outpatient behavioral health treatment with elimination of discrimination in copayments. However, this outpatient services market will likely be quite cost competitive with the emergence of more low cost e-health interventions. Parity will likely also lead to an increase in community hospital MH/SUD services and to an increase in primary health care provision of behavioral health services.

So what are the opportunities for behavioral health provider organizations with parity?

- Low-cost outpatient services with consumer-friendly attributes and positioning (including techenabled services)
- 'Package' pricing for addiction treatment services (focused on managed care plans) for employed individuals
- 'Plug in' services for outpatient physician and/or primary care practices interested in expanding behavioral health services in response to the Parity Act
- Community hospital collaborations
- Service lines focused on SCHIP population
- Service lines focused on Medicare populations — both dual eligible and seniors

As Nebraska providers evaluate these opportunities, it is important not to forget to prepare for more managed care (in the short term) and more integrated delivery models (in the long term). The opportunities will test your technological capacity. You will need

billing systems that manage a wide range of payer and managed care arrangements that can 'blend' funding streams at the consumer level.

Like any major financial change in a market, the Mental Health Parity & Addiction Equity Act of 2008 will result in winners and in losers. It is essential to anticipate, prepare, and adapt to the changes in store.

For Additional Information on Parity:

- Assuring Universal Access to Health Coverage and Primary Care: A Report by America's Internists on the State of the Nation's Health Care 2009 and Recommendations for Reform. (2009, February 2). American College of Physicians. *OPEN MINDS* Circle Library. Available:
www.openminds.com/circlehome/eprint/indres/030909acpmedhome.htm.
- Children's Health Insurance Program Reauthorization Act of 2009. (2009, February 4). *OPEN MINDS* Circle Library. Available:
www.openminds.com/circlehome/indres/021609newschip.htm.
- Mental Health Parity Act of 2007. (2007, April 11). *OPEN MINDS* Circle Library. Available:
www.openminds.com/circlehome/eprint/indres/072307smhpacttext.htm
- Patients With Parity More Likely to Obtain Post-Discharge Follow-Up Care. (2009, January 12). *OPEN MINDS* On-Line News. Available:
www.openminds.com/circlehome/eprint/omol/2009/011209mhcd5.htm.
- Two-Thirds of Primary Care Physicians Are Unable to Obtain Mental Health Services for Patients. (2009, April 27). *OPEN MINDS* On-Line News. Available:
www.openminds.com/circlehome/eprint/omol/2009/042709mhcd3.htm
- Wellstone Act Mental Health Parity Effective Date Delayed Until 2010. (2009, April 20). *OPEN MINDS* On-Line News. Available:
www.openminds.com/circlehome/eprint/omol/2009/042009mhcd1.htm.



Appendix D: New State Regulations Regarding Medicaid Rehabilitation Facilities

The Nebraska behavioral health system and regulations that impact the system are currently being reviewed on a state level to ensure meeting federal criteria and also to maximize federal revenue opportunities. Three issues that currently need review include:

1. Update of the Medicaid Rehabilitation Option (MRO)
2. Update of the Adult Substance Abuse regulations
3. Collaboration between the Nebraska Divisions of Medicaid and Behavioral Health

In discussion with the Nebraska Medicaid division, the Medicaid division representative stated that both Medicaid and the Division of Behavioral Health (DBH) are working together in updating Medicaid Rehabilitation Option (MRO) and Adult Substance Abuse regulations^{xviii}. The combined efforts of Medicaid and DBH have been to develop shared definitions of the services that both Divisions have in common to make certain, to the degree possible, that the two Divisions do not have different expectations of the providers in regard to the MRO and Adult Substance Abuse services.

The state Medicaid plan includes the service definitions and expectations in its regulations and while DBH does not include the service definitions in its regulations. DBH does however include the division's service definitions and expectations in a separately published "Yellow Book". The different approach to definitions and expectations has resulted in problems for providers in achieving authorizations for services to consumers. The Divisions have had at least three meetings with the Nebraska Association of Behavioral Health Organizations (NABHO) to discuss these service definitions in an effort to gain informed feedback from service providers. The Divisions have accepted many suggested changes to the service definitions, and state that they have reached consensus to the degree possible.

The updating process continues and the draft service definitions are on the Division of Medicaid and Long-Term Care (MCLT) website. The draft MCLT care regulations are not ready for viewing, as the Divisions are still making changes to them, based on recommendations from the Center for Medicaid and Medicare Services (CMS) in regard to the last State Plan Amendment submission.

The Regional Behavioral Health Authorities (RBHAs) have voiced concern over the 'shared definitions and expectations'. The concern is about the limited flexibility in the Medicaid definitions and how this may impact the flexibility in the use of state behavioral health funding through DBH. The flexibility currently offered with state behavioral health

funds allows the RBHAs to fill in the gaps for consumer care that is not available with Medicaid funded services.

- Nebraska Medicaid Division Initiatives, <http://www.hhs.state.ne.us/med/cihome.htm>
- Medicaid Rehabilitation Services Option: Overview and Current Policy Issues, The Henry J. Kaiser Family Foundation, Medicaid and the Uninsured Report 2007, <http://www.kff.org/medicaid/upload/7682.pdf>
- Nebraska Medicaid Reform Annual Report, December 2009, Department of Health and Human Services
<http://www.nebraskadvocacyservices.org/includes/downloads/icaidreformreport2009final.pdf>

Appendix E: Magellan Performance Reporting

On April 16, 2008, it was announced that Magellan Behavioral Health was selected as the Administrative Service Organization contractor for these three DHHS Divisions – Behavioral Health, Children & Family Services and Medicaid & Long Term Care. The Magellan Behavioral Health contract began on May 1, 2008 and ends on June 30, 2010 with optional annual contract renewals for State Fiscal Years 2011, 2012 and 2013.

The Magellan Behavioral Health contract includes the following functions for the Nebraska Behavioral Health System:

- Training and Technical Support
- Consumer Eligibility Determination
- Utilization Management
- Information Management
- Data Capture and Transfer Requirements
- Information Reporting
- Claims and Payment Information
- Quality Improvement

The Magellan Behavioral Health contract is monitored by a position created within the Division and is responsible for ensuring the ASO functions purchased are consistent with State of Nebraska requirements. The Magellan contract, as the ASO for the Nebraska Medicaid and Division of Behavioral Health, asks for the following regular and ad hoc reports made available to the state, the six Regional Behavioral Health Authorities, and the providers^{xix}. Some examples of the types of reports include, but are not limited to:

- Turn Around Document (TAD) - A monthly Behavioral Health report that includes, but is not limited to, a count of units authorized or services registered by individual consumer, by service, by provider, and by Region for the current month. These reports are used for billing and payment.
- Duplicate Services Report- Identifies individuals who are receiving services paid by both Medicaid and DBH

- Shifted Authorized/Registered Service Report- Identifies individuals who received a service from either Medicaid, CFS or DBH and there was a shift to another division in the same month
- Average Length of Stay Comparison by service, by region, statewide

Additional regular and ad hoc reports to be made available to the state, the six Regional Behavioral Health Authorities, and the providers include, but are not limited to:

- EPC Demographics
- Discharge Summary
- SED/SPMI Quarterly Summary
- Discharge Compliance Report
- Admission Summary
- Annual Re-Registration Report
- Annual Report
- Utilization – By service, by provider, by region, by service

The ability of Magellan to provide performance measurement data has been identified by both the provider organizations and the Division of Behavioral Health (DBH) to be problematic. DBH initiated a Magellan Quality Improvement Team (MQIT) to address the problems identified below:

- Reliance on and limitations of the ASO data system
- Integration and coordination of data and reports with other DHHS partners
- Data quality for providers has been identified but no change in provider data quality
- Magellan system needs to be cleaned up, clarifying data codes and reviewing report processes
- Multiple issues have been uncovered, adding time to correct actions and improve processes

While the MQIT process identified problems and the source of the problems, quality data for performance measurement has not improved. The MQIT process continues and discussion has led to talks of renegotiating the ASO contract to ensure access to performance measures in the behavioral health system.

Appendix F: New Rulings on IMD Funding and Relevance to Nebraska Facilities

There are two new rulings on IMD funding that have a relevance to Nebraska Institute of Mental Disorder (IMD) facilities. One is the IMD rule change on the Medicaid Home and Community-Based Services (HCBS) Waiver and the other an update on the IMD Exclusion Rule. Both could mean a loss of payment for IMD facilities and resources for the consumer and the behavioral health system of care. The Centers for Medicaid and Medicare Services has been updating rules to fit the 'recovery oriented' model of care in the behavioral health system. This has placed more decision-making at the state level and potentially increased states' financial liability.

The first ruling that could impact the Nebraska behavioral health system is the IMD Rule Change on the **Medicaid Program: Home and Community-Based Services (HCBS) Waivers**.^{xx} The implications for this rule change impacts the design and delivery of care for the aged or disabled, or both; mentally retarded or developmentally disabled, or both; and mentally ill target populations. The ruling would offer states flexibility to combine these target groups in order to provide services based on needs rather than diagnosis or condition, and offer administrative relief from operating multiple waiver programs. The concern from providers and consumers is that the specialized care for the target groups would diminish and in effect move the system of care back to the days of intermingled populations. Below are the specifics for this rule change, File Code CMS-2296-ANPRM, published in the *Federal Register* on June 22, 2009 is as follows:

A. Removing Regulatory Barrier to Designing 1915(c) Waivers Based on Needs Rather Than Diagnosis or Condition

1. States the option to design home and community-based services (HCBS) waiver programs serving more than one target population (Aged or disabled, or both; Mentally retarded or developmentally disabled, or both; and Mentally ill)
2. Increase a State's ability to design service packages based on need, rather than diagnosis or condition.
3. States, with concurrence from stakeholder groups and individuals, have expressed a desire for the flexibility to combine these target groups in order to provide services based upon needs rather than diagnosis or condition, and for administrative relief from operating and managing multiple 1915(c) waiver programs.
4. Under the change, States would still have to determine that without the waiver, participants would require institutional level of care, in accordance with section 1915(c) of the Act. Likewise, the intended proposal to provide additional targeting flexibility for States will not affect the cost-neutrality requirement inherent in section 1915(c) waivers.
5. Requires: (1) The service planning process be person-centered, and (2) the services specified in the plan of care be based upon the needs of the individual, not an average need among one target group.

6. Since the inception of the 1915(c) HCBS waiver program in the 1981, the Centers for Medicare & Medicaid Services (CMS) has supported State efforts to serve individuals in the least restrictive setting possible. However, home and community have not been explicitly defined, and as a consequence, some individuals who receive HCBS in a residential setting managed or operated by a service provider have experienced a provider-centered and institution-like living arrangement, instead of a person-centered and home-like environment with the freedoms that should be characteristic of any home and community-based setting. For some years, we have attempted to address this problem indirectly through our review of State service definitions for HCBS, with limited success. Our intention is to propose to affirmatively identify expectations for characteristics of home and community-based settings.
7. Therefore, CMS is planning to propose adding to 42 CFR subpart G a requirement that individuals receiving HCBS waiver services must reside in the home or community, in accordance with either of two criteria enumerated below:
8. Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or
9. Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, and that meets standards for community living, as defined by the State and approved by the Secretary

The second rule change CMS is considering is an update on the IMD Exclusion Rule. This exclusion, known as the "Medicaid IMD exclusion" and part of the program since its 1965 enactment, bars federal contributions to the cost of medically necessary inpatient care incurred in treating Medicaid beneficiaries ages 21-64 who receive care in certain institutions that fall within the definition of an "institution for mental disease." An "institution for mental diseases" is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services."

The threat to the Nebraska behavioral health system lies in CMS review and discussion of facilities with greater than 16 beds and with 51% or more of its population with a psychiatric diagnosis is considered to be an Institute for Mental Diseases (IMD). The enforcement of the IMD exclusion rule is in the hands of states and there is an increase in states beginning to apply this beyond SNFs to group home settings and/or residential settings with greater than 16 beds and with 51% or more of its population with a psychiatric diagnosis. The impact to Nebraska behavioral health system, should the state decide to enforce the IMD exclusion rule beyond the current SNF, would be displacement of approximately 2,000 Nebraskans from group home residential settings. The reasoning behind the change is other states' is the financial savings gained by diminishing the states Medicaid match.

An additional impact maybe a CMS ruling that targets 18 to 21 year olds who reside in an IMD:

- CMS has ruled that while an under-21 person is in PRTF, she/he is considered an allowable IMD, and no other Medicaid services can be billed other than those billed by the PRTF
- This then begs the question, "If State pays for PRTF (via Title IV-E, etc.), can other Medicaid services be billed by the PRTF provider? Can other Medicaid services be billed by other providers?"

The impact to Nebraska facilities and consumers could be substantial with these rulings. CMS is offering states decision-making power in the implementation. With that in mind, providers, advocates, and consumers still have an opportunity to have a voice with state government.

Appendix G: Nebraska BH Service Funding by Payer

Service Type	State Mental Health General Fund	Medicaid	MHBG	PATH	Other Federal	Other State	County Match	Commercial Insurance (Plan Specific)	SAPTBG	State Substance Abuse General Fund
Community Support	X	X	X						X	X
Day Rehabilitation	X	X	X							
Psychiatric Residential Rehabilitation	X	X	X							
Day Treatment	X	X	X							
Medication Management	X	X	X	X	X	X	X	X	X	X
Outpatient Therapy	X	X	X	X				X	X	X
Day Support	X		X							
Supported Employment	X		X		X – Voc Rehab					
Assertive Community Treatment	X	X								
Dual Residential	X	X							X	X
Post Commitment Days Treatment	X							X		
Acute Inpatient for Commitments	X							X		
Subacute Inpatient for Voluntary & Involuntary	X							X		
Secure Residential	X	X								
24 hour Crisis Phone										
Crisis Assessment	X									
Urgent Assessment										
Urgent Medication Management	X									
Urgent Outpatient	X									
Crisis Response Teams	X									
Crisis Respite	X									
Emergency Community Support	X									
Crisis Stabilization/Treatment (Voluntary)	X	X								
Flex Funds	X									X
Assessment Only	X									X
Outpatient Therapy – MH (Ind, Grp &/or Family)	X	X	X					X		
Outpatient Therapy – Dual (Ind, Grp, &/or Family)		X								
Intensive Case	X	X								

Service Type	State Mental Health General Fund	Medicaid	MHBG	PATH	Other Federal	Other State	County Match	Commercial Insurance (Plan Specific)	SAPTBG	State Substance Abuse General Fund
Management/Community Services										
Psychological Testing										
Recovery Support										
Acute Inpatient	X	X						X		
Subacute Inpatient	X	X								
Supportive Housing	X	X			X – State Real Estate Do Stamps					
Homeless Outreach				X						
Homeless Transition Services	X									
Peer Support Services	X									
Intensive Outpatient		X							X	
Partial Hospitalization		X							X	
Clinically Managed Low Intensity Residential (Halfway House)		X							X	
Clinically Managed Medium Intensity Residential (Intermediate Residential, Therapeutic Community)		X							X	
Clinically Managed High Intensity Residential (Short Term Residential, Dual Disorder Residential)		X							X	
Medically Monitored Intensive Inpatient Services									X	
Ambulatory Detoxification		X							X	
Social Detox		X							X	
Medically Monitored Inpatient Detoxification		X							X	
Treatment Foster Care		X								
Enhanced Treatment Group Home		X								

Appendix H: Behavioral Health System Provider Rates & Reimbursement

Provider Rate Paid Through DBH

- Each of the RBHAs are contracted with a lump sum of state funding and a county match
- Service rates across the six RBHA are collaboratively set

Medicaid Rates – Outpatient Professional Services

DESCRIPTION	PROCEDURE CODES	PHYSICIAN	PSYCHOLOGIST AND PROVISIONAL PSYCHOLOGIST	LIMHP/LMHP/PLMHP RN/LADC/PLADC	PA/APRN
Initial Diagnostic Interview by MD/PhD/PA/APRN	90801	\$128.79	\$99.99 (or \$88.81 Prov)	N/B	\$120.91
Initial Diagnostic Interview by LIMHP	H0031 HO	N/B	N/B	\$78.00 (only LIMHP)	N/B
Biopsychosocial Assessment	H0002	\$218.08	\$218.08	\$181.74 (NB by PLADC/LADC)	\$181.74
Addendum to Biopsychosocial Assessment	H0002 52	\$65.00	\$65.00	\$65.00 (NB by PLADC/LADC)	\$65.00
Substance Abuse Assessment (age 20 or <)	H0001	\$218.08	\$218.08	\$181.74 (NB by PLADC)	\$181.74
Addendum to Substance Abuse Assessment (age 20 or <)	H0001 52	\$65.00	\$65.00	\$65.00 (NB by PLADC)	\$65.00
Sexual Offending Risk Assessment (age 20 or <)	H2000 SK	\$515.53	\$515.53	\$515.53 (NB by PLADC/LADC)	\$515.53
Addendum to SO Risk Assessment (age 20 or <)	H2000 HA	\$256.80	\$256.80	\$256.80 (NB by PLADC/LADC)	\$256.80
Individual Psychotherapy	90804	\$56.96	\$47.04 (or \$46.36 Prov)	\$34.80	\$35.32
Individual Psychotherapy – with Medical Management	90805	\$57.94	N/B	N/B	\$40.87
Individual Psychotherapy	90806	\$106.12	\$86.63 (or \$83.65 Prov)	\$64.02 (or \$63.29 PLADC/LADC)	\$82.36
Individual Psychotherapy – Crisis	90806 ET	\$106.12	\$86.63 (or \$83.65 Prov)	\$64.02 (or \$63.29 PLADC/LADC)	\$82.36
Individual Psychotherapy	90808	\$106.50	\$96.37 (or \$87.64 Prov)	\$70.01 (or \$65.73 PLADC/LADC)	\$65.73
Individual Psychotherapy –	90808 ET	\$106.50	\$96.37 (or \$87.64 Prov)	\$70.01 (or \$65.73 PLADC/LADC)	\$65.73

DESCRIPTION	PROCEDURE CODES	PHYSICIAN	PSYCHOLOGIST AND PROVISIONAL PSYCHOLOGIST	LIMHP/LMHP/PLMHP RN/LADC/PLADC	PA/APRN
Crisis					
CAP Services	H0046	\$64.02	\$64.02	\$64.02	\$64.02
Individual Psychotherapy – with Medical Management	90807	\$108.69	N/B	N/B	\$71.21
Individual Psychotherapy – with Medical Management	90809	\$109.95	N/B	N/B	\$96.56
Individual Psychotherapy – with Medical Management	90817	\$58.04	N/B	N/B	\$46.15
Individual Psychotherapy – with Medical Management	90819	\$110.22	N/B	N/B	\$99.84
Individual Psychotherapy – with Medical Management	90822	\$132.37	N/B	N/B	\$122.58

Medicaid Managed Care Adult SA Rates – Eff 7-1-09

SERVICE	LEVEL	CODE	UNIT	PhD.	PA & APRN	LIMHP, LMHP, PLMHP, RN	LADC PLADC	FACILITY
Substance Abuse Assessment		H0001	One	\$218.08	\$181.74	\$181.74 (NB RNP)	\$181.74 (NB, PLADC)	
Assessment Addendum		H0001 52	One	\$65.00	\$65.00	\$65.00 (NB RN)	\$65.00 (NB PLADC)	
Outpatient	1							
Community Support		H2016 HF	1 month					\$227.42
Group Therapy		H0005	1 session	\$33.03	\$24.79	\$24.79	\$24.79	
Family Therapy with client		90847 HF	1 session	\$93.36	\$90.34	\$83.02	\$82.41	
Family Therapy w/o client		90846 HF	1 session	\$91.45	\$82.26	\$82.26	\$82.26	
Individual Therapy		90806 HF	45 – 50"	\$86.65	\$82.38	\$64.04	\$63.31	
Intensive Outpatient	11.1							
IOP Dual DX		H0015	1 hour					\$26.76
Partial Hospitalization	11.5							
Partial Care Dual Dx		H0035	1 hour					\$71.40

SERVICE	LEVEL	CODE	UNIT	PhD.	PA & APRN	LIMHP, LMHP, PLMHP, RN	LADC PLADC	FACILITY
Clinically Managed Low Intensity Residential Tx	111.1							
Halfway House Dual Dx		H2034	1 day					\$62.03
Clinically Managed Medium Intensity Residential Tx	111.3							
Intermediate Residential Dual Dx		H0019	1 day					\$150.00
Therapeutic Community Dual Dx		H0019 TT	1 day					\$135.00
Clinically Managed High Intensity Residential Treatment	111.5							
Short Term Residential Dual Dx		H0018 HF	1 day					182.43
Residential Treatment Dual Dx		H0018 HH						\$208.15
Ambulatory Detoxification with Extended On-site Monitoring	11-d	H0014	1 day					\$119.32
Clinically Managed Residential Social Detoxification	111.2-D	H0012	1 day					\$168.86
Medically Monitored Inpatient Detoxification	111.7-D	H0010	1 day					R281.43

Appendix I: Medicaid Rates

Medicaid Managed Care MRO Rates – Eff 7-1-09

Procedure Code	Name of Street	Unit	Rate	Billing Notes
H2016 HE	Community Support-Psych	Month	\$277.27	Must use HE modifier
H0040	ACT (Assertive Community Treatment)	Day	\$43.79	
H0040 52	Alternative ACT	Day	\$41.16	Must use 52 modifier
H2017	Day Rehab Half-day	15 min	\$ 2.23	Must bill 12 units (3 hours)
H2018	Day Rehab Full-day	Day	\$53.51	
H2018 TG	Residential Rehab	Day	\$109.45	Must use TG modifier

DESCRIPTION	PROCEDURE CODES	PHYSICIAN	PSYCHOLOGIST AND PROVISIONAL PSYCHOLOGIST	LIMHP/LMHP/PLMHP RN/LADC/PLADC	PA/APRN
Family Psychotherapy w/o Client Present	90846	\$114.30	\$91.43	\$82.24	\$82.24
Family Psychotherapy	90847	\$118.44	\$93.34 (or \$84.46 Prov)	\$83.00 (or \$82.30 PLADC/LADC)	\$95.54
Family Psychotherapy – Crisis	90847 ET	\$118.44	\$93.34 (or \$86.46 Prov)	\$83.00 (or \$82.30 PLADC/LADC)	\$95.54
Provider Mileage per Mile	99082	\$0.45	\$0.45	\$0.45	\$0.45
Family Assessment	H1011	\$69.35	\$69.35	\$69.35 (NB PLADC/LADC)	\$69.35
Group Psychotherapy	90853	\$40.02	\$32.29	\$23.97	\$30.02
Pharmacological Management	90862	\$41.92	N/B	N/B	\$36.72
Conference re Client Treatment	90887	\$27.33	\$22.40 (or \$16.84 Prov)	\$16.72 (or \$16.34 PLADC)	\$16.34
Psychological Testing 1 Hour	96101	N/B	\$88.36	N/B	N/B
Psychological Testing ½ Hour	96101 52	N/B	\$44.09	N/B	N/B

DESCRIPTION	PROCEDURE CODES	PHYSICIAN	PSYCHOLOGIST AND PROVISIONAL PSYCHOLOGIST	LIMHP/LMHP/PLMHP RN/LADC/PLADC	PA/APRN
Annual Supervision Assessment by Psychologist	H0031 AH	N/B	\$81.00 (NB by Prov)	N/B	N/B
Annual Supervision Assessment by LIMHP	H0031 52	N/B	N/B	\$59.86 (only LIMHP)	N/B
E.C.T. (single seizure)	90870	\$54.97	N/B	N/B	N/B
Established Patient Evaluation	99211	\$30.58	N/B	N/B	\$27.25
Established Patient, Focused	99212	\$46.10	N/B	N/B	N/B
Established Patient, Expanded	99213	\$61.18	N/B	N/B	N/B
Established Patient Evaluation	99214	\$83.98	N/B	N/B	N/B
Established patient Evaluation	99215	\$84.03	N/B	N/B	N/B
Outpatient Consultation, Focused	99241	\$45.26	N/B	N/B	N/B
Outpatient Consultation, Expanded	99242	\$52.45	N/B	N/B	N/B
Outpatient Consultation, Detailed	99243	\$85.38	N/B	N/B	N/B
Outpatient Consultation, Comprehensive	99244 99245	\$94.22	N/B	N/B	N/B
Haldol Decanoate, Per 50 mg	J1631	\$3.85	N/B	N/B	\$3.85
Prolixin Decanoate, Per 25mg	J2680	\$3.00	N/B	N/B	\$3.00
Haldo Per 5mg	J1630	\$2.25	N/B	N/B	\$2.25

DESCRIPTION	PROCEDURE CODES	PHYSICIAN	PSYCHOLOGIST AND PROVISIONAL PSYCHOLOGIST	LIMHP/LMHP/PLMHP RN/LADC/PLADC	PA/APRN
Resperdal Consta, Per 0.5mg	J2794	Invoice	N/B	N/B	Invoice
Olanzapine per 2.5mg	S0166	\$7.19	N/B	N/B	\$7.19
Therapeutic or Diagnostic Injection	96372	\$9.59	N/B	N/B	\$9.59



Appendix J: Nebraska Division of Behavioral Health Goals (2010 MHBG Application)

1. Increased access to services
 - ✓ FY 2010 Projected – 29,957
 - ✓ FY 2011 Projected – 29,000
2. Reduced utilization of psychiatric inpatient beds – 30 days
 - ✓ FY 2010 Projected – 3%
 - ✓ FY 2011 Projected – 3%
3. Reduced utilization of psychiatric inpatient beds – 180 days
 - ✓ FY 2010 Projected – 7%
 - ✓ FY 2011 Projected – 7%
4. Evidenced based – number of practices (number)
 - ✓ FY 2010 Projected – 6 practices
 - ✓ FY 2011 Projected – 6 practices
5. Evidence based – adults with SMI receiving supported housing
 - ✓ FY 2010 Projected – 823 consumers
 - ✓ FY 2011 Projected – 700 consumers
6. Evidence based – adults with SMI receiving supported employment
 - ✓ FY 2010 Projected – 388 consumers
 - ✓ FY 2011 Projected – 400 consumers
7. Evidence based – adults with SMI receiving Assertive Community Treatment
 - ✓ FY 2010 Projected – 242 consumers
 - ✓ FY 2011 Projected – 250 consumers
8. Evidence based – adults with SMI receiving family psychoeducation
 - ✓ FY 2010 Projected – No capacity
 - ✓ FY 2011 Projected – No capacity
9. Evidence based – adults with SMI receiving Integrated Treatment of Co-Occurring Disorders
 - ✓ FY 2010 Projected – 74 consumers
 - ✓ FY 2011 Projected – 80 consumers
10. Evidence based – adults with SMI receiving illness self-management
 - ✓ FY 2010 Projected – No capacity
 - ✓ FY 2011 Projected – No capacity
11. Evidence based – adults with SMI receiving medication management
 - ✓ FY 2010 Projected – 4,257 consumers
 - ✓ FY 2011 Projected – 4,200 consumers
12. Client perception of care
 - ✓ FY 2010 Projected – 70%
 - ✓ FY 2011 Projected – 70%
14. Maintain, if not increase, the number of people receiving mental health services
 - ✓ FY 2010 Projected – 29,957 consumers
 - ✓ FY 2011 Projected – 29,000 consumers
15. Maintain per capita state expenditures for community mental health services
 - ✓ FY 2010 Projected – \$37.00
 - ✓ FY 2011 Projected – \$37.00

Appendix K: National Trends Overview

The Key National Trends to Consider

1. Parity legislation now in place
2. Health care reform pending
3. IMD waivers and current ruling
4. Medicaid program integrity and audits
5. Comparative effectiveness
6. System change (and opportunities) with telehealth and emerging virtual consumer

20

OPEN MINDS © 2010. All Rights Reserved.



Parity Overview

- Parity in Medicare
- Parity in SCHIP program
- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
- Included in the Emergency Economic Stabilization Act of 2008
- Signed into law on October 3, 2008
- Regulations from Department of Labor, Health and Human Services, and Treasury pending

21

OPEN MINDS © 2010. All Rights Reserved.





Parity Challenges for Behavioral Health Provider Organizations

1. Billing systems that manage wide range of payer and managed care arrangements – and can ‘blend’ funding streams at consumer level
2. More managed care (in short term)
3. More integrated delivery models (in long term)
4. More competition for consumers now that they have \$

22

OPEN MINDS © 2010. All Rights Reserved.



Long-Term Market Effects of Parity

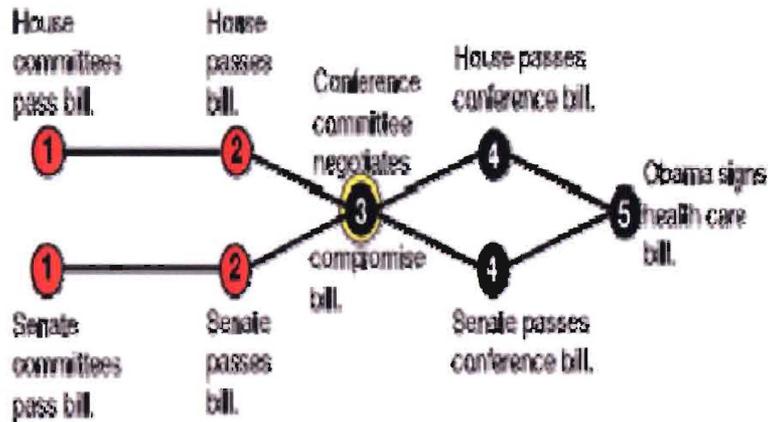
- Increase in financial and clinical integration
- Increased speed of acceptance of neurotech interventions
- Parity + universal coverage = end of ‘safety net’ funding

23

OPEN MINDS © 2010. All Rights Reserved.



Health Care Reform: Process for Development of Legislation



Red means that step is completed. Yellow means in progress.

24

OPEN MINDS © 2010. All Rights Reserved.



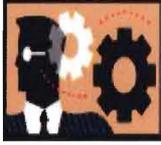
Common Elements in Health Care Reform Proposed Legislation

1. Require reductions in Medicare spending for financing (and likely per person spending in Medicaid as well)
2. Individual mandate to purchase insurance with 'hardship' exception and/or tax credits
3. Employer mandate to provide health insurance, with penalties
4. Basic benefit package to be defined
5. Choice of plans through health insurance exchange and/or public option
6. Expansion of state Medicaid plans likely with proposed state participation of ~10%

25

OPEN MINDS © 2010. All Rights Reserved.





Market Implications of Health Care Reform

- Expansion of Medicaid and state 'role' in policymaking likely
- Behavioral health provider organizations will 'earn' most funding through health system financing mechanisms and consumer contributions
- Role for state department of mental health/addictions to diminish (unless administrator of Medicaid funds)
- Four cost containment/funding strategies to be deployed:
 - ✓ National health information network
 - ✓ Program integrity initiatives
 - ✓ Push to end "FFS" funding
 - ✓ Comparative effectiveness used to determine preferred methodologies

26

OPEN MINDS © 2010. All Rights Reserved.



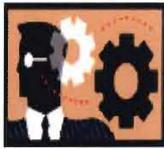
EHR Mandates

- Stimulus funding encouraging tech adoption
 - ✓ Cost reductions in health system administration and duplicative service anticipated
- Plan to mandate interoperable EMRs in order to bill Medicaid and Medicare
- Bioconnectivity = Merger of data from EMR, claims databases, and clinical data from medical devices with connectivity technology
- Comprehensive, web accessible data set accessible to professionals and to consumers

27

OPEN MINDS © 2010. All Rights Reserved.





Move to Eliminate Fee-For-Service Reimbursement

- Interest in moving away from FFS with payers shifting “risk” to provider organizations
 - ✓ Global funding models: Massachusetts health plan recommendations for case rates
 - ✓ Episode-based payment or case rates
 - ✓ Tie payment to performance: P4P payments (such as penalties for readmissions to hospitals)

28

OPEN MINDS © 2010. All Rights Reserved.



IMD Exclusion Rule

- Medicaid law prohibits federal contributions to the cost of medically necessary care furnished by licensed medical care providers to enrolled program beneficiaries
- Any Skilled Nursing Facility (SNF) with greater than 16 beds and with 51% or more of its population with a psychiatric diagnosis is considered to be an Institute for Mental Diseases (IMD)
- Enforced by states and there is an increase in states beginning to apply this beyond SNFs to group home settings and/or residential settings

29

OPEN MINDS © 2010. All Rights Reserved.





IMD Waivers

- Medicaid Program: Home and Community-Based Services (HCBS) Waivers, File Code CMS-2296-ANPRM, published in the Federal Register on June 22, 2009
- This impacts HCBS waivers targeted to those with Mental Illness, Developmentally Disabled, and aging
- Tie into IMD's is likely related to how CMS defines "home and community" which subsequently may impact IMD facilities who provide homes for consumers who qualify for HCBS waivers
- There is the risk of the three populations being inter-mixed in essence moving the industry backwards and against the original intent of the three separate waivers.

30

OPEN MINDS © 2010. All Rights Reserved.



Medicaid Program Integrity & Audits

OIG's Prescription for Policies and Procedures

- "A (facility) must have written policies and procedures that reflect and reinforce current Federal and State statutes and regulations regarding the submission of claims and cost reports.
 - ✓ *The policies must create a mechanism for the billing or reimbursement staff to communicate effectively and accurately with the clinical staff.*"

31

OPEN MINDS © 2010. All Rights Reserved.





Comparative Effectiveness: The Institutionalization of Clinical Decision-Making

- With or without health care reform, third-party payers moving to limit funding to 'approved effective' treatments
- The 'evidence-based practice' movement is the beginning
- Obama proposal on comparative effectiveness (ala European model of NICE) is likely future direction
 - ✓ Defined by DHHS as the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat, and monitor health conditions in "real world" settings

32

OPEN MINDS © 2010. All Rights Reserved.



IOM-Recommended Comparative Effectiveness Research in the Behavioral Health Field

Dementia Detection & Management
Alzheimer's & Other Dementia
Children With ADHD
Serious Emotional Disorders
Autism Spectrum Disorders
Social-Emotional & Developmental Disorders
Major Depressive Disorders
Chronic Pain Management
Pharmacologic Treatment
Post-Suicide-Attempt Management Strategies
Serious & Persistent Mental Illness
Primary Care & Mental Health Care

33

OPEN MINDS © 2010. All Rights Reserved.





Implications of Institutionalization of Clinical Decision-Making

- Treatment options will be narrowed
 - ✓ How implemented raises questions of compatibility with 'consumer directed'
- Delivery of health care knowledge to professionals on "just in time" basis to keep pace with scientific velocity
 - ✓ New web tools for health care professional decision supports essential
- Health care professional education and continuing education focus will change

34

OPEN MINDS © 2010. All Rights Reserved.



The Virtual Consumer – Place Matters Less in Service Delivery

- Technology changes role of place of service for health services – making some institutional settings for some purposes obsolete
- Porting the professional to consumer locations via technology – web-based/e-mail, audio, video
- Remote monitoring possible
- The "Smart Home" – home automation focused on disability support
- Remote professional consultation (e.g. virtual surgery)

35

OPEN MINDS © 2010. All Rights Reserved.



Physician Making an On-Line House Call



36

OPEN MINDS © 2010. All Rights Reserved.



The screenshot shows a web browser window displaying the Cleveland Clinic website. The address bar shows <http://my.clevelandclinic.org/consult/for/submit.aspx>. The page features a navigation menu with items like "Secure Online Services", "Health Information", "Find a Doctor", "Appointments", "Patients & Visitors", and "Institutes & Services". A sidebar on the left lists "Secure Online Services" including MyChart, MyConsult, MyPractice Community, DrConnect, and Contact Secure Online Services. The main content area has a banner for "legacy and innovation" and a section for "Cleveland Clinic Secure Online Services MyConsult". A "CONTACT CLEVELAND CLINIC" box displays the phone number 800.223.2273 and a "Request an Appointment" form. A footer contains a list of links: MyConsult, Global Patient Services, Medical CoVERAGE, MyConsult Login, MyConsult Operations, and MyConsult Technical Help.



The Virtual Consumer – Implications

- Decreased demand for facility-based services – both residential and outpatient
- Home care and ‘mobile care’ facilitated
- A welcome relief for payers, but conflict in patient and family preference
- Home care and e-health regulatory and reimbursement policy update needed
- New challenge is managing ‘mobile and remote’ workforce – competencies and training; productivity; quality



Endnotes

- ⁱ <http://www.alegent.com/137944.cfm>
- ⁱⁱ BHOC Final Report June 2009
- ⁱⁱⁱ <http://www.hhs.state.ne.us/beh/nebhr gb.htm>
- ^{iv} Mental Health Block Grant FY2010 Application, page 42
- ^v <http://www.hhs.state.ne.us/beh/rc/rc.htm>
- ^{vi} Mental Health Block Grant FY2010 Application
- ^{vii} "A Critical Match", Nebraska Center for Rural Health Research, September 2009.
- ^{viii} BHOC Final Report June 2008
- ^{ix} Compilation of Nebraska Medicaid FY09 Behavioral Health Fact Sheet & Nebraska Division of Behavioral Health Spending Fact Sheet
- ^x Nebraska Medicaid FY09 Behavioral Health Fact Sheet
- ^{xi} Nebraska Medicaid FY09 Behavioral Health Fact Sheet
- ^{xii} <http://www.hhs.state.ne.us/beh/MQIT.htm>
- ^{xiii} <http://www.dhhs.ne.gov/beh/mh/MHConsumer/Nebraska2009BehavioralHealthConsumerSurvey.pdf>
- ^{xiv} BHOC Final Report June 2009
- ^{xv} BHOC Final Report June 2009
- ^{xvi} "A Critical Match", Nebraska Center for Rural Health Research, September 2009.
- ^{xvii} http://www.hhs.state.ne.us/Behavioral_Health/
- ^{xviii} <http://www.hhs.state.ne.us/med/cihome.htm>
- ^{xix} Substance Abuse Prevention and Treatment Block Grant FY2010 Application
- ^{xx} File Code CMS-2296-ANPRM, published in the *Federal Register* on June 22, 2009

Behavioral Health Oversight Commission Final Report

Background

LB 928 (2008) revised existing law to create the Behavioral Health Oversight Commission (Commission) with a term of one year, commencing July 1, 2008, and is:

"...responsible to the [behavioral health] division and shall oversee and support implementation of the Nebraska Behavioral Health Services Act. To carry out this duty, the commission shall "(i) conduct regular meetings, (ii) provide advice and assistance to the [behavioral health] division relating to implementation of the act, (iii) promote the interests of consumers and their families, (iv) provide reports as requested by the [behavioral health] division, and (v) engage in such other activities as directed or authorized by the [behavioral health] division" (Nebraska Department of Health and Human Services [DHHS], 2008).

Governor Heineman, in his comments to the Commission at the July 24, 2008 meeting, encouraged the new Commission's efforts to assist the DHHS in developing a strategic vision for the behavioral health division while working within limited resources (NDHHS, 2008).

Charter

The Oversight Commission's Charter, approved August 2008, adopted the following:

The Behavioral Health Oversight Commission shall be responsible to the Division of Behavioral Health (DBH) and shall oversee and support implementation of the Nebraska Behavioral Health Services Act. The Commission will provide advice and assistance to DBH regarding promotion of: (i) the interests of consumers and their families; (ii) both individual and systemic recovery; and, (iii) consumer involvement in all aspects of implementation of the Nebraska Behavioral Health Services Act. This Commission will provide a strategic vision for behavioral health for the State of Nebraska recognizing limited resource availability, and the importance of an environment of recovery for all behavioral health consumers (NDHHS, 2008).

Strategic Focus

A Strategic Focus was developed as a means to identify major areas for study and recommendation by the Commission to DBH. The three areas of Strategic Focus adopted by the Commission were:

- 1. Moving Behavioral Health Forward;**
- 2. Behavioral Health Workforce Shortage;**
- 3. Enhanced Communication and Partnering (NDHHS, 2008).**

The Nebraska Behavioral Health System has been undergoing system change activities beginning with *redesign* in the mid-1990s, *reform* starting in 2004 and moving on to *transformation* in the present. Much work and considerable resources--including human effort, time and commitment along with fiscal resources--have been dedicated to system improvements and transformation. Much work is yet to be done to reach a transformed, recovery-based system that is built upon core values and guiding principles that supports individuals across the life span in their recovery journey.

1. Moving Behavioral Health Forward

The Commission approved the following outline for “Moving Behavioral Health Forward”:

Now that LB 1083 is being implemented, how does the behavioral health system continue to move forward fostering recovery for behavioral health consumers? What should a balanced Nebraska behavioral health system look like?

- **What should the service array be and are there “gaps”?**
 - **What is the role of the Regional Centers?**
 - **What is the role of peer support services?**
 - **What is the role of consumer involvement?**
 - **How do we measure outcomes?**
 - **How do we move to performance-based contracting and oversight?**
 - **How do we integrate funding toward helping consumers access services?**
- (NDHHS, 2008).

“Moving Behavioral Health Forward” recognizes that it is critical to adopt a **Strategic Vision** for implementation by the Division of Behavioral Health as the primary leader in behavioral health and for establishment of trusting and effective partnerships with key stakeholders in the system. This Commission recognizes the importance of strategic visioning to a planning process and believes it is imperative for this visioning and planning to occur in fiscal year 2010. It is the Commission’s intention that these recommendations to the division will be used to gain the investment and commitment of Nebraska’s behavioral health leadership to undertake behavioral health system transformation. Also critical in addressing “Moving Behavioral Health Forward” is the recognition of the importance of endorsing a strategic vision by this Commission as one of its primary responsibilities as established by the Charter. To that end, we offer the following Strategic Vision Statement, as well as Core Values and Guiding Principles and Recommendations.

A. Strategic Vision Statement

The Public Behavioral Health System in the State of Nebraska will:

1. Promote wellness, recovery, resilience, and self determination for adults and children and such system will be consumer and family driven;
2. Focus on and create positive outcomes coupled with a performance evaluation process that supports continuous quality improvement for the division as well as the Regional Behavioral Health Authorities, providers and recipients of services;
3. Provide inclusive and transparent planning through genuine partnership and collaboration with a diverse group of stakeholders, including meaningful participation by consumers, to promote a rational, strategic decision-making environment and process;
4. Focus on prevention and early intervention;
5. Share a cooperative and common vision among DHHS divisions regarding recovery, best practice, access to care, and funding;
6. Encourage public/private partnerships;
7. Pursue every opportunity to maximize available revenue sources, including but not limited to Federal grants and maximization and capture of Federal Medicaid match dollars, and these new revenue sources will be reinvested in the behavioral health system;
8. Implement a process that expands the above seven strategic vision statements into specific processes, activities and objectives to be accomplished and provide progress and accomplishment measurements to ensure the above strategic vision statements are effectively implemented.

B. Core Values and Guiding Principles

Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path toward those goals.

Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey

and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect: Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage.

Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation (U.S. Department of Health and Human Services, 2005).

C. **Recommendations**

It is NOT assumed that new money will be available to implement the recommendations in this document. These recommendations assume that in the strategic planning process priorities will be set and an opportunity will exist for discussion on how existing funds may potentially be used differently.

The Commission recommends the following:

1. The Behavioral Health Division will seek out people with objectivity and expertise in strategic planning who are familiar with behavioral health transformation activities elsewhere to facilitate the planning process and can lead stakeholders (including consumers) in a discussion of what we have and what we need. This includes systems of care, gap analysis, innovative developments and the integration of primary and behavioral health care. This also includes fundamental needs such as employment, safe and affordable housing, opportunities for meaningful and personally rewarding activities and being connected to one's community. In addition, these discussions will include the opportunities for improving all aspects of behavioral health care in a way that is consistent with the vision, core values and principles of recovery and recovery-based care. The Commission encourages the Division to explore states outside of Nebraska that may have experience with behavioral health transformations and are "delivering behavioral health care well" as well as groups outside Nebraska that may employ the desired expertise in strategic planning in behavioral health transformation activities.
 - a. The **strategic plan** will:
 - 1) Encompass at least a 5-year timeframe to provide direction, focus, priorities, goals, and action steps to achieve system transformation and reduce the current reliance on a crisis-oriented mode of operation.

- 2) Recognize the Division of Behavioral Health as exercising primary leadership in behavioral health services and as the driver of policy and policy-based financial decisions within the Department of Health and Human Services.
 - 3) Establish expectations regarding collaboration among the DHHS divisions that eliminates cost shifting, reduces fragmentation, increases funding/reimbursement flexibility, and supports access to appropriate and quality care regardless of payer source and eligibility.
 - 4) Identify long-term funding strategies to ensure realistic, sustainable financial support and maximize available federal revenue sources, including the Federal Medicaid match.
 - 5) Include performance measurements, indicators, competencies and report cards that reflect the mission, vision, values, and principles of recovery and recovery-based care and an outcome evaluation and research process that continuously identifies ways to improve services and supports (Plan-Do-Check-Act Cycle), including those that are consumer operated.
- b. The **strategic planning process** will:
- 1) Include a broad group of informed, empowered stakeholders of the behavioral health system at all stages of the process, including decision making. This requires the development of a plan that includes those who use or have used services and in sufficient numbers to be representative of the perspective of consumers. Meaningful inclusion is not limited to those consumers employed in consumer-specific positions in government. That plan of consumer inclusion is reviewed, refined and implemented as a first priority in development of the planning process. It will ensure meaningful education, supports for authentic “seats at the table” in accord with LB994 (2006) consumer “inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation and research”.
 - 2) Include, in a collaborative and inclusive manner, the development of mission, vision, values, principles, and definitions that reflect individual, program/service, and system perspectives and incorporate both regional and state-wide points of view.
 - 3) Consider the accomplishments and challenges experienced in other states that have previously initiated transformation efforts.

- 4) Incorporate available technology (webinars and other web-based resources) in the planning process in order to improve access and expand opportunities for participation, including fostering opportunities for increased computer access for consumers.
- 5) Utilize the Legislative Behavioral Health Oversight Commission's June 2008 Final report as a guiding document in the strategic planning process. Worthy of special consideration is the following excerpt from that report:

“The Commission finds that many of the goals and responsibilities as set out in LB 1083 have not been accomplished. The Department, in its adopted “LB1083 Behavioral Health Implementation Plan” of July 1, 2004 identifies 108 “deliverables” that the plan states “must be completed in order to achieve the reform.” Many of those “deliverables” remain incomplete and/or unaddressed altogether. Those with the highest priority include:

- ◆ Consumer involvement in all aspects of service planning and delivery.
 - ◆ Development of a consumer focused culture that is driven by the needs of consumers.
 - ◆ A plan for integrating the administration of behavioral health programs.
 - ◆ A comprehensive statewide plan for behavioral health services
 - ◆ Development and management of a data and information system.
 - ◆ A quality improvement plan.
 - ◆ Services that are research based, focus on recovery, and include peer support.
 - ◆ A methodology for measuring consumer, process, and system outcomes.
 - ◆ Development of plans for developing the behavioral health work force.
 - ◆ An integrated rate setting methodology.
 - ◆ Development and implementation of peer support services” (NDHHS, 2008).
2. Suspend the service definition revision process currently underway until the adoption of the strategic plan so that the vision, core values, principles, and definitions of recovery and recovery-based care are be incorporated into new and existing service and support definitions.

3. Suspend the Title 206 Rules and Regulations revision process currently underway until the adoption of the strategic plan so that the vision, core values, principles, and definitions of recovery and recovery-based care can be incorporated into new and existing rules and regulations.
4. Suspend the at-risk managed care planning efforts currently underway until the adoption of the strategic plan so that the vision, core values, principles, and definitions of recovery and recovery-based care can be used to guide discussion, examination, analysis, and decision making around the feasibility of a managed care program in the public behavioral health system.

If an at-risk managed care strategy is ultimately pursued, the “Consultation Report and Recommendations on Nebraska Managed Behavioral Healthcare,” dated May 24, 2009, by ZiaPartners, Inc., shall be used as a resource and guide for that development process.

5. The Behavioral Health Division carry out Recommendation #4, approved by the Legislative Behavioral Health Oversight Commission in its June 2008 Final Report, that reads:

“The Commission recommends the formation of a task force comprised of consumers, providers, physicians, regional administrators, a representative of the Regional Centers, and a representative of the Department to study and define the role of the regional centers. Because much of the responsibility for managing regional emergency systems and creating the continuums of care needed to serve persons needing behavioral health services rests with the regions, the task force should be chaired by a regional administrator.” (Note: The original recommendation included a due date of December 2008 for the completion of a report and recommendations) (NDHHS, 2008).

6. The Behavioral Health Division carry out Recommendation #1, approved by the Legislative Behavioral Health Oversight Commission in its June 2008 Final Report, that reads:

“The Commission recommends that the Department fulfill the mandate of the Act which stipulates “consumer involvement in all aspects of service planning and delivery.” To accomplish this, the Department should:

- a. Expand the training opportunities for consumers in developing leadership and advocacy skills.
- b. Provide for peer support positions integrated throughout the continuum of care by including these positions in all services where it is appropriate and including the cost of these positions in the rates paid for the service.
- c. Continue to broaden consumer advocacy & inclusion at all levels of the system.

- d. Provide for consumer inclusion in developing consumer outcomes and system level research (NDHHS, 2008).

2. Behavioral Health Workforce Shortage

The Commission approved the following outline for “Behavioral Health Workforce Shortage”:

There is a behavioral health workforce shortage nationally and in the state of Nebraska. There are an inadequate number of psychiatrists and other mental health and substance abuse professionals to provide necessary services to consumers. Education and training are needed to grow the workforce. Collaborate with private, government and academic partners to investigate ways to cultivate a workforce, funding, and incentives for growing the behavioral health workforce.

Discussion

On December 9, 2008, Dr. Steve Wengel and Dr. Susan Boust, practicing psychiatrists affiliated with the University of Nebraska Medical Center (UNMC), gave a presentation to the Behavioral Health Oversight Commission. The presentation presented an initiative that sought to address the behavioral health workforce shortage and to increase the quality of care across the state. It proposed a Behavioral Health Education Center (Center) and education outreach to sites across the state that would be administered by UNMC. A new philosophy and training model would focus on resilience and recovery-oriented practices, treat co-occurring mental illness and substance abuse issues and focus on evidence-based practices including consumers and their families as well as other stakeholders as participants in developing the curriculum.

A budget of approximately \$1.9 million was referenced during the discussion. During the BHOC meeting, discussion occurred about “silos” of professional training and the desire to more effectively move professionals from an institutional setting to a community-based setting, giving people in rural areas access to a psychiatrist via telehealth opportunities and improved opportunities for delivery of care through a multidisciplinary approach. There was an emphasis on peers as providers and the need to involve consumers in the planning process from the beginning.

The Behavioral Health Oversight Commission voted unanimously on December 9, 2008 to support the initiative as presented by Drs. Wengel & Boust. Also noting the BHOC supports consumer involvement from the beginning of the initiative.

Legislative Action

On January 21, 2009, LB 603, a bill addressing the behavioral health workforce shortage was introduced by the Health & Human Services Committee and referred to the Health & Human Services Committee on January 23, 2009. A hearing was held on February 19, 2009. LB 603, which also included a number of other behavioral health issues, was passed by the legislature

on May 21, 2009 by a 41 (yes) and 2 (no) vote of the Legislature. LB 603 was signed into law by Governor Heineman on May 26, 2009. LB 603 addresses the behavioral health workforce shortage by establishing a Behavioral Health Education Center. The Center will:

1. Provide funding for two additional medical residents in a Nebraska based psychiatry program beginning in 2010 until a total of eight additional psychiatry residents are added in 2013. Each of these residents would participate in rural training for a minimum of one year. Beginning in 2012, a minimum of two of the eight residents would be active in the rural training each year;
2. Focus on training of behavioral health professionals utilizing the telehealth network that is already established throughout Nebraska. This is particularly helpful to rural areas in Nebraska;
3. Establish learning collaborative partnerships with other higher education institutions in the state, hospitals, law enforcement, community-based agencies, consumers and their families in order to develop evidence-based, recovery-focused, interdisciplinary curriculum and training for behavioral health professionals delivering behavioral health services in community-based agencies, hospitals and law enforcement;
4. Beginning in 2011, two interdisciplinary behavioral health training sites would be developed until a total of six sites have been developed. Each of these sites would provide annual interdisciplinary training opportunities for a minimum of three behavioral health professionals.

A total of \$1,385,160 was appropriated from general funds to the University of Nebraska for fiscal year 2009-10 to administer this program.

Recommendation

The BHOC is pleased that LB 603 passed and acknowledges that there is more work required to address the behavioral health workforce shortage, in both rural and urban areas in Nebraska, but this is a great first step.

3. Enhanced Communication and Partnering

The Commission approved the following outline for “**Enhanced Communication and Partnering**”:

Foster, encourage and promote creative ways to develop services and supports that consumers want and need while maximizing existing funding, using open communication and developing trusting relationships. We accomplish this by promoting partnerships and multi-dimensional communication among consumers, the divisions of the Department of Health and Human Services, the Behavioral Health

Regions, Regional Centers, Community-Based Agencies, peer providers, law enforcement and Behavioral Health Division advisory committees.**Discussion**

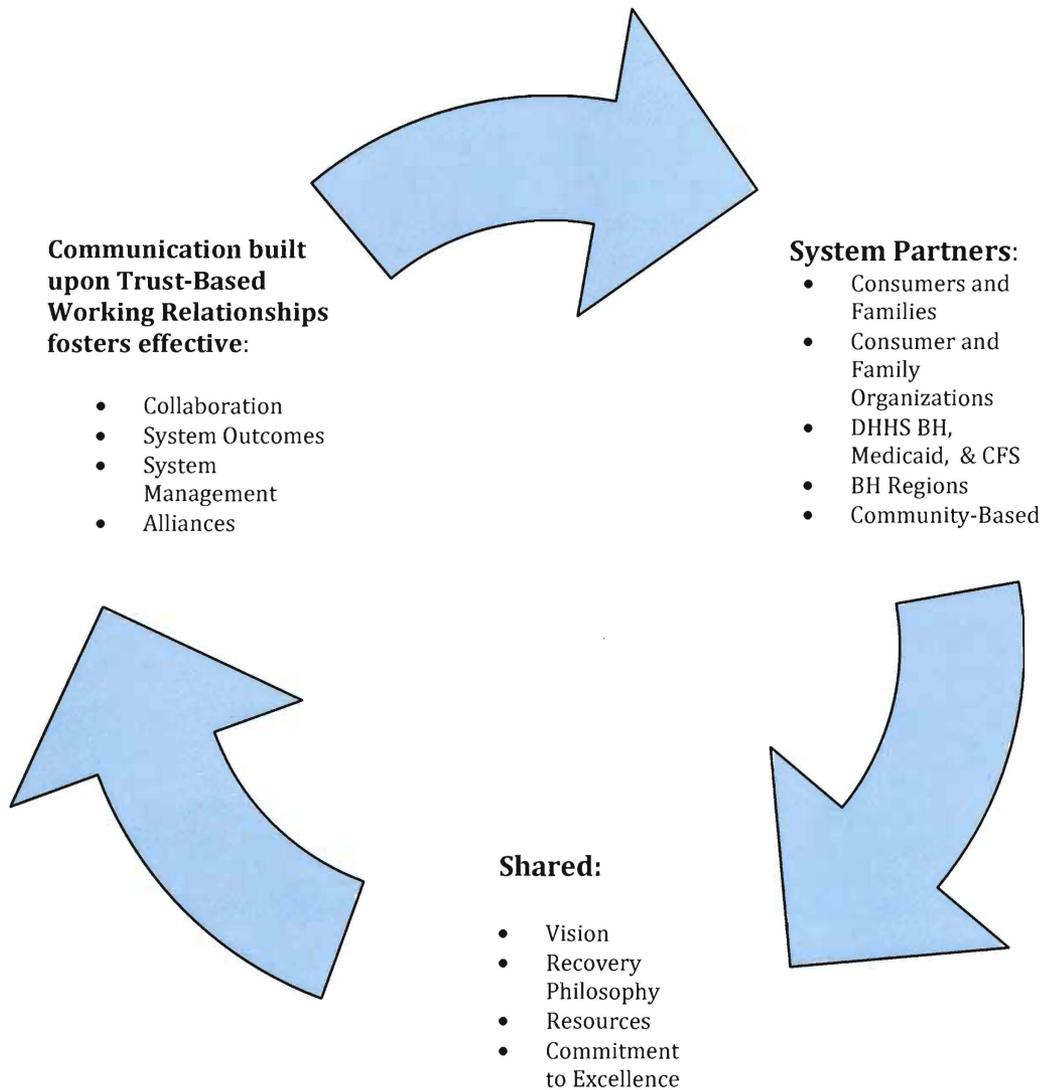
The third point of the Strategic Vision Statement addresses the provision of: *“inclusive and transparent planning through genuine partnership and collaboration with a diverse group of stakeholders (including consumers) to promote a rational, strategic decision-making environment and process.”* We recognize that the success of a transformed, recovery-based system is built upon core values and guiding principles. **Critical to the ongoing success of a transformed system is open, transparent communication built upon trusting relationships between and among all stakeholders. As such, this strategic focus was adopted for emphasis.**

Communication, collaboration and cooperation are keys to system reform and transformation. As change elements are introduced within a system stakeholders at every level must have the opportunity to assist in the design of system components, provide input and direction in the identification of needed services and supports, and participate in the evaluation of the system. Consumers and their families must have credible opportunities to participate in transformation efforts. The system must provide opportunities for leadership development to assure that consumers and their families possess the tools to participate in ways that are meaningful to them. In Connecticut's mental health system transformation they identified that "listening to the suggestions and continuing guidance of those who need or use services is one of the most basic and essential characteristics of a recovery-oriented service system."

The lines of communication must be open between and among all system partners and stakeholders to assure that system strengths, barriers, gaps and needs are freely shared and addressed in a timely manner. There are numerous opportunities for communication to occur within the Nebraska Behavioral Health System. Many times the effectiveness of communication is based in its intent, integrity, and positive regard for desired outcomes.

Recommendation

Open communication and development of trusting relationships is an area requiring more development during the strategic planning process. All communication points are either opportunities or missed opportunities depending on how system stakeholders and partners utilize the communication points. Opportunities are designed to enhance communication and partnerships at strategic intersects of the Nebraska Behavioral Health System. **Opportunities for communication should be evaluated, refined and improved upon in the strategic planning process. Frequency of such communications should be defined during the planning process.**



References

- Nebraska Department of Health and Human Services (2008). *Legislative Bill 928*.
http://dhhs.ne.gov/Behavioral_Health/BHcommission/1-July-24-08/Appendix-3-LB928.pdf
- Nebraska Department of Health and Human Services (2008). *Behavioral Health Oversight Commission July 24, 2008 III. Welcome – Governor Dave Heineman*. Retrieved from
http://dhhs.ne.gov/Behavioral_Health/BHCommission/1-July-24-08/Appendix-2-Gov.pdf
- Nebraska Department of Health and Human Services (2008). *Behavioral Health Oversight Commission Charter and Strategic Focus Adopted: August 11, 2008*. Retrieved from
http://dhhs.ne.gov/Behavioral_Health/BHCommission/2-Aug-11-08/Appendix-2-Rhonda%20Hawks-Final-Charter.pdf
- Nebraska Department of Health and Human Services (2008). *Behavioral Health Oversight Commission Strategic Focus Adopted: August 11, 2008*. Retrieved from
http://dhhs.ne.gov/Behavioral_Health/BHCommission/2-Aug-11-08/Appendix-3-Rhonda-Hawks-Final-Strategic-Focus.pdf
- Nebraska Department of Health and Human Services (2008). *Behavioral Health Oversight Commission Final Report June 2008*. Retrieved from
http://www.hhs.state.ne.us/Behavioral_Health/BHcommission/1-July-24-08/BHOCFinalReport-06-2008.pdf
- United States Department of Health and Human Services (2005). *The 10 Fundamental Components of Recovery*. Retrieved from
<http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>

Additional Resources

Connecticut Department of Mental Health and Addiction Services (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. Retrieved from <http://www.ct.gov/dmhas/LIB/dmhas/publications/practiceguidelines.pdf>

Missouri Department of Mental Health (2008). *Comprehensive Plan for Mental Health Creating Communities of Hope January 2008 – January 2013*. Retrieved from <http://www.dmh.mo.gov/transformation/FINALVERSIONJULY12008.pdf>

National Alliance on Mental Illness (2009). *Grading the States A Report on America's Hhealth Care System for Adults with Serious Mental Illness*. Retrieved from http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459

Pennsylvania Department of Public Welfare Office of Mental Health and Substance Abuse Services (2005). *A Call for Change Toward a Recovery-Oriented Mental Health Service System for Adults*. Retrieved from <http://www.dpw.state.pa.us/Resources/Documents/Pdf/Publications/ACallForChange.pdf>

**Behavioral Health Oversight Commission
Members & Position of Appointment
July 1, 2008 – June 30, 2009**

Rhonda Hawks, Chair
Consumer Advocate

J. Rock Johnson
Consumer

Dr. Brad Bigelow
Provider of Community-Based Behavioral Health Services

Mary Hepburn O'Shea
Provider of Community-Based Behavioral Health Services

Pete Tulipana
Provider of Community-Based Behavioral Health Services

Beth Baxter
Regional Behavioral Health Authority Administrator

Patti Jurjevich
Regional Behavioral Health Authority Administrator

Kathy Seacrest
Regional Behavioral Health Authority Administrator

TyLynne Bauer
Representative of the Norfolk Regional Center

Bill Gibson
Representative of the Lincoln Regional Center

Jim Egley
Representative of the city of Norfolk

Joe Patterson
Representative of the city of Hastings

Regulatory Reform to Reduce Administrative Costs in the Nebraska Behavioral Health System

December, 2010

The Behavioral Health Support Foundation gathered a Consensus Panel to develop a Regulatory Reform Initiative to reduce unnecessary administrative costs throughout the State of Nebraska's behavioral health care system. The focus of the Regulatory Reform Initiative is to ensure that regulatory rules pertaining to the system, as established in administrative rule and statute, are coordinated as much as possible and that duplicative and conflicting rules are modified to reduce cost and improve efficiency. The Regulatory Reform Initiative was developed in response to insights learned from the 2009 Nebraska Behavioral Health System Strategic Planning Initiative. Both Initiatives have been made possible through the funding and support of the Behavioral Health Support Foundation, a charitable foundation established by private sector donors to fund and support behavioral health services in communities throughout the State of Nebraska. A Consensus Panel consisting of consumers, consumer advocates, representatives from Division of Behavioral Health and Division of Medicaid and Long-Term Care, provider organizations, Regional Behavioral Health Authorities, and psychiatrists met regularly from August through November 2010 to review system regulatory requirements and develop recommendations for regulatory reform. (See attached listing of Consensus Panel members.)

As a result of the Consensus Panel's work on this Regulatory Reform Initiative, five reforms have been identified:

1. Deemed status for nationally-accredited programs
2. Cost analysis prior to administrative rule change
3. Licensure for rehabilitation professionals
4. Establishing a transparent process for the allocation of behavioral health services funds to the Medicaid program
5. Removing barriers to e-health

Recommendation #1: Deemed Status for Nationally-Accredited Programs



Behavioral health organizations are subject to multiple layers of administrative rules, regulations, licensure requirements, reviews, and audits. Many of these are duplicative and overlapping. All are costly for the organization as well as each administrative authority charged with enforcement. Behavioral health organizations are required to be nationally accredited and therefore conform to national standards related to health and safety, organizational and business practices, treatment planning and delivery, and all other aspects of program operations.

Deemed status is a practice whereby health organizations already nationally-accredited are deemed to be in compliance with state and local standards. Deemed status is utilized across the country for purposes of eliminating costly redundancies, maximizing scarce government resources, coordinating multiple layers of regulation, increasing efficiency, and reducing cost. It is a practice already recognized and in place in various areas within the Nebraska Department of Health and Human Services, such as Adult Day Services for the elderly and the Special Enhanced Medical Assistance program for Woman and Children. It assures consistency and the current application of national accreditation standards regarding provider organization best practices.

A solution is to administratively adopt or legislatively mandate deemed status for nationally accredited programs (The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, COA) for identified Nebraska Health and Human Services licenses, rules, regulations, and service definitions applicable to all behavioral health programs, program plans, service expectations, staffing, and staffing ratios. This is a practice that contributes to maximizing the use of public and private sector dollars for direct client care.

Recommendation #2: Cost Analysis Prior to Administrative Rule Change

Currently, there is no public cost benefit analysis when new rules, regulations, service definitions, contractual, or other requirements are proposed by the Nebraska Department of Health and Human Services. Without such analysis, behavioral health providers and taxpayers alike are subject to unfunded mandates and unanticipated costs, and public policy makers have no means of determining whether such costs are justified by the benefits to the public good.



The Nebraska Legislature requires a fiscal impact statement on all proposed legislation, which is available to the public throughout the public hearing, debate, and voting process. There is no equivalent requirement for the Nebraska Department of Health and Human Services which establishes and implements rules, regulations, operational processes, and contractual requirements on a daily basis, all with significant financial impact to stakeholders.

The Division of Medicaid and Long-Term Care and the Division of Behavioral Health have both recently proposed substantial rule, regulation, and service definition changes, which are currently at varying stages of the rule-making process. Any number of these changes as written are highly prescriptive and will result in significant rule expansion and resultant costs to provider organizations and businesses if adopted. Yet, there has been no formal cost/benefit analysis of these proposed rule changes.

A solution is to adopt statutory language requiring a cost analysis and enumeration of anticipated benefits to provider organizations and businesses resulting from proposed administrative rule, regulation, service definition, or contractual changes and requirements imposed by divisions of the Nebraska Department of Health and Human Services. Upon completion of a cost benefit analysis, the State would be required to disclose the results to affected businesses and the public at large in a reasonable time prior to any public hearing.

Recommendation #3: Licensure for Rehabilitation Professionals

Rehabilitation professionals should be allowed to sign off on medical rehabilitation services as this is consistent with their training and scope of practice to improve quality of care and reduce related costs. Federal Medicaid rules require a licensed professional to sign off on treatment plans. There currently is no license category in State statute for Master's trained rehabilitation professionals. As a result, services provided by Masters trained rehabilitation professionals must have a licensed mental health professional sign off on treatment plans, creating a costly duplication of functions without an identifiable improvement in quality of care.



A solution is to create a licensure status for master level trained behavioral health rehabilitation professionals in Nebraska that meets the federal requirements. The State of Iowa has a rehabilitation program at Drake University in Des Moines, Iowa which has demonstrated excellent education for behavioral health rehabilitation professionals which may be used as a model here in Nebraska. A work group of behavioral health, rehabilitation and State Medicaid stakeholders should be established and convened to draft licensure criteria and quantify the advantages and disadvantages of creating a new rehabilitation professional category, resulting in proposed legislation.

Recommendation #4: Establish a Transparent Process for the Allocation of Behavioral Health Services Funds to the Medicaid Program



Within the Division of Behavioral Health, a transparent and separate budgeting process needs to be established for the allocation of Division of Behavioral Health services (Program 38) funds to be used as matching funds for the Medicaid program (Program 348).

There are no limitations on the total amount of Medicaid matching funds being taken from Program 38 (Division of Behavioral Health), as shown in the table below.

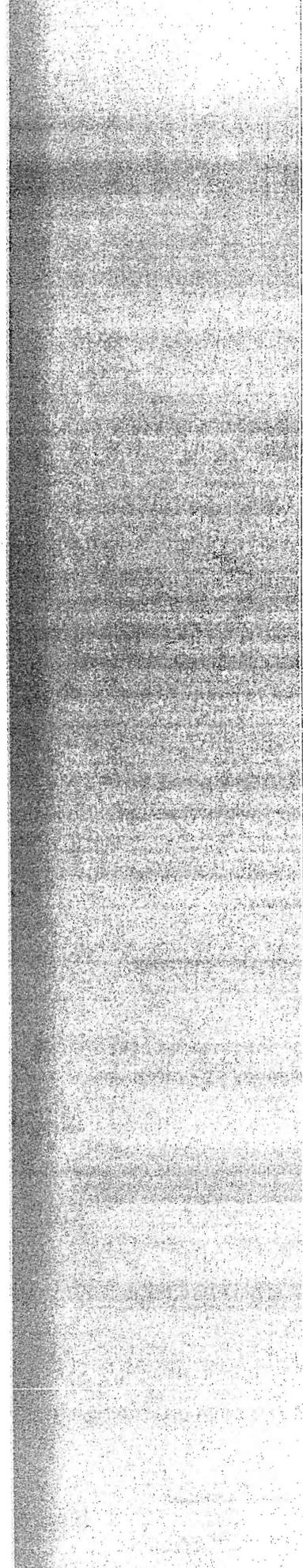
1. There is no limitation on what Medicaid Matching funds from Program 38 can be used for, including service types or providers.
2. The current system does not ensure fiscal responsibility and accountability in either the Medicaid or Behavioral Health appropriations. For example, Medicaid claimed to save several million dollars in Program 348 (Medicaid). Medicaid accomplished this in part, by using \$8 million from Program 38 in FY 09. This is not a clear and transparent method of accounting and reporting.
3. Statutory language allowing the use of Program 38 funds as Medicaid match was repealed with LB 1083, yet the use of funds has expanded. See table below.
4. Approval of Program 38 funds as Medicaid match is occurring without Regional and county approval of appropriations to community-based services.
5. The result of this practice, if not changed, is reduced funding provided through Program 38.

For the period from state FY95 through state FY09, the actual cost to the Division of Behavioral Health for Medicaid services increased from \$1.0 million to approximately \$8.3 million or 728%. See table below:

	FY 95	FY 99	FY 05	FY 07	FY 08	FY 09
Actual cost to Program 38 for Medicaid services	\$1,000,000	\$ 2,000,000	\$2,530,938	\$2,635,145	\$8,385,069	\$8,278,615

Proposed solutions include:

1. Adopt statutory language that does not permit the use of Division of Behavioral Health appropriations as Medicaid match.

- 
2. State accounting practices should clearly be able to identify program expenditures by program and report through a transparent process.
 3. All quarterly financial reports for Programs 38 and 348 should be provided to Regions, provider organizations, consumers, the Division of Behavioral Health, stakeholders, and the Legislature for review and comment. These reports shall clearly identify expenditures by service, number of persons served, and similar statistical categories.
 4. Any unexpended revenues from identified match funds should be retained by the Division of Behavioral Health and the Regional Behavioral Health Authorities to maximize utilization of funds.

Recommendation #5: Removing Barriers to E-Health

There are issues with consumer access to behavioral health services within the State of Nebraska, especially in rural and frontier areas. The increased utilization of e-health would greatly improve consumer access to behavioral health services, but current regulations and policies limit this provision of service. Behavioral health service providers that are not part of a hospital or a Federally Qualified Health Center are experiencing barriers to providing e-health behavioral health services. Some private insurance companies do not cover e-health services.



A solution is to convene a study group of interested behavioral health care providers, Nebraska Health and Human Service staff, and electronic health service industry professionals to identify barriers to the cost effective use of e-health service delivery. The study group can then make recommendations to appropriate state legislative and regulatory bodies, to establish specific rule changes to eliminate barriers and create a plan for the delivery of new e-health services. This process will need to include an overview of current e-health service regulations and policies at the state and federal level including private insurance coverage.

E-health services can greatly reduce the cost of delivery of necessary health care to all citizens using behavioral health services, thus, allowing these savings to be utilized in other areas across the continuum of care.

The Regulatory Reform Initiative to Reduce Administrative Costs was funded by the Behavioral Health Support Foundation. The Behavioral Health Support Foundation is a charitable foundation established by private sector donors to fund behavioral health services in the community. For information, contact: Rhonda Hawks, BHSF Vice President, at 402-691-9518 or rhawks@tenaska.com

The Nebraska Adult Behavioral Health System Consensus Panel was facilitated by *OPEN MINDS*. Founded in 1987, *OPEN MINDS* provides market research and management consulting specializing in the mental health, addictions, social services, disability support, and related public health sectors of the health and human services field. *The OPEN MINDS* mission is to provide payers and provider organizations serving consumers with complex health and human service needs with the market and management knowledge needed to improve their organizational efficiency and effectiveness. For further information, contact Monica E. Oss, Chief Executive Officer at 717-334-1329 or monicaoss@openminds.com

The Nebraska Adult Behavioral Health System Consensus Panel was created in January 2010 to develop strategies for improvement of the Nebraska behavioral health system, analyze the role of the public behavioral health stakeholders, and establish specific initiatives for system improvements. The Consensus Panel is comprised of 25 stakeholders representing a variety of organizations and community interests including consumers and families, consumer advocates, Division of Behavioral Health, Division of Medicaid and Long-Term Care, provider organizations, Regional Behavioral Health Authorities, and psychiatrists. The membership of the Nebraska Adult Mental Health System Consensus Panel Membership is listed on the following page.

Nebraska Adult Mental Health System Consensus Panel Membership

Name	Title	Organization
Mary Barry-Magsamen	Executive Director	St. Monica's Behavioral Health Services
Connie Barnes	Executive Director	Behavioral Health Specialist, Inc. - Norfolk
Beth Baxter	Regional Program Administrator	Region 3 Behavioral Health Authority
Susan J. Boust, M.D.	Medical Director	The Behavioral Health Education Center of Nebraska
Carole Boye	Chief Executive Officer	Community Alliance
Dr. Linda Burkle	Director of Divisional Social Services	The Salvation Army - Western Division
Roxie Cillessen	Division of Medicaid and Long-Term Care	Technical Advisor
Pat Connell	Vice President	Boys Town National Research Hospital
Sheri Dawson	Division of Behavioral Health Services	Technical Advisor
Jonah Deppe	Executive Director	NAMI Nebraska
Scott Dugan	President & Chief Executive Officer	Mid-Plains Center for Behavioral Healthcare Services, Inc.
Shannon Engler	Director of Mental Health Services	Bryan LGH Medical Center
Aimee Folker	Community Stakeholder	Consumer
Ingrid Gansebom	Regional Administrator	Behavioral Health Authority, Region 4
Rhonda Hawks	Principal	Behavioral Health Support Foundation
CJ Johnson	Regional Administrator	Behavioral Health Authority, Region 5
Jessica Jones	Behavioral Health Clinical Director	The Salvation Army - Omaha Social Services
Patti Jurjevich	Regional Administrator	Behavioral Health Authority, Region 6
Sheree Keely	Vice President of Behavioral Health Services	Alegent Health - Omaha
Vicki Maca	Division of Behavioral Health Services	Technical Advisor
Dr. Donna Polk-Primm	Executive Director	Nebraska Urban Indian Health Coalition, Inc.
Amy Richardson	Vice President of Program	Lutheran Family Services of Nebraska
Nancy Rippen	Community Stakeholder	Consumer
Jean Sassatelli	Senior Director of Behavioral Health	Catholic Charities of Omaha
Kathy Seacrest	Regional Administrator	Behavioral Health Authority, Region 2
Dean Settle	Executive Director	Lancaster Community Mental Health Center
Rebecca Valdez	Executive Director	Latino Center of the Midlands

Specifications & Procedures to Measure System Performance & Access to Care

**Designed by The Nebraska Adult
Behavioral Health System Consensus
Panel**

**Prepared For
Behavioral Health Support Foundation**

Prepared By



163 York Street
Gettysburg, Pennsylvania 17325-1933
717-334-1329
<http://www.openminds.com>

December 8, 2010

Table of Contents

I. Introduction.....	3
II. Outcomes: Performance Measurement Domain One.....	6
III. Consumer Perception of Service & Recovery: Performance Measurement Domain Two	12
IV. Consumer Continuity of Care & Access to Care: Performance Measurement Domain Three.....	17
V. Cost Effectiveness & Efficient Use of System Resources: Performance Measurement Domain Four.....	27
VI. Appendix: Consensus Panel Membership List	41

I. Introduction

OPEN MINDS is pleased to present the Behavioral Health Support Foundation with the results of the work performed by the Consensus Panel in this Specifications and Procedures to Measure System Performance and Access to Care Report. (A listing of Consensus Panel members is attached.) The goals of the Consensus Panel convened by the Behavioral Health Support Foundation for the Enhanced Performance Measurement Initiative are to:

- Understand the performance of the system – in total and by component
- Provide information needed to make system budgeting decisions
- Identify areas for system improvement
- Identify best practices with good outcomes for future system investment
- Improve the return on investment of public dollars by improving the performance of the system for consumers

The Consensus Panel met in a series of collaborative meetings from August through November 2010 to identify and prioritize recommended performance measures for the adult behavioral health system. The intent of the Consensus Panel was to first create an initial measurement system platform that could lead to the future creation of a performance measurement scorecard to serve all age groups. The Consensus Panel recognizes that the child and adolescent behavioral health system can equally benefit from a performance score card. As such, the adult performance measures can easily be adapted for children and adolescents at any time in the future.

The development of the recommended performance measurement system was based on:

1. Determining the availability of dependable data to make decisions within and about the behavioral health system
2. Assessment of performance measurement in other state systems
3. Assessment of the performance measurement and related data collection across the Nebraska behavioral health system, including:
 - Division of Behavioral health
 - Division of Medicaid and Long Term Care

- Magellan Behavioral Health¹
 - Regional Behavioral Health Authorities
 - Provider organizations
4. Understanding the current use of standard performance measurement instruments in the system

The Consensus Panel recommended the following system performance measures by domain and for inclusion in the Nebraska behavioral health system dashboard:

Domain One -- Consumer Outcomes:

1. Profile of adult clients by employment status
2. Profile of adult consumers living in a private residence at time of admission (stability in housing)
3. Consumers arrested and booked by local law enforcement

Domain Two -- Consumer Perception of Service and Recovery:

1. Consumer outcomes

Domain Three -- Consumer Continuity of Care & Access to Care:

1. Number of adults served by the Nebraska Behavioral Health System
2. Access/penetration rate to behavioral health services by rural populations
3. Percent of discharges, where treatment team recommended community services are available, when patient is discharge ready
4. System service utilization

Domain Four -- Cost Effectiveness & Efficient Use of System

1. Per user expenditures for behavioral health services
2. Ratio of administrative cost to service cost and administrative cost versus service spending
3. Consumer admissions into inpatient behavioral health services in a year

¹ Magellan Health Services is the current ASO. However a different ASO may be contracted in the future.

4. Consumers using outpatient behavioral health services in a year
5. Consumer average length of stay
6. Decreased rate of readmissions to state psychiatric hospitals within 30-days
7. 180 day readmission rate/community tenure

Note that the domain of “clinical outcomes” was omitted from this report. The Consensus Panel invested considerable time and discussion on this domain and determined that additional work would be needed to identify an operational definition and measurable performance outcomes for this domain. A clinical outcomes domain will be evaluated for inclusion in the performance dashboard at a later time.

Following are the specifications and procedures for each performance measure by domain.

II. Consumer Outcomes: Performance Measurement Domain One

Consumer Outcomes - 1-1. Profile of Adult Clients by Employment Status	
Purpose	<p>To create a profile of adult clients by employment status at the time of admission to services:</p> <ul style="list-style-type: none"> • By service type • By region • Statewide • By diagnostic group (mental health, substance abuse, co-occurring disorder) <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
Required Submission Type	Excel spreadsheet
Comments/ Recommendations	<p>This is a quarterly and annual report. Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Magellan Behavioral Health • NBHS NOMS Report • Division of Behavioral Health • Division of Medicaid and Long Term care <p>Unless specifically indicated otherwise, the following definitions apply:</p> <p>Services: Inpatient, residential, outpatient, community rehabilitative, and supportive services</p> <p>Employment: Known employment status includes: employed and unemployed</p>
Target Nebraska Benchmark for this Measure	NOMS 2009 state data
Target National Benchmark for this Measure	NOMS 2009 national data

Data Elements - 1-1. Profile of Adult Clients by Employment Status

Qualifications/ Definitions	The percentage of adult consumers employed at the time of admission: <ul style="list-style-type: none"> • By service type
Formula	The number of adults consumers employed by service type, per quarter, at the time of admission, divided by the total number of adult consumers at the time of admission, by service type, per quarter, expressed as a percentage
Qualifications/ Definitions	The percentage of adult consumers employed at the time of admission: <ul style="list-style-type: none"> • By region
Formula	The number of adult consumers employed by region, per quarter, at the time of admission, divided by the total number of adult consumers at the time of admission by region, per quarter, expressed as a percentage
Qualifications/ Definitions	The percentage of adult consumers employed at the time of admission: <ul style="list-style-type: none"> • Statewide
Formula	The number of adult consumers employed statewide, per quarter, at the time of admission, divided by the total number of adult consumers at the time of admission, statewide, per quarter, expressed as a percentage
Qualifications/ Definitions	The percentage of adult consumers employed at the time of admission: <ul style="list-style-type: none"> • By diagnostic group
Formula	The number of adult consumers employed by diagnostic group, per quarter, at the time of admission, divided by the total number of adult consumers at the time of admission, by diagnostic group, per quarter, expressed as a percentage

Consumer Outcomes - 1-2: Profile of Adult Consumers Living in Private Residence at Time of Admission (Stability in Housing)

<p>Purpose</p>	<p>To create a profile of adult clients living in a private residence at time of admission:</p> <ul style="list-style-type: none"> • By service type • By region • Statewide • By diagnostic group (mental health, substance abuse, co-occurring disorder) <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
<p>Required Submission Type</p>	<p>Excel spreadsheet</p>
<p>Comments/ Recommendations</p>	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Magellan Behavioral Health • NBHS NOMS Report • Division of Behavioral Health • Division of Medicaid and Long Term Care <p>Unless specifically indicated otherwise, the following definition applies:</p> <p>Stable Housing: Adult mental health consumers living in private residence</p> <p>Services: Inpatient, residential, outpatient, community rehabilitative, and supportive services</p> <p>Note: Also includes Jail/Correctional Facility and Homeless or Shelter status.</p>
<p>Target Nebraska Benchmark for this Measure</p>	<p>NOMS 2009 state data for Profile of Client’s Change in Living Situation (including homeless status) Measure</p>
<p>Target National Benchmark for this Measure</p>	<p>NOMS 2009 national data for Profile of Client’s Change in Living Situation (including homeless status) Measure</p>

**Data Elements - 1-2: Profile of Adult Consumers Living in Private Residence at Time of Admission
(Stability in Housing)**

Qualifications/ Definitions	The percentage of adult clients living in a private residence at time of admission: <ul style="list-style-type: none"> • By service type
Formula	The number of adult clients who were living in a private residence by service type, per quarter, at the time of admission divided by the total number of adult clients at the time of admission, by service type, per quarter, expressed as a percentage
Qualifications/ Definitions	The percentage of adult clients living in a private residence at time of admission: <ul style="list-style-type: none"> • By region
Formula	The number of adult clients who were living in a private residence by region, per quarter, at the time of admission divided by the total number of adult clients at the time of admission, by region, per quarter, expressed as a percentage
Qualifications/ Definitions	The percentage of adult clients living in a private residence at time of admission: <ul style="list-style-type: none"> • Statewide
Formula	The number of adult clients who were living in a private residence statewide, per quarter, at the time of admission divided by the total number of adult clients at the time of admission, statewide, per quarter, expressed as a percentage
Qualifications/ Definitions	The percentage of adult clients living in a private residence at time of admission: <ul style="list-style-type: none"> • By diagnostic group
Formula	The number of adult clients who were living in a private residence by diagnostic group, per quarter, at the time of admission divided by the total number of adult clients at the time of admission, by diagnostic group, per quarter, expressed as a percentage

Consumer Outcomes - 1-3: Consumers Arrested and Booked by Local Law Enforcement

Purpose	<p>To assess the total number of mentally ill consumers who have been arrested and booked by local law enforcement and percentage by total population:</p> <ul style="list-style-type: none"> • Statewide • By diagnostic group (mental health and substance abuse)
Required Submission Type	<p>Excel spreadsheet</p>
Comments/ Recommendations	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following source:</p> <ul style="list-style-type: none"> • Division of Behavioral Health - Criminal justice data base, crossed with the Magellan data base for community behavioral health
Target Nebraska Benchmark for this Measure	<p>Collect data for one year both statewide and regionally and establish benchmark measure.</p>
Target National Benchmark for this Measure	<p>Not applicable</p>

Data Elements - 1-3: Consumers Arrested and Booked by Local Law Enforcement

Qualifications/ Definitions	To assess the number of mentally ill consumers who have been arrested and booked by a local law enforcement agency into local jail: <ul style="list-style-type: none"> • Statewide
Formula	The sum of mentally ill consumers who have been arrested and booked by local law enforcement agency into local jail statewide
Qualifications/ Definitions	To assess the number of mentally ill consumers who have been arrested and booked by a local law enforcement agency into local jail: <ul style="list-style-type: none"> • By diagnostic group
Formula	The sum of mentally ill consumers who have been arrested and booked by local law enforcement agency into local jail by diagnostic group
Qualifications/ Definitions	To assess the total percentage of mentally ill consumers who have been arrested and booked by local law enforcement agency into local jail <ul style="list-style-type: none"> • Statewide
Formula	The percentage of mentally ill consumers who have been arrested and booked by local law enforcement agency into local jail statewide, divided by the total population of adults arrested/booked
Qualifications/ Definitions	To assess the total percentage of mentally ill consumers who have been arrested and booked by local law enforcement agency into jail <ul style="list-style-type: none"> • By diagnostic group
Formula	The percentage of mentally ill consumers who have been arrested and booked by local law enforcement agency into local jail by diagnostic group, divided by the total population of adults arrested/booked

III. Consumer Perception of Service & Recovery: Performance Measurement Domain Two

Consumer Perception of Service & Recovery - 2-1: Consumer Outcomes	
Purpose	<p>To assess the number and percentage of adult consumers responding positively to the Outcome Section questions on the Annual Nebraska Consumer and Family Survey. Survey questions listed below:</p> <p>As a result of services I received:</p> <ol style="list-style-type: none"> 1. I deal more effectively with daily problems 2. I am better able to control my life 3. I am better able to deal with crisis 4. I am getting along better with my family 5. I do better in social situations 6. I do better in school and/or work 7. My housing situation has improved 8. My symptoms are not bothering me as much <p>Responding positively to the Outcome Sections Questions is defined as a consumer's average score for the above questions being at least agree (4), from the following responses: strongly agree (5), agree(4), neutral (3), disagree (2) and strongly disagree (1)</p> <ul style="list-style-type: none"> • By Region <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
Required Submission Type	Excel spreadsheet
BOTH Comments/ Recommendations	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following source:</p> <ul style="list-style-type: none"> • Division of Behavioral Health / Nebraska Annual Consumer and Family Survey
Target Nebraska Benchmark for this Measure	Collect data for one year by region and establish benchmark measure
Target National Benchmark for this Measure	Not applicable

Data Elements - 2-1: Consumer Outcomes

Qualifications/ Definitions	<p>To assess the number of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey:</p> <ul style="list-style-type: none"> • I deal more effectively with daily problems
Formula	Total number of consumers who responded positively (strongly agree or agree) to this question, by region
Qualifications/ Definitions	<p>Percentage of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey:</p> <ul style="list-style-type: none"> • I deal more effectively with daily problems
Formula	The number of consumers who responded positively (strongly agree or agree) to the this question divided by the total number of consumers who answered this question, by region, expressed as a percentage
Qualifications/ Definitions	<p>To assess the number of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey:</p> <ul style="list-style-type: none"> • I am better able to control my life
Formula	Total number of consumers who responded positively (strongly agree or agree) to this question, by region
Qualifications/ Definitions	<p>Percentage of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey:</p> <ul style="list-style-type: none"> • I am better able to control my life
Formula	The number of consumers who responded positively (strongly agree or agree) to the this question divided by the total number of consumers who answered this question, by region, expressed as a percentage
Qualifications/ Definitions	<p>To assess the number of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey:</p> <ul style="list-style-type: none"> • I am better able to deal with crisis

Formula	Total number of consumers who responded positively (strongly agree or agree) to this question, by region
Qualifications/ Definitions	Percentage of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey: <ul style="list-style-type: none"> • I am better able to deal with crisis
Formula	The number of consumers who responded positively (strongly agree or agree) to the this question divided by the total number of consumers who answered this question, by region, expressed as a percentage
Qualifications/ Definitions	To assess the number of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey: <ul style="list-style-type: none"> • I am getting along better with my family
Formula	Total number of consumers who responded positively (strongly agree or agree) to this question, by region
Qualifications/ Definitions	Percentage of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey: <ul style="list-style-type: none"> • I am getting along better with my family
Formula	The number of consumers who responded positively (strongly agree or agree) to the this question divided by the total number of consumers who answered this question, by region, expressed as a percentage
Qualifications/ Definitions	To assess the number of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey: <ul style="list-style-type: none"> • I do better in social situations
Formula	Total number of consumers who responded positively (strongly agree or agree) to this question, by region
Qualifications/ Definitions	Percentage of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey: <ul style="list-style-type: none"> • I do better in social situations

Formula	The number of consumers who responded positively (strongly agree or agree) to the this question divided by the total number of consumers who answered this question, by region, expressed as a percentage
Qualifications/ Definitions	To assess the number of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey: <ul style="list-style-type: none"> • I do better in school and/or work
Formula	Total number of consumers who responded positively (strongly agree or agree) to this question, by region
Qualifications/ Definitions	Percentage of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey: <ul style="list-style-type: none"> • I do better in school and/or work
Formula	The number of consumers who responded positively (strongly agree or agree) to the this question divided by the total number of consumers who answered this question, by region, expressed as a percentage
Qualifications/ Definitions	To assess the number of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey: <ul style="list-style-type: none"> • My housing situation has improved
Formula	Total number of consumers who responded positively (strongly agree or agree) to this question, by region
Qualifications/ Definitions	Percentage of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey: <ul style="list-style-type: none"> • My housing situation has improved
Formula	The number of consumers who responded positively (strongly agree or agree) to the this question divided by the total number of consumers who answered this question, by region, expressed as a percentage
Qualifications/ Definitions	To assess the number of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey: <ul style="list-style-type: none"> • My symptoms are not bothering me as much

Formula	Total number of consumers who responded positively (strongly agree or agree) to this question, by region
Qualifications/ Definitions	<p>Percentage of adult consumers responding positively to the following question from the Outcome Section of the Annual Nebraska Consumer and Family Survey:</p> <ul style="list-style-type: none"> • My symptoms are not bothering me as much
Formula	The number of consumers who responded positively (strongly agree or agree) to the this question divided by the total number of consumers who answered this question, by region, expressed as a percentage

IV. Consumer Continuity of Care & Access to Care: Performance Measurement Domain Three

Consumer Continuity of Care & Access to Care - 3-1: Number and Percentage of Adults Served by the Nebraska Behavioral Health System	
Purpose	<p>The total number and percentage of adults served in the Nebraska public behavioral health system:</p> <ul style="list-style-type: none"> • By region • Statewide • By service • Diagnostic group (mental health, substance abuse, co-occurring disorder) <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
Required Submission Type	Excel spreadsheet
Comments/ Recommendations	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Magellan Behavioral Health • NBHS NOMS Report • Division of Behavioral Health • Division of Medicaid and Long Term Care <p>Unless specifically indicated otherwise, the following definition applies: Services: Inpatient, residential, outpatient, community rehabilitative, and supportive services</p>
Target Nebraska Benchmark for this Measure	NOMS 2009 state data
Target National Benchmark for this Measure	NOMS 2009 national data

Data Elements - 3-1: Number & Percentage of Adults Served by the Nebraska Behavioral Health System

Qualifications /Definitions	The total number of adults served in the Nebraska public behavioral health system: <ul style="list-style-type: none"> • By region
Formula	Total number of adults served in the Nebraska public behavioral health system by region, per quarter
Qualifications/ Definitions	The percentage of adults served in the Nebraska public behavioral health system: <ul style="list-style-type: none"> • By region
Formula	The number of adults served in the Nebraska public behavioral health system by region, per quarter, divided by the total number of adults living in the region, per quarter, expressed as a percentage
Qualifications/ Definitions	The total number of adults served in the Nebraska public behavioral health system: <ul style="list-style-type: none"> • Statewide
Formula	Total number of adults served in the Nebraska public behavioral health system statewide, per quarter
Qualifications/ Definitions	The percentage of adults served in the Nebraska public behavioral health system: <ul style="list-style-type: none"> • Statewide
Formula	The number of adults served in the Nebraska public behavioral health system statewide, per quarter, divided by to the total number of adults living in the state, per quarter, expressed as a percentage
Qualifications/ Definitions	The total number of adults served in the Nebraska public behavioral health system: <ul style="list-style-type: none"> • By service

Formula	Total number of adults served in the Nebraska public behavioral health system by service, per quarter
Qualifications/ Definitions	The percentage of adults served in the Nebraska public behavioral health system: <ul style="list-style-type: none"> • By service
Formula	The number of adults served in the Nebraska public behavioral health system by service, per quarter divided by the total number of adults served, per quarter
Qualifications/ Definitions	The total number of adults served in the Nebraska public behavioral health system: <ul style="list-style-type: none"> • By diagnostic group
Formula	Total number of adults served in the Nebraska public behavioral health system by diagnostic group, per quarter
Qualifications/ Definitions	The percentage of adults served in the Nebraska public behavioral health system: <ul style="list-style-type: none"> • By diagnostic group
Formula	The number of adults served in the Nebraska public behavioral health system by diagnostic group, per quarter divided by the total number of adults served, per quarter

Consumer Continuity of Care & Access to Care - 3-2: Access/Penetration Rate to Behavioral Health Services by Rural/Frontier Populations

<p>Purpose</p>	<p>The number and percentage of adults living in rural/frontier areas receiving behavioral health services:</p> <ul style="list-style-type: none"> • By region • Statewide • By service • By diagnostic group (mental health, substance abuse, co-occurring disorder) <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
<p>Required Submission Type</p>	<p>Excel spreadsheet</p>
<p>Comments/ Recommendations</p>	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Magellan Behavioral Health • NBHS NOMS Report • Division of Behavioral Health • Division of Medicaid and Long Term Care <p>Unless specifically indicated otherwise, the following definition applies: Services: Inpatient, residential, outpatient, community rehabilitative, and supportive services</p>
<p>Target Nebraska Benchmark for this Measure</p>	<p>NOMS 2009 state data</p>
<p>Target National Benchmark for this Measure</p>	<p>NOMS 2009 national data</p>

Data Elements - 3-2: Access/Penetration Rate to Behavioral Health Services by Rural/Frontier Populations

Qualifications/ Definitions	The number of adults living in rural/frontier areas receiving behavioral health services <ul style="list-style-type: none"> • By region
Formula	Total number of adults living in rural/frontier areas receiving behavioral health services by region, per quarter
Qualifications/ Definitions	The percentage of adults living in rural/frontier areas receiving behavioral health services: <ul style="list-style-type: none"> • By region
Formula	The number of adults living in rural/frontier areas receiving behavioral health services by region, per quarter divided by the total population of adults living in rural/frontier areas by region, per quarter, expressed as a percentage
Qualifications/ Definitions	The number of adults living in rural/frontier areas receiving behavioral health services: <ul style="list-style-type: none"> • By Statewide
Formula	Total number of adults living in rural/frontier areas receiving behavioral health services statewide, per quarter
Qualifications/ Definitions	The percentage of adults living in rural/frontier areas receiving behavioral health services: <ul style="list-style-type: none"> • By Statewide
Formula	The number of adults living in rural/frontier areas receiving behavioral health services statewide, per quarter divided by the total population of persons living in rural/frontier areas, statewide, per quarter, expressed as a percentage
Qualifications/ Definitions	The number of adults living in rural/frontier areas receiving behavioral health services: <ul style="list-style-type: none"> • By Service

Formula	Total number of adults living in rural/frontier areas receiving behavioral health services by service, per quarter
Qualifications/ Definitions	The percentage of adults living in rural/frontier areas receiving behavioral health services: <ul style="list-style-type: none"> • By Service
Formula	The number of adults living in rural/frontier areas receiving behavioral health services by service, per quarter divided by the total population of persons living in rural/frontier areas, per quarter, expressed as a percentage
Qualifications/ Definitions	The number of adults living in rural/frontier areas receiving behavioral health services: <ul style="list-style-type: none"> • By Diagnostic group
Formula	Total number of adults living in rural/frontier areas receiving behavioral health services by diagnostic group, per quarter
Qualifications/ Definitions	The percentage of adults living in rural/frontier areas receiving behavioral health services: <ul style="list-style-type: none"> • By Diagnostic group
Formula	The number of adults living in rural/frontier areas receiving behavioral health services by diagnostic group, per quarter divided by the total population of persons living in rural/frontier areas, per quarter, expressed as a percentage

Consumer Continuity of Care & Access to Care - 3-3: Percent of Discharges from Hospital, Where Treatment Team Recommended Community Services are Available, When Patient is Discharge Ready

<p>Purpose</p>	<p>To assess the percentage of adult discharges, where treatment team recommended community services are available when patient is:</p> <ul style="list-style-type: none"> • Discharge ready • Approved for payment • Not approved for payment <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
<p>Required Submission Type</p>	<p>Excel spreadsheet</p>
<p>Comments/ Recommendations</p>	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Psychiatric hospitals and psychiatric inpatient units <p>Unless specifically indicated otherwise, the following definition applies:</p> <p>Available: Community based non inpatient program or service has available opening and can receive the client</p> <p>Discharge ready: Client no longer meets acute inpatient criteria</p> <p>Approved for payment: Client funding source has approved payment for specified lower level of care</p> <p>Not approved for payment: Client funding source has not approved payment for specified lower level of care</p>
<p>Target Nebraska Benchmark for this Measure</p>	<p>Collect data for one year both statewide and regionally and establish benchmark measure</p>
<p>Target National Benchmark for this Measure</p>	<p>Not applicable</p>

Data Elements - 3-3 Percent of Discharges from Hospital, Where Treatment Team Recommended Community Services are Available, When Patient is Discharge Ready

Qualifications/ Definitions	The percentage of discharges, where treatment team recommended community services are available when patient is: <ul style="list-style-type: none"> • Discharge ready
Formula	The number of discharges, where treatment team recommended community services are available when patient is discharge ready, per quarter divided by the total number of discharges, per quarter, expressed as a percentage
Qualifications/ Definitions	The percentage of discharges, where treatment team recommended community services are available when patient is: <ul style="list-style-type: none"> • Approved for payment
Formula	The number of discharges, where treatment team recommended community services are available when patient is discharge ready and approved for payment, per quarter divided by the total number of discharges, per quarter, expressed as a percentage
Qualifications/ Definitions	The percentage of discharges, where treatment team recommended community services are available when patient is: <ul style="list-style-type: none"> • Not approved for payment
Formula	The number of discharges, where treatment team recommended community services are available when patient is discharge ready and not approved for payment, per quarter divided by the total number of discharges, per quarter, expressed as a percentage

Consumer Continuity of Care & Access to Care - 3-4: System Service Utilization

Purpose	<p>To assess the Magellan count of services registered, billed and paid</p> <ul style="list-style-type: none"> • By region • Statewide • By service • By diagnostic group (mental health, substance abuse, co-occurring disorder) <p>These profiles will be created for both Medicaid authorized clients and clients registered/authorized by Division of Behavioral Health.</p>
Required Submission Type	Excel spreadsheet
Comments/ Recommendations	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Magellan Behavioral Health • NBHS NOMS Report • Division of Behavioral Health • Division of Medicaid and Long Term Care <p>Services: Inpatient, residential, outpatient, community rehabilitative, and supportive services</p>
Target Nebraska Benchmark for this Measure	Collect data for one year both statewide and regionally and establish benchmark measure
Target National Benchmark for this Measure	Not applicable

Data Elements - 3-4: System Service Utilization

Qualifications/ Definitions	To assess the Magellan count of services registered, billed and paid: <ul style="list-style-type: none"> • By region
Formula	Total number of services registered, billed and paid, by region, per quarter
Qualifications/ Definitions	To assess the Magellan count of services registered, billed and paid: <ul style="list-style-type: none"> • Statewide
Formula	Total number of services registered, billed and paid, statewide, per quarter
Qualifications/ Definitions	To assess the Magellan count of services registered, billed and paid: <ul style="list-style-type: none"> • By service
Formula	Total number of services registered, billed and paid, by service, per quarter
Qualifications/ Definitions	To assess the Magellan count of services registered, billed and paid: <ul style="list-style-type: none"> • By diagnostic group
Formula	Total number of services registered, billed and paid, by diagnostic group, per quarter

**V. Cost Effectiveness & Efficient Use of System Resources:
Performance Measurement Domain Four**

Cost Effectiveness & Efficient Use of System Resources - 4-1: Per User Expenditures for Behavioral Health Services	
Purpose	<p>To assess per user spending for behavioral health services:</p> <ul style="list-style-type: none"> • By state • By region • Diagnostic group (mental health, substance abuse and co-occurring disorders) <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
Required Submission Type	Excel spreadsheet
Comments/ Recommendations	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Magellan Behavioral Health • NBHS NOMS Report • Division of Behavioral Health • Division of Medicaid and Long Term Care
Target Nebraska Benchmark for this Measure	Collect data for one year both statewide and regionally and establish benchmark measure
Target National Benchmark for this Measure	Not applicable

Data Elements - 4-1: Per User Expenditures for Behavioral Health Services

Qualifications/ Definitions	To assess the statewide per user spending for behavioral health services:
Formula	Actual behavioral health state expenditures divided by the number of consumers who receive behavioral health services statewide, per quarter
Qualifications/ Definitions	To assess per user spending for behavioral health services: <ul style="list-style-type: none"> • By region
Formula	Actual behavioral health state expenditures divided by the number of consumers who receive behavioral health services by region, per quarter
Qualifications/ Definitions	To assess per user spending for behavioral health services: <ul style="list-style-type: none"> • By diagnostic group
Formula	Actual behavioral health state expenditures divided by the number of consumers who receive behavioral health services by diagnostic group, per quarter

Cost Effectiveness & Efficient Use of System Resources - 4-2: Ratio of Administrative Cost to Service cost and Administrative Cost Versus Service Spending

Purpose	To assess the ratio of administrative costs to service costs <ul style="list-style-type: none"> • DBH: Administrative costs versus service spending • Regions: Administrative costs versus service spending • Medicaid: Magellan fee versus behavioral health spending
Required Submission Type	Excel spreadsheet
Comments/ Recommendations	This is a quarterly and annual report. Data will be obtained from the following sources: <ul style="list-style-type: none"> • DBH: Administrative costs versus service spending • Regions: Administrative costs versus service spending • Medicaid: Magellan fee versus behavioral health spending
Target Nebraska Benchmark for this Measure	Collect data for one year both statewide and regionally and establish benchmark measure
Target National Benchmark for this Measure	Not applicable

Data Elements - 4-2: Ratio of Administrative Cost to Service cost and Administrative Cost Versus Service Spending

Qualifications/ Definitions	To assess the ratio of administrative costs to service costs <ul style="list-style-type: none"> • DBH: Administrative costs versus service spending
Formula	Total DBH administrative costs divided by overall spending on services, per quarter
Qualifications/ Definitions	To assess the ratio of administrative costs to service spending <ul style="list-style-type: none"> • Regions: Administrative costs versus service spending
Formula	Total administrative costs divided by overall spending on services, per quarter
Qualifications/ Definitions	To assess the ratio of administrative costs to service costs <ul style="list-style-type: none"> • Medicaid: Magellan fee versus behavioral health spending
Formula	Total administrative fees divided by overall spending on behavioral health services, per quarter

Cost Effectiveness & Efficient Use of System Resources - 4-3: Adult Admissions into Inpatient Behavioral Health Services in a Year

<p>Purpose</p>	<p>To assess the number and percentage of adults admitted into inpatient behavioral health services annually:</p> <ul style="list-style-type: none"> • By region • By diagnostic group (mental health, substance abuse, co-occurring disorder) <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
<p>Required Submission Type</p>	<p>Excel spreadsheet</p>
<p>Comments/ Recommendations</p>	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Division of Behavioral Health • Division of Medicaid and Long Term Care • Psychiatric hospitals and inpatient psychiatric units • Lincoln Regional Center (90-beds)
<p>Target Nebraska Benchmark for this Measure</p>	<p>NOMS 2009 data</p>
<p>Target National Benchmark for this Measure</p>	<p>NOMS 2009 data</p>

Data Elements - 4-3: Adult Admissions into Inpatient Behavioral Health Services in a Year

Qualifications/ Definitions	To assess the number of adult admissions into inpatient behavioral health services annually: <ul style="list-style-type: none"> • By region
Formula	Total number of adult admissions to inpatient behavioral health services annually, by region
Qualifications/ Definitions	To assess the percentage of adult admissions to inpatient behavioral health services annually: <ul style="list-style-type: none"> • By region
Formula	The number of adult admissions into inpatient behavioral health services by region, annually divided by the total number of all admissions to behavioral health services, annually, expressed as a percentage
Qualifications/ Definitions	To assess the number of adult admissions into inpatient behavioral health services annually: <ul style="list-style-type: none"> • By diagnostic group
Formula	Total number of adult admissions to inpatient behavioral health services annually by diagnostic group
Qualifications/ Definitions	To assess the percentage of adult admissions to inpatient behavioral health services annually: <ul style="list-style-type: none"> • By diagnostic group
Formula	The number of adult admissions to inpatient behavioral health services by diagnostic group, annually divided by the total number of all admissions to behavioral health services annually, expressed as a percentage

Cost Effectiveness & Efficient Use of System Resources - 4-4: Adult Consumers Using Residential Community Based and Non-Residential Community based Behavioral Health Services in a Year

<p>Purpose</p>	<p>To assess the number and percentage of adult consumers admitted to community based non-residential outpatient and community based behavioral health services:</p> <ul style="list-style-type: none"> • By region • By diagnostic group (mental health, substance abuse, co-occurring disorder) <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
<p>Required Submission Type</p>	<p>Excel spreadsheet</p>
<p>Comments/ Recommendations</p>	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Magellan Behavioral Health • NBHS NOMS Report • Division of Behavioral Health • Division of Medicaid and Long Term Care
<p>Target Nebraska Benchmark for this Measure</p>	<p>Collect data for one year both statewide and regionally and establish benchmark measure</p>
<p>Target National Benchmark for this Measure</p>	<p>Not applicable</p>

Data Elements - 4-4: Adult Consumers Using Residential Community Based and Non-Residential Community based Behavioral Health Services in a Year

Qualifications/ Definitions	To assess the number of adult admissions to non-inpatient/non-residential outpatient and community based behavioral health services: <ul style="list-style-type: none"> • By region
Formula	Total number of adult admissions to non-inpatient/non-residential outpatient and community based behavioral health services by region, per quarter
Qualifications/ Definitions	To assess the percentage of adult admissions to non-inpatient/non-residential outpatient and community based behavioral health services : <ul style="list-style-type: none"> • By region
Formula	The number of adult admissions to non-inpatient/non-residential outpatient and community based behavioral health services by region, per quarter divided by the total number of adult admissions to behavioral health services, per quarter, expressed as a percentage
Qualifications/ Definitions	To assess the number of adult admission to non-inpatient/non-residential outpatient and community based behavioral health services: <ul style="list-style-type: none"> • By diagnostic group
Formula	Total number of adult admissions to non-inpatient/non-residential outpatient and community based behavioral health services by diagnostic group, per quarter
Qualifications/ Definitions	To assess the percentage of adult admissions to non-inpatient/non-residential outpatient and community based behavioral health services : <ul style="list-style-type: none"> • By diagnostic group
Formula	The number of adult admissions to non-inpatient/non-residential outpatient and community based behavioral health services by diagnostic group, per quarter divided by the total number of adult admissions to behavioral health services, per quarter, expressed as a percentage

Cost Effectiveness & Efficient Use of System Resources - 4-5: Consumer Average Length of Stay

Purpose	<p>To assess the average length of stay of consumers in the inpatient, residential, outpatient levels of care:</p> <ul style="list-style-type: none"> • By region • Diagnostic group (mental health, substance abuse, co-occurring disorder) • By service type <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
Required Submission Type	<p>Excel spreadsheet</p>
Comments/ Recommendations	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Magellan Behavioral Health • NBHS NOMS Report • Division of Behavioral Health • Division of Medicaid and Long Term Care • Lincoln Regional Center (90-acute beds) <p>Service type: Inpatient, Outpatient, Residential: secure, intermediate, dual diagnosis, psychiatric residential rehabilitative, short-term, therapeutic and half way house</p>
Target Nebraska Benchmark for this Measure	<p>Collect data for one year both statewide and regionally and establish benchmark measure</p>
Target National Benchmark for this Measure	<p>Not applicable</p>

Data Elements - 4-5: Consumer Average Length of Stay

Qualifications/ Definitions	To assess the average length of stay of consumers in inpatient, outpatient, and residential settings: <ul style="list-style-type: none"> • By region
Formula	Computation of the average length of stay for adult consumers by inpatient, outpatient, residential settings by region, per quarter
Qualifications/ Definitions	To assess the average length of stay of consumers in inpatient, outpatient, and residential settings: <ul style="list-style-type: none"> • By diagnostic group
Formula	Computation of the average length of stay for adult consumers by inpatient, outpatient, and residential settings by diagnostic group, per quarter
Qualifications/ Definitions	To assess the average length of stay of consumers in inpatient, outpatient, and residential settings: <ul style="list-style-type: none"> • By service
Formula	Computation of the average length of stay for adult consumers by inpatient, outpatient, and residential (secure, intermediate, dual diagnosis, psychiatric residential rehabilitative, short-term, therapeutic, half way house) settings by service, per quarter

Cost Effectiveness & Efficient Use of System Resources - 4-6: Decreased Rate of Readmission to Psychiatric Units/Hospitals Within 30 Days

Purpose	<p>To obtain the percentage of individuals readmitted to psychiatric hospital within 30-days of discharge from inpatient psychiatric hospital:</p> <ul style="list-style-type: none"> • By region • By diagnostic group (mental health, substance abuse, co-occurring disorder) <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
Required Submission Type	Excel spreadsheet
Comments/ Recommendations	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Magellan Behavioral Health • NBHS NOMS Report • Division of Behavioral Health • Division of Medicaid and Long Term Care • Lincoln Regional Center (90-acute inpatient beds) • Inpatient psychiatric hospitals (HEDIS)
Nebraska Benchmark	NOMS 2009 state data
National Benchmark	NOMS 2009 national data

Data Elements - 4-6: Decreased Rate of Readmission to Psychiatric Units/Hospitals Within 30 Days

<p>Qualifications/ Definitions</p>	<p>To obtain the percentage of individuals readmitted to the psychiatric hospital within 30-days of discharge from inpatient psychiatric hospital:</p> <ul style="list-style-type: none"> • By region
<p>Formula</p>	<p>The number of individuals readmitted to the psychiatric hospital within 30-days of discharge from inpatient psychiatric hospital by region, per quarter divided by the total number of consumers discharged from psychiatric hospitals, per quarter, expressed as a percentage</p>
<p>Qualifications/ Definitions</p>	<p>To obtain the percentage of individuals readmitted to the psychiatric hospital within 30-days of discharge from inpatient psychiatric hospital:</p> <ul style="list-style-type: none"> • By diagnostic group
<p>Formula</p>	<p>The number of individuals readmitted to the psychiatric hospital within 30-days of discharge from inpatient psychiatric hospital by diagnostic group, per quarter divided by the total number of adults discharged from psychiatric hospitals, per quarter, expressed as a percentage</p>

Cost Effectiveness & Efficient Use of System Resources - 4-7: 180 Day Readmission Rate / Community Tenure

<p>Purpose</p>	<p>To assess the percentage of days consumers are in the community and not in an inpatient setting 180 days after discharge from an inpatient psychiatric hospital:</p> <ul style="list-style-type: none"> • By region • By diagnostic group <p>These profiles will be created for both Medicaid clients and clients funded by the Division of Behavioral Health.</p>
<p>Required Submission Type</p>	<p>Excel spreadsheet</p>
<p>Comments/ Recommendations</p>	<p>This is a quarterly and annual report.</p> <p>Data will be obtained from the following sources:</p> <ul style="list-style-type: none"> • Magellan Behavioral Health • NBHS NOMS Report • Division of Behavioral Health • Division of Medicaid and Long Term Care • Lincoln Regional Center (90-acute beds)
<p>Nebraska Benchmark</p>	<p>NOMS 2009 state data</p>
<p>National Benchmark</p>	<p>NOMS 2009 national data</p>

Data Elements - 4-7: 180 Day Readmission Rate / Community Tenure

Qualifications/ Definitions	<p>To assess the percentage of days consumers are in the community and not in an inpatient setting after discharge from an inpatient psychiatric hospital:</p> <ul style="list-style-type: none"> • By region
Formula	<p>The number of days consumers are in the community and not in an inpatient setting 180 days after discharge from an inpatient psychiatric hospital by region, per quarter, divided by 180, expressed as a percentage</p>
Qualifications/ Definitions	<p>To assess the percentage of days consumers are in the community and not in an inpatient setting after discharge from an inpatient psychiatric hospital:</p> <ul style="list-style-type: none"> • By diagnostic group
Formula	<p>The number of days consumers are in the community and not in an inpatient setting after discharge from an inpatient psychiatric hospital by diagnostic group, per quarter divided by 180, expressed as a percentage</p>

VI. Consensus Panel Membership List

Name	Title	Organization
Mary Barry-Magsamen	Executive Director	St. Monica's Behavioral Health Services
Connie Barnes	Executive Director	Behavioral Health Specialist, Inc. - Norfolk
Beth Baxter	Regional Administrator	Behavioral Health Authority, Region 3
Susan J. Boust, M.D.	Medical Director	The Behavioral Health Education Center of Nebraska
Carole Boye	Chief Executive Officer	Community Alliance
Dr. Linda Burkle	Director of Divisional Social Services	The Salvation Army - Western Division
Roxie Cillessen	Division of Medicaid and Long-Term Care	Technical Advisor
Pat Connell	Vice President	Boys Town National Research Hospital
Sheri Dawson	Division of Behavioral Health Services	Technical Advisor
Jonah Deppe	Executive Director	NAMI Nebraska
Scott Dugan	President & Chief Executive Officer	Mid-Plains Center for Behavioral Healthcare Services, Inc.
Shannon Engler	Director of Mental Health Services	Bryan LGH Medical Center
Aimee Folker	Community Stakeholder	Consumer
Ingrid Ganseborn	Regional Administrator	Behavioral Health Authority, Region 4
Rhonda Hawks	Principal	Behavioral Health Support Foundation
CJ Johnson	Regional Administrator	Behavioral Health Authority, Region 5
Jessica Jones	Behavioral Health Clinical Director	The Salvation Army - Omaha Social Services
Patti Jurjevich	Regional Administrator	Behavioral Health Authority, Region 6
Sheree Keely	Vice President of Behavioral Health Services	Alegent Health - Omaha
Vicki Maca	Division of Behavioral Health Services	Technical Advisor
Donna Polk-Primm	Executive Director	Nebraska Urban Indian Health Coalition, Inc.
Amy Richardson	Vice President of Program	Lutheran Family Services of Nebraska
Nancy Rippen	Community Stakeholder	Consumer
Jean Sassatelli	Senior Director of Behavioral Health	Catholic Charities of Omaha
Kathy Seacrest	Regional Administrator	Behavioral Health Authority, Region 2
Dean Settle	Executive Director	Lancaster Community Mental Health Center
Rebecca Valdez	Executive Director	Latino Center of the Midlands



Committee Report, Vol. 16 , No.3

**Community-based Behavioral Health:
Funds, Efficiency, and Oversight**

Legislative Audit Office

April 2010

Performance Audit Committee

Senator John Harms, Chair
Senator Danielle Conrad, Vice Chair
Speaker Mike Flood
Senator Lavon Heidemann
Senator Arnie Stuthman
Senator Dennis Utter
Senator John Wightman

Legislative Audit Office

Martha Carter, Legislative Auditor
Don Arp, Jr., Analyst
Clarence Mabin, Analyst
Dana McNeil, Analyst
Stephanie Meese, Legal Counsel
Sandy Harman, Committee Clerk

Audit reports are available on the Unicameral's Web site (www.nebraskalegislature.gov)
or can be obtained from Martha Carter, Legislative Auditor, at (402) 471-2221.

LEGISLATIVE AUDIT OFFICE

Nebraska Legislature

State Capitol • Box 94945 • Lincoln, NE 68509-4945 • (402) 471-2221



printed on recycled paper

Committee Report, Vol. 16 , No. 3

**Community-based Behavioral Health: Funds,
Efficiency, and Oversight**

April 2010

Prepared by
Don Arp, Jr.
Clarence Mabin

Table of Contents

I. Committee Recommendations

II. Performance Audit Section Report

III. Fiscal Analyst's Opinion

IV. Background Materials

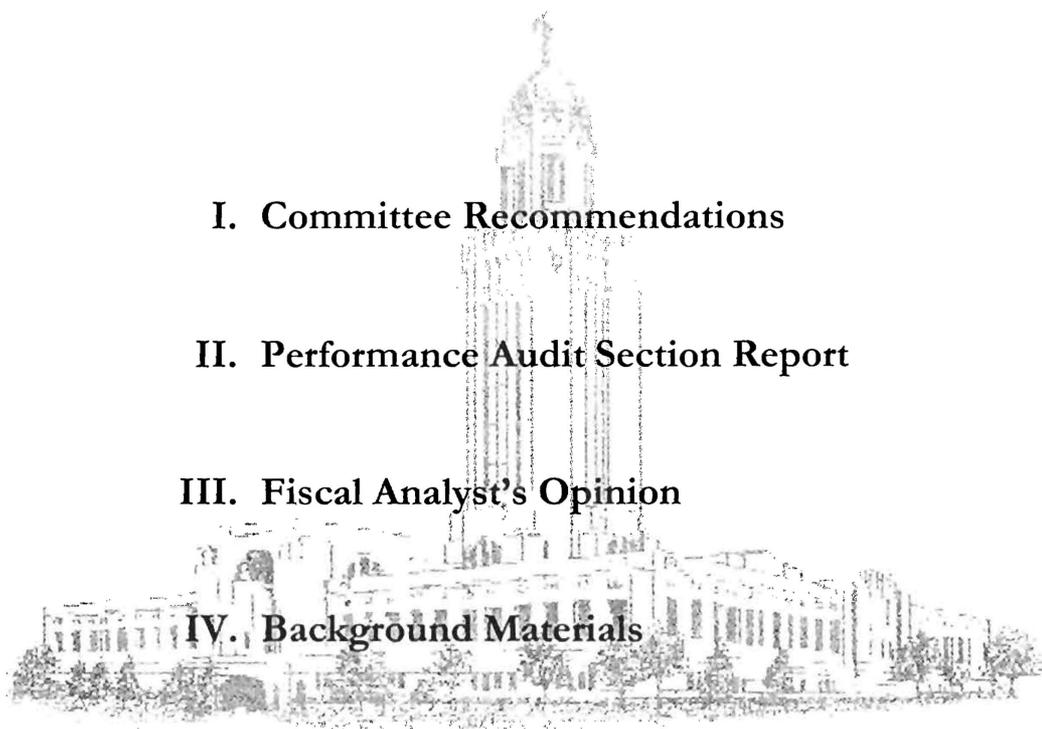
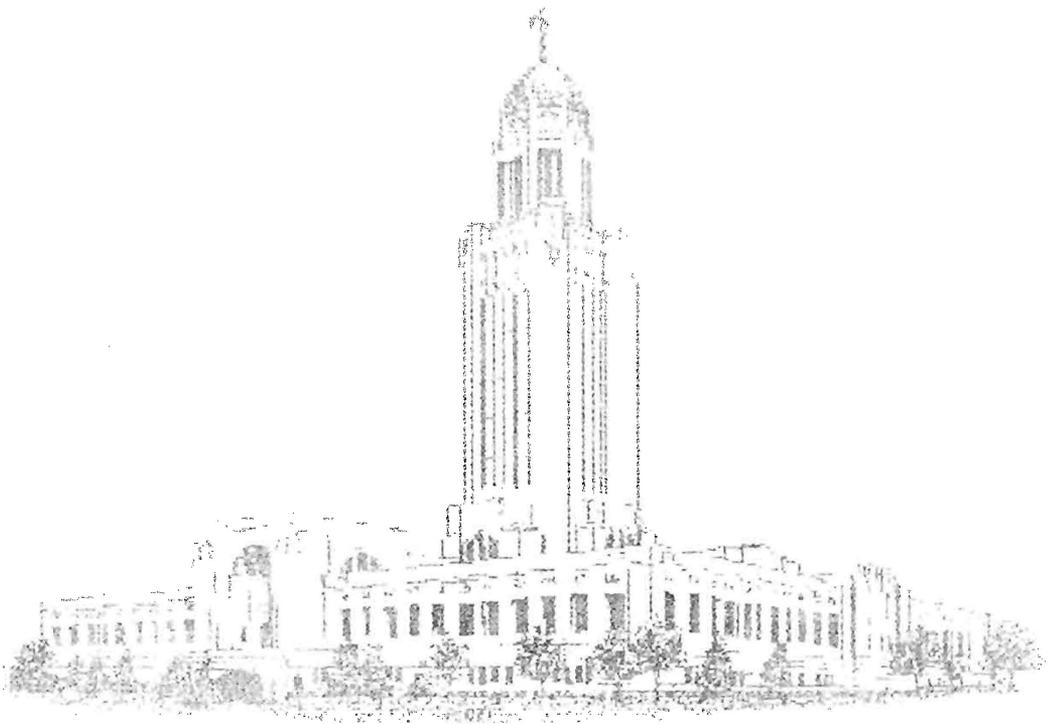


Table of Contents



I. Committee Recommendations

Audit Summary and Committee Recommendations

Audit Summary

With the passage of the Nebraska Behavioral Health Services Act (LB 1083) in 2004, the Legislature undertook statewide behavioral health reform, which emphasized community-based services. The Act provides the structure for the administration and provision of community-based behavioral health services in Nebraska, including the promulgation of rules and regulations, authority to set service rates, and requirements for audits and oversight. The Act authorizes several entities to play roles in the provision of community-based behavioral health services, including the Department of Health and Human Services Division of Behavioral Health (Division), regional governing boards in six regions across the state, regional staff, and service providers.

This performance audit examined whether: (1) funds intended to pay for community-based behavioral health services differentiated from funds intended to pay for administrative costs; (2) administrative responsibilities between the Division and the regions are clear and efficient; and (3) oversight mechanisms are adequate. Audit staff identified a number of concerns, many of which are described as part of the following recommendations from the Legislative Performance Audit Committee.

Committee Recommendations

The Committee is extremely concerned about the audit findings, which it believes demonstrate serious failings in the Department's implementation of the 2004 Nebraska Behavioral Health Services Act (LB 1083). Six years after enactment of LB 1083, the Department has failed to develop a statewide comprehensive plan for behavioral health services, which would provide the behavioral health regions and others with needed guidance about the goals for behavioral health reform in the state. In addition, the Department has failed to promulgate regulations as required. Under LB 1083, the behavioral health regions are required to follow the Department's regulations as part of the balance between the Department's broader authority over behavioral health compared to each region's narrower responsibility for the services within its boundaries. The absence of regulations undermines the Department's role in this regard.

The Committee is equally disturbed by some smaller, yet significant, findings. For example, the agency's attempt to justify a previous Director's bypassing statutory controls on competitive bidding by

citing the agency's broad authority to "integrate and coordinate the public behavioral health system" strains reason. Under this interpretation, a Director could avoid *any* statutory requirement by claiming it was necessary for the integration and coordination of the system.

Similarly, the Director's response to inconsistencies in policies relating to audits of behavioral health services that are purchased by the behavioral health regions reflects a lack of concern for the oversight that the Department should be providing. Audit staff found that two regions were permitted to use an error rate *double* that being used by other regions, and that another region's policies contained no sanction provision for violation of the policies. In response, the Director claimed that "the audits met minimum standards yet we do not require uniformity." This contradictory statement makes no sense and fails to explain why fundamental procedures, such a single allowable error rate and the presence of sanctions, would not be considered "minimum standards."

Also of concern to the Committee are the number of instances in which the agency's written response to the draft audit report provided information that was either contradictory to what audit staff had been told during the audit or was entirely new. It causes additional work for both the agency and the audit staff that could have been avoided if the full and correct information had been provided during the data gathering phase of the audit.

The Committee concludes that the audit identifies significant problems and that the agency's response to the audit findings is insufficient, in some cases failing to take the identified problem seriously. The Committee makes the following specific recommendations.

Recommendation 1:

The Committee will ask the Auditor of Public Accounts to conduct an audit of, at a minimum, whether the Department and regions are maintaining the appropriate separation between funds designated for services and those designated for administration. The Auditor may also wish to consider whether the Department has established appropriate internal controls over the funds that flow to the regions.

Recommendation 2:

The Committee will forward its concerns about the need for DHHS to develop a comprehensive strategic plan for behavioral health services to the Legislature's Health and Human Services Committee for follow-up.

Recommendation 3:

The Committee has begun a preaudit inquiry into the timeliness of regulation promulgation by state agencies, including DHHS.

Discussion: The Administrative Procedure Act, which governs the regulation promulgation process, contains no deadline for completion of regulations that are required by statute. Consequently, six years after enactment of LB 1083, the Committee finds itself in the frustrating position of being unable to find the Department in violation of any statute although the Committee fully believes that the lengthy delay has undermined the legislature's intention that regulations be in place to facilitate LB 1083's implementation.

In his written response to the draft audit report, the Director noted that the development of the LB 1083 regulations has been coordinated with related regulations and that the draft regulations have been revised five times to incorporate stakeholder input. The Committee appreciates that efficiencies may be gained by such coordination and that input prior to initial of the formal rulemaking process may be beneficial for complex regulations. However, such efforts *must be balanced* with the reality that regulations cannot serve their intended purpose if they are not promulgated within a reasonable period of time after a statute's enactment. The Committee believes that six years after enactment is unreasonable.

Recommendation 4:

The Committee directs the audit staff to follow-up and report back to the Committee on when the draft regulations implementing LB 1083 are scheduled for public hearing, which the Director suggested would happen in "early 2010."

Recommendation 5:

The Committee believes that services provided by regions when competitive bidding fails to produce a qualified bidder should subsequently be put out for competitive bid and will draft legislation for the 2011 legislative session to accomplish that.

Recommendation 6:

The Committee directs audit staff to follow-up to determine whether all of the financial and program audits required of the regions take place this year as the Department indicates will happen, in contrast to inconsistencies in completing audits in the past. If the Department finds in the future that it is unable to conduct all of these audits due to staffing concerns, as it reports has happened in the past, the Committee recommends that the Department notify the Committee immediately.

Recommendation 7:

The Committee recommends that the Department revise the minimum standards for audits of services purchased by behavioral health regions to include a single allowable error rate and a sanction policy for noncompliance. The Committee requests that the Department provide a copy of the revised standards to the Committee with the implementation plan due following the release of this report.

Recommendation 8:

The Committee recommends that the Division review the behavioral health regions' policies for all types of audits and ensure that those policies comply with minimum standards established by the Division.

Audit Section Findings

Section II: Separation of Administrative and Service Funds

Finding #1: DHHS and the regional authorities differentiate in budget proposals and year-end accounting reports the funds spent on administrative costs from the funds spent for services.

Finding #2: Although regions do not require service providers to account separately for funds spent on administrative costs and service costs, larger providers in three regions do report separate figures.

Discussion: Assessing whether expenditures are being properly recorded as administrative or services is a financial audit function, which the Performance Audit Section is not authorized to undertake.

Section III: Clarity and Efficiency of Administrative Responsibilities

Finding #3: Statute clearly delineates that the regions have some autonomy with regard to the services provided within their boundaries, but they must operate within a framework established by the Division.

Finding #4: Clarity of the responsibilities between the Division and the regions is likely harmed by the weaknesses in the Division's planning efforts identified by Behavioral Health Oversight Commission (BHOC) and the absence of updated regulations.

Discussion: Comprehensive planning for the delivery of an appropriate array of services across the state was a critical element of LB 1083's vision for shifting behavioral health care to community-

based services. Similarly, properly promulgated regulations would provide uniform definitions and processes for the regions to follow.

Finding #5: The responsibilities of the Division and regions with regard to the selection of service providers are efficient to the extent that the Division has appropriate processes in place.

Finding #6: The Division acknowledged one instance in which the Director deviated from the competitive bidding requirements due to a provider withdrawing mid-contract. This is a deviation that the Nebraska Behavioral Health Services Act does not appear to allow.

Discussion: Division representatives told us that they did not intend to deviate from the competitive bidding requirements in the future.

Finding #7: The Division's interpretation of the statute that allows regions to provide services in the absence of qualified bidders has created an extension of the grandfather clause because once a region begins providing a service, it never has to reopen the service to competitive bidding.

Discussion: This is a policy issue for the Committee's consideration.

Section IV: Oversight

CPA Audits

Finding #8: The regions complied with the requirements to have yearly financial audits.

Finding #9: The Division takes several steps to ensure audits of the regions are scheduled, conducted, and reviewed.

Finding #10: The Division was not compliant with the contractual requirement to audit regionally provided services on a yearly basis. One of the six regions had no services purchased audits between 2005 and 2008.

Finding #11: This noncompliance also raises questions about the effectiveness of the Division's review and monitoring of the audit timeline submitted with regional budget plans.

Discussion: Division representatives told us they do not have enough staff to conduct all of the required audits. As the state is facing a significant budget deficit in the current biennium, this problem may get worse.

Finding #12: Some regions' policies for conducting services purchased audits varied inappropriately from the Division's policies.

Discussion: It is within the Division's authority to ensure that the region's audit policies conform to minimum standards established by the Division.

Program Fidelity Audits

Finding #13: The Division is substantially compliant with the requirement to conduct timely program fidelity audits of regionally-provided services.

Finding #14: All six regions had adequate procedures for program fidelity audits.

Consumer Input

Finding #15: The Division conducts several consumer outreach activities, including an annual survey that suggests consumers are generally satisfied with the services they received.

Finding #16: The Division responds to recommendations from different consumer groups.

Data Reporting and Analysis

Finding #17: The Division is compliant with a requirement that it collect and report on the status of people in need of and receiving behavioral health services.

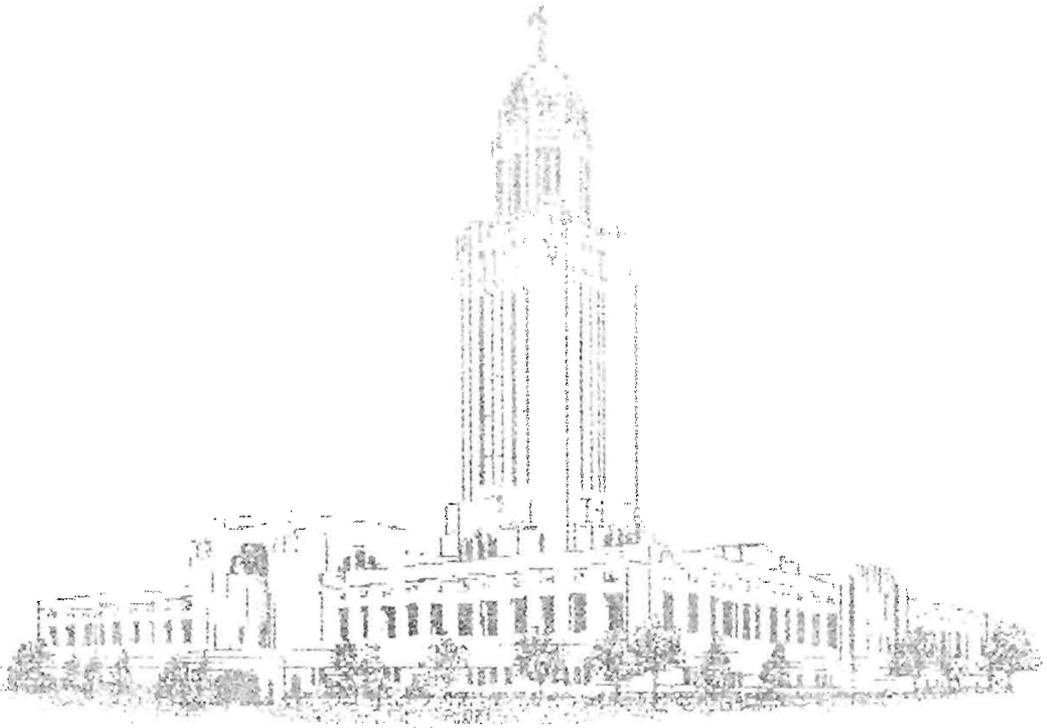
Finding #18: Division staff do not analyze program fidelity audit information to note trends in identified weaknesses for either specific providers or groups of providers.

Finding #19: The Division's lack of formal data analysis was noted as an area of concern in a 2007 review by the federal Center for Substance Abuse Treatment.

Finding #20: By not compiling consumer feedback from the helpline, the Division is missing an opportunity to increase consumer involvement in the behavioral health system.

Discussion: According to Division representatives, they review data from program fidelity audits and consumer outreach activities to identify immediate problems but do not compile and analyze the information to identify patterns or trends that develop over time.

Finding #21: There are adequate mechanisms in existence to oversee the behavioral health delivery system; however some are not functioning as well as they should be. This is particularly concerning since the Behavioral Health Oversight Commission (BHOC), which had the broadest oversight responsibility, has been eliminated.



II. Performance Audit Section Report

Legislative Audit Office Draft Report
**Community-based Behavioral Health:
Funds, Efficiency, and Oversight**

November 2009

Prepared by
Don Arp, Jr.
Clarence Mabin
Angie McClelland

CONTENTS

INTRODUCTION	iii
SECTION I: Nebraska’s Community Behavioral Health System	1
The Division of Behavioral Health.....	1
The Regions.....	2
Private Contractors	3
SECTION II: Behavioral Health Administrative Costs	5
The Division	5
The Regions.....	5
Private Service Providers	6
SECTION III: Administrative Responsibilities	9
Administrative Structure.....	9
Clarity of Authority	9
System Efficiency	11
SECTION IV: Behavioral Health Oversight Mechanisms	15
The Oversight Environment	15
Financial Oversight	16
Programmatic Oversight	17
Consumer-based Activities.....	20
Advisory Resources.....	22

INTRODUCTION

In June 2009, the Legislative Performance Audit Committee directed the Legislative Performance Audit Section to conduct a performance audit of the Department of Health and Human Services Division of Behavioral Health's (Division) administration of the behavioral health system and answer the following questions:

1. How are funds that are intended to pay for community-based behavioral health services differentiated from funds intended to pay for administrative costs?
2. Are the administrative responsibilities of the Department of Health and Human Services and the regional administrations, in regards to community-based behavioral health, clear and efficient?
3. What oversight mechanisms exist in the community behavioral health system and are these mechanisms adequate to ensure proper functioning of the system?

Section I of this report provides an overview of Nebraska's behavioral health system. Sections II through IV answer the specific questions posed for this audit. Section V contains our findings and recommendations.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In conducting this analysis, we reviewed the Nebraska Behavioral Health Services Act, rules and regulations, and Division policies and internal documents. We also interviewed Division staff. The Division provided the financial data cited in this report. Audit staff did not independently verify the financial data.

We appreciate the cooperation and assistance of Division staff during the audit.

SECTION I: Behavioral Health Services in Nebraska

In this section we give a brief background of Nebraska's behavioral health system, including statutory responsibilities of each entity involved.

Nebraska's Community Behavioral Health System

Nebraska's behavioral health system was established in 1974, with elements of centralization and local control designed to meet the service needs of Nebraska citizens. The current system is comprised of the Division, groups of counties that make up regional behavioral health authorities (regions), and behavioral health service providers, which can be regions or private contractors.¹

A major restructuring of the state's behavioral health system occurred in 2004, with the Legislature's passage of LB 1083, the Nebraska Behavioral Health Services Act. The Act sought to address an over-reliance on the state's regional centers, and move toward community based services. The Behavioral Health Oversight Commission (BHOC) noted in its 2008 report that, "Consistent with advances in research and treatment, evolving best practices, the legal and civil rights of those with mental illness or other disability as established in the U.S. Supreme Court Olmstead decision, and the advocacy of consumers, families, and professionals alike, LB 1083 envisioned and mandated the provision of services closer to home, family, and support services and in the least restrictive setting."

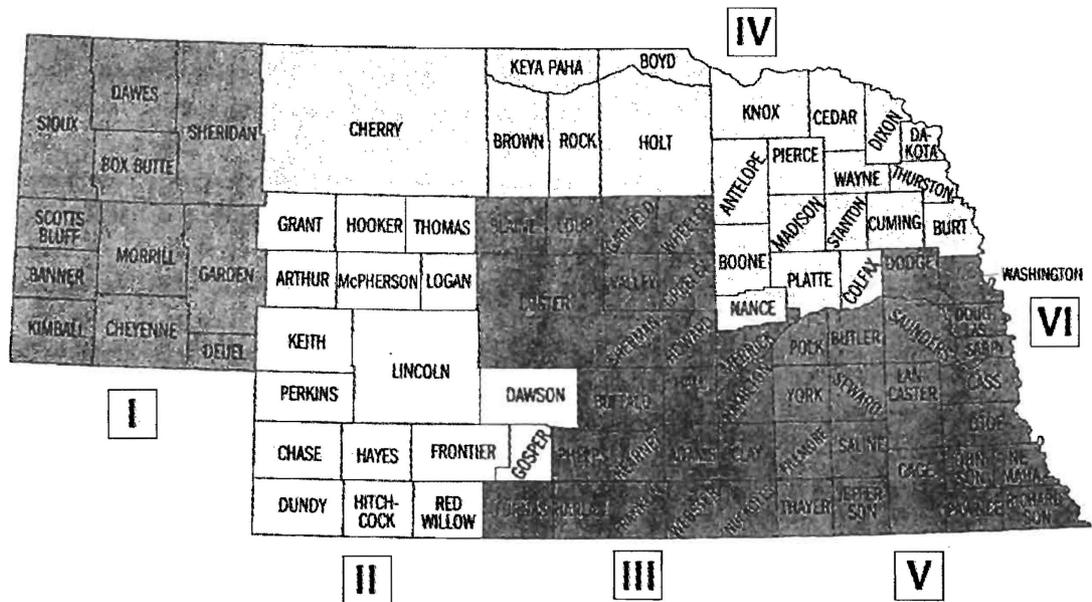
The Division

By law, the Division must direct the administration and coordination of the behavioral health system. The Division does so by overseeing the regions, including approving regional budgets and auditing regions' behavioral health programs and services.² Additionally, the Division sets the reimbursement rates for services and consumer fees, and is required to conduct statewide planning to ensure that an appropriate array of community-based behavioral health services are provided.³ The Division is also responsible for adopting the rules and regulations to carry out the Act, which the regions must follow.⁴

To facilitate consumer feedback and provide state oversight, the Director of Behavioral Health must appoint a chief clinical officer and establish an Office of Consumer Affairs.⁵ We will discuss the Division's oversight activities in Section IV of this report.

The Regions

The state is divided into six behavioral health regions, as shown below. Acting under the Interlocal Cooperation Act, the counties in each region are required to establish a behavioral health authority.⁶ One county board member from each county in a region serves on the regional governing board. The counties must provide a portion of the funding for the operation of their region's behavioral health authority and for the provision of behavioral health services in the region.⁷



Regional Governing Boards and Authorities

Each regional governing board oversees a regional behavioral health authority and is required to appoint a regional administrator to administer and manage the region.⁸ Each region is responsible for the development and coordination of publicly-funded behavioral health services within its service area. In doing so, it must ensure that these actions follow the rules and regulations established by the Division.⁹

Each region must:

- submit budgets to the Division for approval;
- plan to ensure that an appropriate array of community-based behavioral health services are provided in the regions;
- coordinate and conduct audits of programs and services;

- provide annual reports and other reports required by the Division;
- initiate and oversee contracts for behavioral health services;
- encourage consumer involvement “in all aspects of service planning and delivery within the region;” and
- coordinate its activities with the Division’s Office of Consumer Affairs.¹⁰

In addition to their statutory responsibilities, the regions sign contracts with the Division that provide further details about the regions’ responsibilities in financial processes, oversight and other areas.

The regions are allowed to provide services under certain circumstances, which we discuss in more detail in Section III of this report.¹¹

Private Contractors

Additionally, regions enter into contracts with individual private contractors. The same rules and regulations that apply to the regions also apply to service providers.¹² The Division requires certain elements to be included in the contracts between the regions and service providers, including the submission of budget plans, participation in reporting and recordkeeping, and participation in oversight activities such as audits of programs and services.¹³

Notes

¹ The Nebraska Comprehensive Community Mental Health Act was enacted in 1974 with LB 302.

² Neb. Rev. Stat. § 71-806(1).

³ Neb. Rev. Stat. § 71-806(1).

⁴ Neb. Rev. Stat. § 71-806(2).

⁵ Neb. Rev. Stat. § 71-805(1-2).

⁶ Neb. Rev. Stat. § 71-808(1).

⁷ Neb. Rev. Stat. § 71-808(3). Counties in each region consult with their regional governing board to determine the amount of funding to be provided by each county.

⁸ Neb. Rev. Stat. § 71-808(1 and 2).

⁹ Neb. Rev. Stat. § 71-809(1).

¹⁰ Neb. Rev. Stat. §§ 71-809(1) and 71-808(2).

¹¹ Neb. Rev. Stat. § 71-809(2).

¹² The introductory language of 204 NAC Ch. 4 states: “The requirements under this chapter apply to Regional Governing Boards (hereafter referred to as ‘region’) as well as an organization or individual (hereafter referred to as ‘provider’) receiving community mental health funds directly from the Department or from the Department through a Regional Governing Board.”

¹³ FY2008-2009 Contract, Section IV: Contractor Duties and Responsibilities (Subsections A and F) and Section IX: Audits, Services Purchased and Program Fidelity Verification Requirements.

SECTION II: Behavioral Health Administrative Costs

In this section we describe how funds that are intended to pay for community-based behavioral health services are differentiated from funds intended to pay for administrative costs associated with providing those services.

The Department of Health and Human Services Division of Behavioral Health (Division), regions, and providers all have administrative duties and accompanying costs. Following is a discussion of how the entities account for their administrative costs.

The Division

The Division maintains separate budgets for state-level behavioral health administrative funds and funds it provides to the regions. For FY2008-09, the Division spent \$2.1 million (consisting of both state and federal funds) to administer Nebraska's behavioral health system.¹ According to Division staff, the administrative costs constitute approximately 1.2 percent of total behavioral health system expenditures.²

The Regions

The regions receive funding for administrative and service-provision costs from the Division and from the counties that make up each region. For FY2008-09, the Division distributed \$87.3 million to the regions.³

By law, each county must contribute to the regional authority one dollar for every three dollars appropriated from the General Fund. In FY2008-09, the regions received approximately \$117 million from these sources, almost \$5 million of which was used for administrative expenses. Division staff noted that most regions use county matching funds to pay for their administration costs.⁴

Rules and regulations require the regions to submit yearly budget plans,⁵ which include estimated expenditures for mental health services, substance abuse services, and administration.⁶ After the fiscal year has ended, regions are required to submit reports of their actual expenditures to the Division.⁷ Division staff said that they compare the reports of actual expenditures when they review the regions' budget estimates for the upcoming fiscal year.⁸

For FY2008-09, the regions spent between 3.0 and 11.5 percent of their total revenue for administrative expenses (shown in Table 1).

Table 1: Actual Regional Administrative Expenditures for FY2008-09

Region	Actual Administrative Totals	Actual Revenue (state, local, and other fund sources)	Percentage of Funds Used Specifically for Administration*
1	\$691,918	\$6,010,114	11.5%
2	\$356,880	\$7,084,505	5.0%
3	\$592,747	\$19,159,500	3.0%
4	\$537,794	\$15,440,723	3.5%
5	\$1,431,018	\$29,324,749	4.9%
6	\$1,269,503	\$40,073,688	3.2%
Total	\$4,879,860	\$117,093,279	---

Table prepared by the Legislative Audit Office using data provided by the Division of Behavioral Health.

*Administrative includes both coordination costs and administration costs under the "System Coordination" section of the budget form.

Private Service Providers

Like the regions, each private service provider submits a budget plan with its contract, including estimated expenditures for mental health services, substance abuse services, and administration.⁹ Private providers apply for reimbursement from the regions after they have provided a service.¹⁰

According to Division staff, providers' administrative costs typically run between 15 and 20 percent, although some organizations, such as hospitals, have administrative costs that are often more than 20 percent for their total expenditures.¹¹ Audit staff did not verify these percentages.

A survey of regional administrators found that although the regional budget plan guidelines do not require providers to report administrative costs separately, some providers do. Three of the six regions noted that larger providers gave separate figures for administrative and services costs, both in budgets and in year-end actuals. The other three regions said that their providers do not. All six regions noted that because most providers are small enterprises and are paid on a unit cost or fee-for-service basis, they cannot provide separate figures like the larger providers.

FINDING: DHHS and the regional authorities differentiate in budget proposals and year-end accounting reports the funds spent on administrative costs from the funds spent for services.

FINDING: Although regions do not require service providers to separately account for funds spent on administrative costs and service costs, larger providers in three regions do report separate figures.

Notes

¹ Budget Status Report from the Nebraska Information System as of June 30, 2009 for Agency 25, Program 268. E-mail from Sue Adams, October 14, 2009.

² Meeting with Scot Adams, Vicki Maca, Susan Adams, and Karen Harker, June 18, 2009.

³ Budget Status Report from the Nebraska Information System as of June 30, 2009 for Agency 25, Program 38.

⁴ Meeting with Scot Adams, Vicki Maca, Susan Adams, and Karen Harker, June 18, 2009.

⁵ 203 NAC Ch. 4-003.

⁶ Behavioral Health Division form 10a.

⁷ FY2008-2009 Contract, Section IV: Contractor Duties and Responsibilities (Subsection F).

⁸ Telephone conversation with Susan Adams, September 11, 2009.

⁹ FY2008-2009 Contract, Section IV: Contractor Duties and Responsibilities (Subsection A).

¹⁰ Telephone conversation with Susan Adams, September 11, 2009.

¹¹ Meeting with Scot Adams, Vicki Maca, Susan Adams, and Karen Harker, June 18, 2009 and telephone conversation with Susan Adams, September 11, 2009.

SECTION III: Administrative Responsibilities

In this section, we discuss whether the administrative responsibilities of the Department of Health and Human Services Division of Behavioral Health (Division) and the regional administrations, in regards to community-based behavioral health, are clear and efficient.

Administrative Structure

By law, the Division is the “chief behavioral health authority” for Nebraska, responsible for the overall administration of the public behavioral health system, including coordinating and overseeing the work of the regions.¹ The Division must approve or disapprove regional budgets and plans and audit the regional authorities and all behavioral health programs and services.² Further, the Division is required to adopt and promulgate rules and regulations to carry out the Act and to conduct strategic planning plan for the delivery of behavior health services.³ In short, the Division is responsible for ensuring that the necessary types of services are available throughout the state.

In contrast, each region is responsible for coordinating and overseeing the network of community-based service providers within its geographic boundaries, thus executing a critical role in serving its residents. The legislative history for LB 1083 reflects the Legislature’s intention that the regions exercise local control within the framework set out by the Division. For example, Senator Jim Jensen, Chair of the Health and Human Services Committee and introducer of LB 1083, stated:

We don’t want to tell communities what to do. They need to decide for themselves what is best for their community. Then the state has the overall plan.⁴

However, regions do not have unlimited control over the services provided within their boundaries. They must follow the provisions of the Act, the rules and regulations promulgated by DHHS, and the requirements of contracts they sign with the Division.

Clarity of Authority

We found that the responsibilities of the Division and regions seemed clear, at least in statute. To determine whether they were clear in practice, we asked Division representatives and regional administrators whether their responsibilities under the Act (as described above) were clear to them. The Division representatives and some regional administrators told us there were times when their responsi-

bilities were not clear; however, they provided no specific examples of problems they had encountered. From our own analysis we identified two practical problems that are likely to contribute to confusion about responsibilities.

FINDING: Statute clearly delineates that the regions have some autonomy with regard to the services provided within their boundaries, but they must also operate within a framework established by the Division.

Inadequate Comprehensive Planning

By law, the Division is responsible for the “comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care.”⁵ In 2008 and 2009, the Behavioral Health Oversight Commission (BHOC), created by the Legislature to help oversee implementation of LB 1083, called into question the extent of the Division’s planning. BHOC found that “many of the goals and responsibilities as set out in LB 1083 have not been accomplished,” noting that many of the 108 deliverables identified in DHHS’ “LB1083 Behavioral Health Implementation Plan” remained “incomplete and/or unaddressed altogether.” Some of these issues, according to BHOC, include:

- a plan for integrating the administration of behavioral health programs;
- a comprehensive statewide plan for behavioral health services;
- services that are research based, focus on recovery, and include peer support;
- a quality improvement plan; and
- a methodology for measuring consumer, process, and system outcomes.⁶

To address these shortcomings, BHOC recommended that the Division adopt a strategic vision for behavioral health that would lead to the “establishment of trusting and effective partnerships with key stakeholders in the system.” BHOC said such planning was “imperative.” Division staff confirmed that the Division has not completed comprehensive statewide planning and coordination for community-based behavioral health services.⁷

Through our survey, we found that some regional administrators believe that the lack of a comprehensive statewide plan for the provision of services created some instances of confusion between the Division and the regions. According to one of the regional representa-

tives, the absence of the plan “creates a void in vision, direction and leadership.”⁸

Regulations Not Promulgated

An issue closely related to inadequate comprehensive planning is the lack of updated rules and regulations. As of the writing of this report, the promulgation of rules and regulations to implement the reforms of LB 1083 has not been completed—five years after passage of the bill. Although the Division and regions provided no examples of problems arising from this issue, updated rules and regulations with accurate statutory citations seems to us to be a resource that could add increased clarity to operating the community-based behavioral health system.

FINDING: Clarity of the responsibilities between the Division and the regions is likely harmed by the weaknesses in the Division planning efforts identified by BHOC and the absence of updated regulations.

System Efficiency

The behavioral health system’s most important goal is the provision of services to those who need them. Therefore, to determine the efficiency of the system, we examined whether the Division has in place the required processes for the selection of service providers (we did not assess the efficiency of the delivery of individual services). To conduct this analysis, we reviewed relevant portions of the Act, rules and regulations, the regions’ processes for contracting with service providers, and the circumstances in which regions may provide services without conducting a competitive bidding process.

Service Provision

As mentioned earlier in this report, the regions must provide an appropriate array of services, either through private providers or themselves. When not providing a service itself, a region must conduct a competitive bidding process to select the service provider(s).

Bidding Procedures

Pursuant to a section of the Act often referred to as the “grandfather clause,” a region can provide a service, without first conducting a competitive bidding process, if it provided the service on July 1, 2004.⁹ Currently, although private contractors provide most of the services in the system, all six regions provide some services under the grandfather clause.¹⁰

For services not covered by the grandfather clause, regions must conduct a competitive bidding process. Bidders participating in the process are assessed by region staff, as part of the request for proposal (RFP), to determine if they meet the “enrollment of providers” requirements set by the Division.¹¹ These requirements are: demonstration of capacity, state certification or national accreditation, an on-site visit, and primary source verification.¹²

If a provider meets the bidding requirements and is accepted by the region, it must sign a contract, agreeing to participate in required financial processes and other oversight activities. The provider then carries out a service and applies for reimbursement from the region.

FINDING: The responsibilities of the Division and regions with regard to the selection of service providers are efficient to the extent that the Division has appropriate processes in place.

Director’s “Exemption”

Division staff noted that the Division Director once allowed a deviation from the competitive bidding procedures (they termed it a “waiver”) when a provider unexpectedly withdrew from an active contract.¹³ The Director believed this was necessary because the community could not do without the particular service for the time it would take to conduct the bidding process.¹⁴

Nothing in the plain language of the Act authorizes such a waiver. Although the currently promulgated rules and regulations make provision for a waiver, such action pertains only to certain chapters of that title of the administrative code, none of which address the actual bidding process.¹⁵ Use of the waiver in this instance seems unsupported by statute. Division staff, including the Director, said that they are not inclined to grant a waiver in an instance such as this again.

FINDING: The Division acknowledged one instance in which the Director deviated from the competitive bidding requirements due to a provider withdrawing mid-contract. This is a deviation that the Nebraska Behavioral Health Services Act does not appear to allow.

Failure to Find a Provider

In addition to providing services under the grandfather clause, a region may provide a service if the bidding process does not identify a qualified bidder and the Division director authorizes the region to provide the service.¹⁶ According to Division representatives, when a region is authorized to provide a service because there was no qualified bidder, it does not need to open that service for bidding again.¹⁷

We found that the Act itself and the legislative history of LB 1083 are both silent on whether the Legislature intended for regions to indefinitely provide a service under these circumstances, as they are allowed to do for grandfathered services.

FINDING: The Division's interpretation of the statute that allows regions to provide services in the absence of qualified bidders has created an extension of the grandfather clause because once a region begins providing a service, it never has to reopen the service to competitive bidding.

Notes

¹ Neb. Rev. Stat. § 71-806 (1).

² Neb. Rev. Stat. § 71-806 (1) (d) and (i).

³ Neb. Rev. Stat. § 71-806 (1) (c) and (2).

⁴ Legislative History, LB 1083 (2004), remarks by Sen. Jim Jensen, March 17, 2004, pg. 11633.

⁵ Neb. Rev. Stat. § 71-806 (1) (c).

⁶ Behavioral Health Oversight Commission Final Report, June 22, 2009, pg. 7.

⁷ and telephone conversation with Sue Adams, September 10, 2009.

⁸ Written statements from regional administrators.

⁹ Neb. Rev. Stat. § 71-809 (2). The Division used the Budget Planning Document, which describes services provided by each region, submitted by the regions during the fiscal year previous to the July 1, 2004, as the baseline of services provided by the regions prior to the implementation of LB 1083 (Meeting with Scot Adams, Vicki Maca, and Sue Adams, October 6, 2008).

¹⁰ Budget Plan documents from all six regions provided by the Division.

¹¹ Neb. Rev. Stat. § 71-809 (2) (a-c)

¹² Network Management Review document. Demonstration of Capacity: Examines necessary facility licenses, professional licenses, insurance, fiscal viability, Medicaid enrollment (if services are eligible), and program plans for services provided in network. Program plans must contain: entry and discharge criteria; assessment procedures; discuss how consumer input is completed; staffing; and quality improvement processes. State certification or national accreditation: New providers must apply for State Certification or State Certification through National Accreditation. On-site visit: Verifies information used to demonstrate capacity, examines clinical record keeping practices, and conducts a data audit to verify information reported to the Division. For providers without national accreditation, a quality assurance review is also necessary. Primary source verification: All documents used to meet requirements are compiled and verified by network management.

¹³ Meeting with Scot Adams, Vicki Maca, and Sue Adams, October 6, 2008; E-mail from Sue Adams, December 8, 2008, with answers approved by Scot Adams.

¹⁴ Meeting with Scot Adams, Vicki Maca, and Sue Adams, October 6, 2008.

¹⁵ NAC Title 204, Chap. 2.

¹⁶ Neb. Rev. Stat. § 71-809 (2) (a-c).

¹⁷ E-mail from Sue Adams, December 8, 2008, with answers approved by Scot Adams.

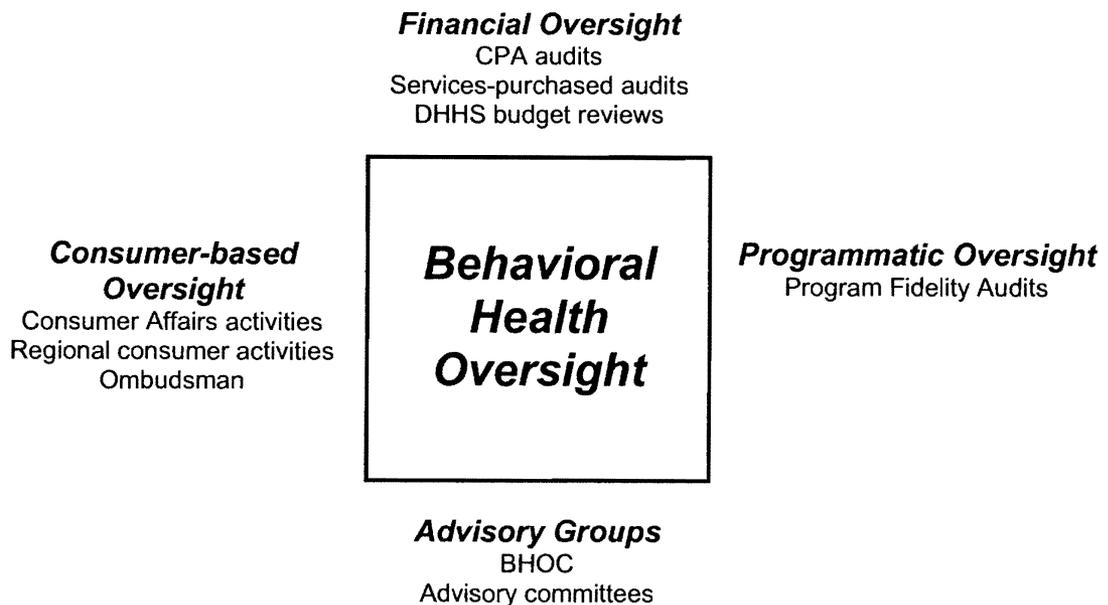
SECTION IV: Behavioral Health Oversight Mechanisms

In this section, we discuss the oversight mechanisms that exist in the community behavioral health system and whether these mechanisms are adequate to ensure proper functioning of the system.

The Oversight Environment

There are several oversight mechanisms in place at various levels of the behavioral health system and that are executed by the Division, the regions, or independent contractors. These mechanisms include:

- financial oversight (CPA audits and services purchased audits);
- programmatic oversight (reviews of budget plans, program fidelity audits, audits from other entities such as the Legislature or accreditation organizations);
- consumer-based activities such as conferences and helplines; and
- input from advisory groups.



Financial Oversight

Budget Reviews

As part of its oversight responsibilities, the Division must review and approve regional budgets.¹ Division staff use budget plans submitted by the regions to examine, among other items, the spectrum of services provided and estimated administrative costs. Division staff also compare the list of services provided to a master list of services to ensure that the provisions of the so-called “grandfather clause” are followed by regions that are providing services themselves. Division staff noted that they work closely with regional staff during budget submission and that it is routine for them to ask for more information from the regions regarding budget issues.² Staff also said that they ask the regions to either submit more information or re-submit budget plans to address issues.³

CPA Audits

Each region and private service provider must have an independent, annual financial audit conducted by a certified public accountant.⁴

We found that all regions complied with the requirement to have yearly financial audits. None of the audits reviewed identified any issues that rose to the level of “material” significance. We did not determine whether each private service provider also had a financial audit.

The Division takes several steps to ensure audits of the regions are scheduled, conducted, and reviewed. Regions submit an audit timeline with their budget plans indicating when audits will occur, which Division staff said they check against incoming audits. Once completed, the regions send audit reports to the Division. According to the Division, staff review the audit reports, noting any deficiencies on a cover sheet that must also be signed by the reviewer.⁵

FINDING: The regions complied with the requirements to have yearly financial audits.

FINDING: The Division takes several steps to ensure audits of the regions are scheduled, conducted, and reviewed.

Services-purchased Audits

Services-purchased audits, required annually for each service, assess whether providers actually delivered the services they billed to the Division or the regions. Division staff audit region-provided services; region staff audit subcontractor-provided services. We reviewed the

audits conducted by the Division, but lacked the time to examine the audits done by region staff of subcontractors.

Similar to the CPA audits, the Division requires regions to submit a timeline for completion and reviews the report once completed. When we reviewed the services-purchased audits performed by Division staff from 2002 to 2008, we found that the Division conducted nine reviews of five regions' services during that time. Contrary to contract, no region's services were audited yearly.⁶ Division staff explained that Division understaffing has meant fewer audits.⁷ Division staff could not offer a clear explanation of why Region 3 did not have a services-purchased audit by the Division from 2005-2008, although staff reiterated that personnel levels were an issue starting in 2006.⁸ This noncompliance also raises questions about the Division's review and monitoring of the audit timeline submitted with regional budget plans.

FINDING: The Division was not compliant with the contractual requirement to audit regionally provided services on a yearly basis. One of the six regions had no services purchased audits between 2005 and 2008.

FINDING: This noncompliance also raises questions about the effectiveness of the Division's review and monitoring of the audit timeline submitted with regional budget plans.

The Division's and the regions' written procedures for reporting audit results are similar, however variations exist. Variations found included a region with no sanctions policy and two regions that allow a ten percent error rate in services-purchased audits, rather than the five percent rate set by contract. The contract requires reviewers to evaluate at least two percent of purchased services. If the error rate exceeds five percent, reviewers must increase the sample size to five percent.

FINDING: Some regions' policies for conducting services purchased audits varied inappropriately from the Division's policies.

Programmatic Oversight

In addition to oversight of behavioral health services expenditures, the Division and regions exercise oversight by tracking the use of broad categories of services. Further, the Division and regions conduct program fidelity audits that assess whether services sufficiently meet the needs of consumers.

Information Systems and Reporting

By law, the Division must maintain an information system for “all persons receiving state-funded behavioral health services.”⁹ Data required to be collected by the system includes the number of persons:

- receiving regional center services;
- ordered by a mental health board to receive inpatient or outpatient treatment and receiving regional center services;
- voluntarily admitted to a regional center and receiving regional center services;
- waiting to receive regional center services;
- waiting to be transferred from a regional center to community-based services or other regional center services;
- admitted to behavioral health crisis centers.¹⁰

Currently, the Division contracts with Magellan Behavioral Health for what it calls a “management information system” for community-based services.¹¹ Providers enter information directly into the Web-based application. The Division, regions, and providers can access the reports developed by the information system.¹² The Division also uses Magellan to track services for consumers at the Lincoln Regional Center, but, according to Division staff, this is not at the level of specificity required by statute.¹³ According to Division staff, to comply with statute in this regard, the regional centers generate their own weekly data reports that are then sent to the Division.¹⁴ All of these sources of data are used to develop reports to the Legislature and the Governor, as required by law.¹⁵

FINDING: The Division is compliant with a requirement that it collect and report on the status of people in need of and receiving behavioral health services.

Program Fidelity Audits

A program fidelity audit reviews program plans and delivered services. The audits assess whether service providers have processes to ensure consistency in service quality and compliance with applicable grant requirements, and with state and federal laws and regulations.¹⁶ Contracts require audit teams – comprised of HHS and, or, region staff members – to review provider records, including clinical records, and “other programmatic and clinical details of the service.” The reviewers must examine “sufficient” clinical records and other documentation to verify that the service provider complied with at least 95 percent of state standards, the minimum benchmark set by the Division for program fidelity audits.^{17 18}

The Division and the regions must complete program fidelity audits at least once every three years for each service offered by a pro-

vider.¹⁹ If a region provides the services, Division staff conducts the audit; if the region subcontracts for services, region staff conducts the audit and submits the results to the Division.²⁰

Although the Division has done program fidelity audits since 2002, timeframe requirements were not placed in contracts until 2006 after a review of auditing procedures by a DHHS workgroup.²¹ Prior to 2006, the only major requirement in audit guidelines stated that the regions could not conduct program fidelity audits on themselves, but instead had to use a neutral entity, with some regions using peer reviewers from a state behavioral health group.²² Now, programs must be reviewed at least once every three years.²³

According to the Division, between 2006 and 2009, only one program was not audited.²⁴ Division staff noted that a lack of personnel has limited completion of program fidelity audits in the past.²⁵ However, staff also noted that the Division “demonstrates growth” and improvement in this area while operating within its appropriations.²⁶

FINDING: The Division is substantially compliant with the requirement to conduct timely program fidelity audits of regionally-provided services.

In conducting program fidelity audits Division staff uses a workbook outlining standards, definitions and audit procedures. Contract requires each region to develop written procedures and formats for reporting results of their audits of subcontractors.²⁷ All six had minimal but adequate written procedures — from one sentence to three sentences of instruction.

FINDING: All six regions had adequate procedures for program fidelity audits.

Regions submit their program fidelity audit reports to the Division for review. Division staff stated they review these audits primarily to correct any issues identified in the audits.²⁸ Division representatives told us they do not analyze the information to discern trends in identified weaknesses among providers.²⁹

FINDING: Division staff do not analyze program fidelity audit information to note trends in identified weaknesses for either specific providers or groups of providers.

The federal Center for Substance Abuse and Treatment, in a 2007 review to determine federal block grant compliance, also identified this lack of formal analysis. In their subsequent report, the reviewers emphasized the importance of data analysis and concluded that Nebraska had “no systematic process for analyzing and reporting data

for decision-making” and “no formal plan exists for improving analytical and management capacity for data usage.”³⁰ The reviewers wrote that “data appear to be underutilized due to limited personnel resources” in the Division.³¹

FINDING: The Division’s lack of formal data analysis was noted as an area of concern in a 2007 review by the federal Center for Substance Abuse Treatment.

Consumer-based Activities

In addition to audits and other reviews, consumer input provides another level of oversight of the community-based behavioral health system. Consumers, as the direct recipients of services, have a singular role in the assessment of those services.

Office of Consumer Affairs

Recognizing the important role consumers could play in their treatment, the 2004 reform legislation increased consumer involvement in the behavioral health system.³² The Legislature created the Office of Consumer Affairs (Office) within the Division and gave it the mission of planning, facilitating, and strengthening consumer involvement in behavioral health issues.³³ The Office has four staff members, including a Program Administrator, who must be a current or former consumer of behavioral health services.³⁴

Office staff conduct several activities designed to inform and respond to behavioral health services consumers.³⁵ These activities include organizing an annual conference for consumers, administering e-mail listservs for consumers and providers, conducting a yearly consumer satisfaction survey, and operating a consumer helpline.³⁶ Division staff noted that more than 100 consumers attend the annual conference and that the helpline typically receives between 300 and 700 phone calls each year.³⁷

Each year the Office conducts a survey of “persons receiving mental health and/or substance abuse services” in the behavioral health system.³⁸ The survey asks consumers, both adults and children/adolescents (parents or guardians often responding), to report on their satisfaction with several factors, including service access, quality and appropriateness of service, outcomes, participation in treatment planning, and general satisfaction. In 2008, the survey had a 31% response rate for adults and a 42% response rate overall.³⁹ In the survey, consumers gave generally positive reviews of the system. Adults responding to the 2008 survey reported 72.0-81.9% satisfaction with various services offered and outcomes. Responding

youth and their parents reported 58.4-82.0% satisfaction with various services offered and outcomes.⁴⁰

FINDING: The Division conducts several consumer outreach activities, including an annual survey that suggests consumers are generally satisfied with the services they received.

Although the Division conducts several outreach activities with consumers, it is missing opportunities to take advantage of some of the sources of data available to it. For example, Division staff acknowledged that they do formally compile information from consumers at the annual conference, but not from the consumer helpline.⁴¹ Not compiling this data is missing an opportunity to maximize consumer involvement in the system.

FINDING: By not compiling consumer feedback from the helpline, the Division is missing an opportunity to increase consumer involvement in the behavioral health system.

Consumer Input at the Regional Level

In addition to the state-level Consumer Affairs Office, the Division requires each region to have a designated consumer specialist on staff to deal with consumer issues on the local level.⁴² Regional consumer specialists also field consumer calls regarding services concerns and can often guide consumers through their local behavioral health system more easily than the state-level employees.⁴³ The regional specialists and Office staff communicate regularly to discuss consumer issues.

Regions are also required to have grievance procedures in place as part of their accreditation process. Currently, according to Division staff, all regions are accredited and have met the requirement. As the Division is not accredited, it is not required to have grievance procedures; however, Division staff said that there has been a call for state-level grievance procedures, which would address concerns about services provided by the regions.⁴⁴

Office of the Public Counsel (Ombudsman)

In 2008, the Legislature gave the Office of the Public Counsel (Ombudsman) the authority to investigate complaints from consumers of services provided by both the regions and private providers. The investigatory authority granted applied only to consumers who were patients of a state regional center within the prior 12 months.⁴⁵

The legislation also created the position of deputy public counsel for institutions, which has purview over state regional centers, the Bea-

trice State Development Center and the state veterans' facilities. During floor debate, Sen. Mike Flood said the extended authority would give the Ombudsman the ability to determine if a patient had received the appropriate care from one end of the services continuum to the other.⁴⁶

Advisory Resources

Behavioral Health Oversight Commission

The Legislature established the Behavioral Health Oversight Commission (BHOC) with the passage of LB 1083 (2004).⁴⁷ Until July 2008, the BHOC reported to the Legislature; after that date, it reported to the Director of Behavioral Health until it sunset on June 30, 2009.⁴⁸

BHOC was required to oversee and support implementation of LB 1083 by providing advice and assistance to the Division relating to the implementation of the Act. In addition, BHOC promoted the interests of consumers and their families, and was required to provide reports and engage in other activities as directed by the Division.⁴⁹

As mentioned earlier in this report, in June 2008, BHOC published a report that noted the accomplishments of recent behavioral health reform efforts, but also contained findings and recommendations for future efforts. In its report, BHOC found that “many of the goals and responsibilities as set out in LB 1083 have not been accomplished.”⁵⁰ In June 2009, BHOC released its final report, which reiterated many of the issues noted in its 2008 report and called for the adoption of a statewide strategic plan for behavioral health.⁵¹

FINDING: BHOC found that “many of the goals and responsibilities as set out in LB 1083 have not been accomplished.”

With the elimination of BHOC in June 2009, there is no central entity providing a check on the high-level progress of the Division toward implementing the goals of LB 1083. As noted in a previous performance audit report, with the sunset of BHOC, there is no designated entity to review service reduction or discontinuation notices made by the Division.⁵²

Specialized Advisory Committees

LB 1083 also established two specialized behavioral health-related advisory committees: the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance

Abuse Services.⁵³ Members of both committees are appointed by the governor.

By law, the committees hold regular meetings and are charged with, among other duties, providing advice and assistance to the Division and promoting the interests of behavioral health consumers and their families. They are also required to provide reports and engage in other activities as directed by the Division.⁵⁴ Thus the committees, part of a behavioral health system designed to be responsive to individual consumers statewide, have a vital oversight role in that system.

Committee members develop recommendations during quarterly meetings attended by Division staff. The meeting agendas and minutes, posted on the DHHS Web site, typically identify any new recommendations as well as the Division's response to recommendations from prior meetings.⁵⁵ Generally, the Division responds to both committees' new recommendations at the following meeting.

FINDING: There are adequate mechanisms in existence to oversee the behavioral health delivery system; however some are not functioning as well as they should be. This is particularly concerning since the Behavioral Health Oversight Commission, which had the broadest oversight responsibility, has been eliminated.

Notes

¹ Neb. Rev. Stat. § 71-806 (1) (d).

² Meeting with Scot Adams, Sue Adams, Willard Bouwens, and Bob Zagozda, August 28, 2008.

³ Meeting with Scot Adams, Sue Adams, Willard Bouwens, and Bob Zagozda, August 28, 2008.

⁴ NAC Title 204, Chapter 4, 004 and NAC Title 203, Chapter 4, 006; Contract Number DHHSBH-09-REGION 1.

⁵ Written communication from Sue Adams, October 29, 2009.

⁶ Our review included both standard services purchased audits and those performed as part of the Division's Professional Partner Program for regional youth wraparound services.

⁷ Telephone conversation with Sue Adams, September 30, 2009.

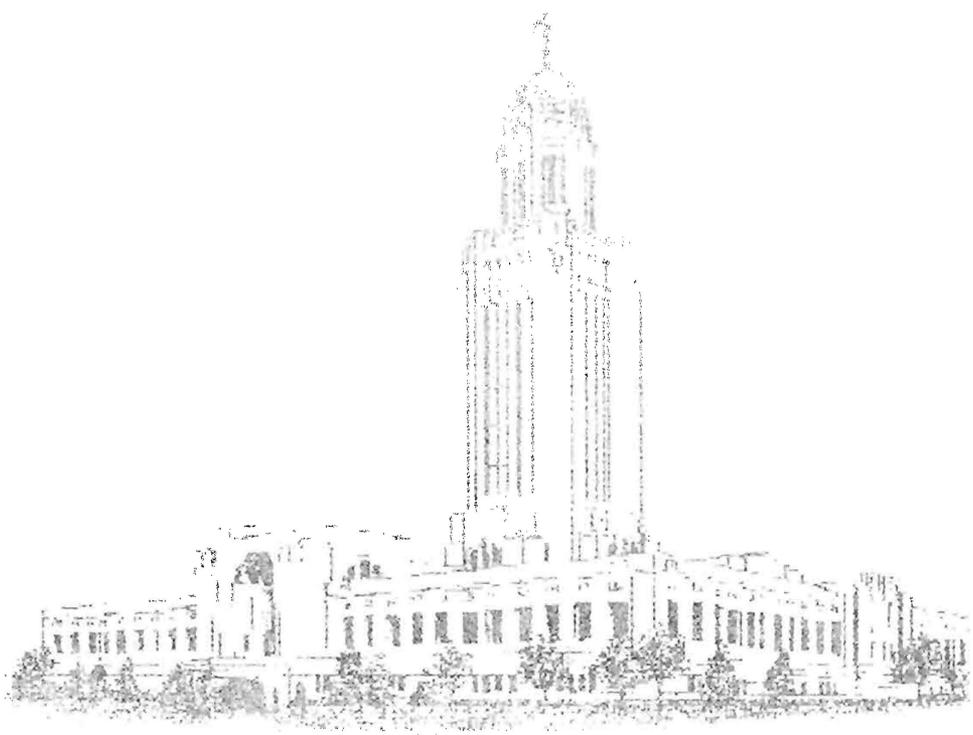
⁸ Written communication No. 2 from Sue Adams, October 27, 2009; written communication from Sue Adams, October 28, 2009.

-
- ⁹ Neb. Rev. Stat. §71-810 (7).
- ¹⁰ Neb. Rev. Stat. §71-810 (7) (a-h).
- ¹¹ Written communication from Sue Adams, October 30, 2009.
- ¹² Written communication from Sue Adams, October 30, 2009.
- ¹³ Written communication from Sue Adams, October 30, 2009.
- ¹⁴ Written communication from Sue Adams, October 30, 2009.
- ¹⁵ Written communication from Sue Adams, October 30, 2009; Neb. Rev. Stat. §71-810 (7) (h).
- ¹⁶ Nebraska Behavioral Health System Audit Orientation Workbook.
- ¹⁷ Regional Contract for Behavioral Health and Network Management Services, pg. 12. (Each region has the same components in its contract, including audit requirements, but the contracts are separate documents.)
- ¹⁸ Nebraska Behavioral Health System Audit Orientation Workbook.
- ¹⁹ Nebraska Behavioral Health System Audit Orientation Workbook.
- ²⁰ Regional Contract for Behavioral Health and Network Management Services, pg. 11. The contract allows regions to have approved “neutral” parties conduct these audits instead of DHHS.
- ²¹ Written communication from Sue Adams, October 27, 2009.
- ²² Meeting with Scot Adams, Vicki Maca, Sue Adams, and Bob Zagozda, April 2, 2009; Written communication from Sue Adams, October 27, 2009.
- ²³ Nebraska Behavioral Health System Audit Orientation Workbook.
- ²⁴ Written communication from Sue Adams, October 27, 2009.
- ²⁵ Meeting with Scot Adams, Vicki Maca, Sue Adams, and Bob Zagozda, April 2, 2009.
- ²⁶ Written communication from Sue Adams, October 27, 2009.
- ²⁷ In a meeting with Scot Adams, Vicki Maca, Sue Adams, and Bob Zagozda, April 2, 2009, we were told that if a region changes or revises its audit procedures, regional staff are required to report this to DHHS when they submit their annual budget plan.
- ²⁸ Meeting with Scot Adams and Sue Adams, May 6, 2009.
- ²⁹ Meeting with Scot Adams and Sue Adams, May 6, 2009.
- ³⁰ Technical Review Report: Performance Partnership Grant Core Technical Review, September 28, 2007, Division of State and Community Assistance Center for Substance Abuse Treatment, pgs. 3-4.
- ³¹ Technical Review Report: Performance Partnership Grant Core Technical Review, September 28, 2007, Division of State and Community Assistance Center for Substance Abuse Treatment, pg. 21.
- ³² Neb. Rev. Stat. §71-803 (3) (d).
- ³³ <http://www.dhhs.ne.gov/beh/mh/mhadvo.htm>
- ³⁴ Neb. Rev. Stat. §71-805(1-2).
- ³⁵ <http://www.dhhs.ne.gov/beh/mh/mhadvo.htm>
- ³⁶ Meeting with Scot Adams and Sue Adams, May 6, 2009.
- ³⁷ Meeting with Scot Adams and Sue Adams, May 6, 2009.
- ³⁸ Nebraska 2008 Behavioral Health Consumer Surveys Summary of Results, pg 1.
- ³⁹ Nebraska 2008 Behavioral Health Consumer Surveys Summary of Results, pg 6.
- ⁴⁰ Nebraska 2008 Behavioral Health Consumer Surveys Summary of Results, pg 7.
- ⁴¹ Meeting with Scot Adams and Sue Adams, May 6, 2009.
- ⁴² FY09 Regional Budget Plan Guidelines for Behavioral Health Services, pg. 13. The Division required each region to “identify the individual with responsibility for Regional Consumer and Family Systems Coordination” in its 2009 Budget Plan. The Uniform Application FY 2008—State Implementation Report, Community Mental Health Services Block Grant states that the regional consumer specialists were first required in 2007.
- ⁴³ Meeting with Scot Adams and Sue Adams, May 6, 2009.
- ⁴⁴ Meeting with Scot Adams and Sue Adams, May 6, 2009.
- ⁴⁵ Legislative History, LB 467 (2008), remarks by Sen. Mike Flood, January 17, 2008, pg. 46.
- ⁴⁶ Ibid., pg. 37.
- ⁴⁷ Neb. Rev. Stat. § 71-818.
- ⁴⁸ LB 928 (2008)
- ⁴⁹ Behavioral Health Oversight Commission of the Legislature Final Report - June 2008, pg. 1.
- ⁵⁰ Behavioral Health Oversight Commission, Final Report, June 2008.
- ⁵¹ Behavioral Health Oversight Commission, Final Report draft, June 22, 2009.
- ⁵² Department of Health and Human Services: Statutory Compliance in Closing the Lincoln Regional Center Community Transition, released _____.

⁵³ Neb. Rev. Stat. §71-814 and §71-815. Neb. Rev. Stat. §71-816(3-4) also establishes the State Committee on Problem Gambling.

⁵⁴ Neb. Rev. Stat. §71-814(2) and 71-815(2).

⁵⁵ Section staff reviewed the meeting minutes from both committees for the last two years. For the State Advisory Committee on Mental Health Services, we reviewed the meeting minutes from Aug. 7, 2007, to Nov. 4, 2008. The minutes were unavailable for the meetings of Feb. 6, 2007, May 1, 2007, Feb. 5, 2009 and May 7, 2009. For the State Advisory Committee on Substance Abuse Services, we reviewed the meeting minutes from Feb. 21, 2007, to Jan. 13, 2009.



III. Fiscal Analyst's Opinion

State of Nebraska

LEGISLATIVE COUNCIL



RECEIVED

NOV 24 2009

LEGISLATIVE AUDIT

Legislative Fiscal Office
PO Box 94604, State Capitol
Lincoln, NE 68509-4604

MEMO

TO: Martha Carter

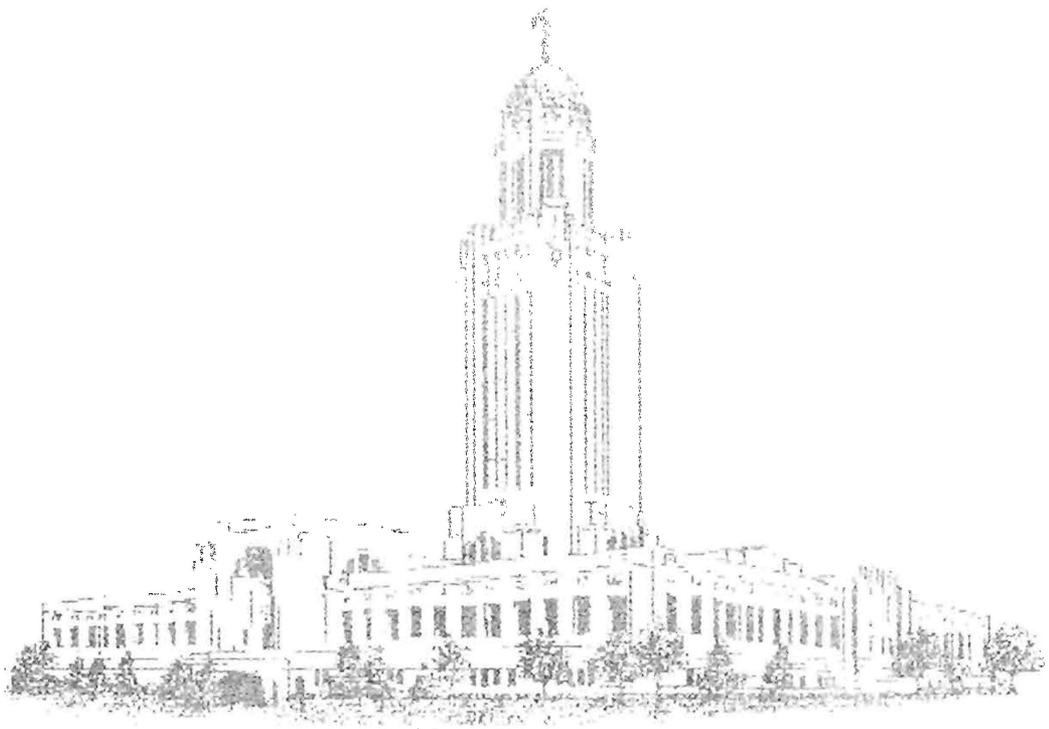
FROM: Michael Calvert and Sandy Sostad

RE: Performance Audit – Community-based Behavioral Health

DATE: November 23, 2009

This memo is in response to your request of November 2 asking for our opinion as to whether the recommendations from the performance audit on “Community-based Behavioral Health: Funds, Efficiency and Oversight” can be implemented with existing appropriations.

It appears to us that all of the recommendations can be implemented with existing staff and resources of the Department of Health and Human Services or the Auditor of Public Accounts.



IV. Background Materials

BACKGROUND MATERIALS

The “background materials” provided here are materials (in addition to the Section’s report) that were available to the Committee when it issued the findings and recommendations contained in Part III of this report. They include:

- the Section’s draft findings and recommendations (provided for context);
- the agency’s response to a draft of the Section’s report;
- the Legislative Auditor’s summary of the agency’s response.

Section V: Findings and Recommendations

Section II: Separation of Administrative and Service Funds

Finding #1: DHHS and the regional authorities differentiate in budget proposals and year-end accounting reports the funds spent on administrative costs from the funds spent for services.

Finding #2: Although regions do not require service providers to account separately for funds spent on administrative costs and service costs, larger providers in three regions do report separate figures.

Discussion: Assessing whether expenditures are being properly recorded as administrative or services is a financial audit function, which the Performance Audit Section is not authorized to undertake.

Recommendation: The Committee may wish to consider asking the Auditor of Public Accounts to assess whether the Division's and regions' expenditures for administration and delivery of services are being recorded appropriately.

Section III: Clarity and Efficiency of Administrative Responsibilities

Finding #3: Statute clearly delineates that the regions have some autonomy with regard to the services provided within their boundaries, but they must operate within a framework established by the Division.

Finding #4: Clarity of the responsibilities between the Division and the regions is likely harmed by the weaknesses in the Division's planning efforts identified by BHOC and the absence of updated regulations.

Discussion: Comprehensive planning for the delivery of an appropriate array of services across the state was a critical element of LB 1083's vision for shifting behavioral health care to community-based services. Similarly, properly promulgated regulations would provide uniform definitions and processes for the regions to follow.

Recommendation: The Performance Audit Committee may wish to establish statutory deadlines for the Division's completion of the comprehensive planning process and the updating of the regulations implementing LB 1083.

Finding #5: The responsibilities of the Division and regions with regard to the selection of service providers are efficient to the extent that the Division has appropriate processes in place.

Finding #6: The Division acknowledged one instance in which the Director deviated from the competitive bidding requirements due to a provider withdrawing mid-contract. This is a deviation that the Nebraska Behavioral Health Services Act does not appear to allow.

Discussion: Division representatives told us that they did not intend to deviate from the competitive bidding requirements in the future.

Recommendation: If a future need for such deviations arises, the Committee may wish to introduce legislation to allow them, for emergencies or other designated situations.

Finding #7: The Division's interpretation of the statute that allows regions to provide services in the absence of qualified bidders has created an extension of the grandfather clause because once a region begins providing a service, it never has to reopen the service to competitive bidding.

Discussion: This is a policy issue for the Committee's consideration.

Recommendation: If the Committee believes that services provided by region when competitive bidding fails to produce a qualified bidder should at some future point be put out for competitive bid, it may wish to introduce legislation to accomplish that.

Section IV: Oversight

CPA Audits

Finding #8: The regions complied with the requirements to have yearly financial audits.

Finding #9: The Division takes several steps to ensure audits of the regions are scheduled, conducted, and reviewed.

Recommendation: None.

Services Purchased Audits

Finding #10: The Division was not compliant with the contractual requirement to audit regionally provided services on a yearly basis. One of the six regions had no services purchased audits between 2005 and 2008.

Finding #11: This noncompliance also raises questions about the effectiveness of the Division's review and monitoring of the audit timeline submitted with regional budget plans.

Discussion: Division representatives told us they do not have enough staff to conduct all of the required audits. As the state is facing a significant budget deficit in the current biennium, this problem may get worse.

Recommendation: If the Division cannot complete all of the required services purchase audits, the Division should develop a plan that ensures some services in all regions are audited regularly.

Finding #12: Some regions' policies for conducting services purchased audits varied inappropriately from the Division's policies.

Discussion: It is within the Division's authority to ensure that the region's audit policies conform to minimum standards established by the Division.

Recommendation: The Division should immediately review the region's audit policies for all types of required audits and require regions to comply the Division's standards.

Program Fidelity Audits

Finding #13: The Division is substantially compliant with the requirement to conduct timely program fidelity audits of regionally-provided services.

Finding #14: All six regions had adequate procedures for program fidelity audits.

Recommendation: None.

Consumer Input

Finding #15: The Division conducts several consumer outreach activities, including an annual survey that suggests consumers are generally satisfied with the services they received.

Finding #16: The Division responds to recommendations from different consumer groups.

Data Reporting and Analysis

Finding #17: The Division is compliant with a requirement that it collect and report on the status of people in need of and receiving behavioral health services.

Finding #18: Division staff do not analyze program fidelity audit information to note trends in identified weaknesses for either specific providers or groups of providers.

Finding #19: The Division's lack of formal data analysis was noted as an area of concern in a 2007 review by the federal Center for Substance Abuse Treatment.

Finding #20: By not compiling consumer feedback from the helpline, the Division is missing an opportunity to increase consumer involvement in the behavioral health system.

Discussion: According to Division representatives, they review data from program fidelity audits and consumer outreach activities to identify immediate problems but do not compile and analyze the information to identify patterns or trends that develop over time.

Recommendation: The Division should develop a plan for increasing its analysis of audit results and consumer input. If such analysis cannot be conducted on all data every year, the Division should ensure that each type of data is analyzed at least every other year.

Oversight Generally

Finding #21: There are adequate mechanisms in existence to oversee the behavioral health delivery system; however some are not functioning as well as they should be. This is particularly concerning since the Behavioral Health Oversight

Commission, which had the broadest oversight responsibility, has been eliminated.

Recommendation: The Division should make additional efforts to ensure that the existing oversight mechanisms under its authority are used to their fullest extent.

Recommendation: The Committee may wish to consider having audit staff conduct intensive followup for a period of time to ensure that improvements in the oversight system occur.

December 3, 2009

RECEIVED

Martha Carter, Legislative Auditor
Legislative Audit and Research
State Capitol, Room 1201
Lincoln, NE 68509

DEC 03 2009

LEGISLATIVE AUDIT

Dear Ms. Carter:

Thank you for your recent report, "Community-based Behavioral Health: Funds, Efficiency, and Oversight," dated November 2, 2009.

I write to provide the Division of Behavioral Health (DBH) response. I will make some general comments then respond to the findings and recommendations. First, I appreciate the positive nature of this Report.

Second, the creation of multiple entities (regions and the DBH) allows each entity to address needs of the local consumers, while also taking into account the level of professional staff available since that factor and others differ across the state. Nebraska's behavioral health system continues to evolve over time as does any large system that strives to improve services to individuals. Thus, the goal is to achieve reasonable assurance of accountability, efficiency and oversight. These regional differences may account for the multiple responses that were provided to an inquiry from the LPAC, but does not by itself indicate system weakness or lack of oversight, though such multiplicity almost always makes management more complex.

Third, I would note that while the title of the draft report suggests a review of the entire community-based system, the report touches only upon the regions and DBH. The 2010 appropriation to DBH is approximately \$170 million. Program 038, Aid, is approximately \$100 million. Of this, approximately \$75 million is with the regions. The remainder (25%) is spent on other community-based services, which is not addressed in your report.

My response focuses on the Findings and Recommendations listed on page 27 of the draft report. I make no comment on 21 of the 32 Findings and Recommendations.

With regard to Finding 2, all agencies which receive an independent financial audit will separate out administrative costs from program costs for that agency according to generally accepted accounting principles. Thus, it is not accurate to note that these are not identified. Each agency and each region has this information, and while it may not be aggregated, there is not a business reason to do so.

With regard to Finding 4, I take exception to use of the phrase, "likely harmed." The report provides no basis for such a conclusion. It provides evidence of the variety with which each region approaches the issues. It should be noted that systems planning has been ongoing

and abundant during recent years. I would direct the reader to the DBH web site for documents in this category. In particular, I would urge attention to the annual Mental Health Block Grant application which provides a rich assortment of detail concerning the strengths, weakness, opportunities and threats facing the system while also focusing attention onto 17 specific goal areas, which reflect growth, change and accomplishment. Regions have taken this information and do have strategic plans which address the unique needs of the consumers in their region.

Further, DBH has had a contract with the University of Nebraska to facilitate a statewide strategic planning process since November, 2008. Additional considerations have caused the delay of this process, but not to the harm of the system. Some of these considerations have included an offer from the private sector to conduct a strategic planning process, national healthcare reform debate, and the downturn of the economy in the nation and Nebraska.

DBH has coordinated its efforts with the Division of Medicaid and Long-Term Care (DMLTC) so that DBH and DMLTC regulations are considered jointly for the public to focus its attention to the relationship between both sets. The regulations in DBH have been revised five times to address issues raised by stakeholders and further meetings continue to coordinate with the DMLTC regulations to provide consistency across the agency. This is significant work that has taken considerable time and received much public input. We continue to receive input as late as last week.

With regard to the Recommendations associated with Findings 3 and 4, we expect the revised rules and regulations to be completed in early 2010.

With regard to Finding 6, as I was not the director during this time period, I cannot speak to what circumstances or considerations led to the deviation from the competitive bidding requirements. DHHS could not find a prohibition in statute for the Director's actions. Sections 71-805, 71-806 and 204 NAC Chapter 2 grants the Director broad accountability to "integrate and coordinate the public behavioral health system." While it was an unusual action, it appears to have best served the system's emergency needs in that particular area at that time. If current law doesn't allow for handling such emergencies, the law could be revised.

With regard to Finding 10 & 11, I would like to note that all FY 2010 audits have been scheduled with regions. Staff reductions during prior years did hamper the DBH capacity to perform all of its assigned functions, notably, 5 (all managers) of 27 positions (including support positions) were eliminated between 2005 and 2008, exactly the period of behavioral health reform implementation. At the same time, funding to regions increased by nearly 50%. Workloads and resource trends were in opposition to one another. Recent reorganizations have helped. Present budget reductions increase the need for DBH to give priority to all functions expected of it, focusing attention onto the most important areas.

With regard to Finding 12, we believe the audits met minimum standards yet we do not require uniformity. This is not to say that any one of these approaches is “inappropriate” or wrong. The majority of services audits are complete. Regions are in compliance. Nothing of substantial concern was reported.

With regard to Finding 18, we believe that DBH staff do compile and analyze program fidelity information to note trends. Conversations about program performance form the heart of working agendas for the Division Quality Improvement Team (DQIT), Magellan Quality Improvement Team (MQIT), and Statewide Quality Improvement Team (SQIT). These data improvement teams involve regions, providers, consumers, and Magellan. Minutes with analysis therein are available. These teams have been working since 2007 and earlier under various other names.

With regard to Finding 19, the 2007 Corrective Action Plan noted a multitude of actions that were the result of analysis in this area. The State is not now within a Corrective Action relationship with CSAT/SAMHSA. This Finding is dated.

With regard to Finding 20, we believe that DBH compiles consumer data from the annual conference. Phyllis McCaul has done this.

With regard to the Recommendation for these Findings, the DBH continues to increase still further the level of consumer involvement in these and other activities in the wake of the hiring of Carol Coussons de Reyes, the new Administrator for the Office of Consumer Affairs in May, 2009. DBH wishes to note that a Quality Improvement Team has been established within the past 2 years. Its activities relate to regions, Magellan, providers, consumers, regional centers, and the federal government. All quality processes are coordinated within this team. From these processes, we see improvements to data – its collection, analysis, and distribution - on an ongoing basis.

In conclusion, the Division appreciates the work of the audit team and its efforts over the past eight months. We believe the report is more complete with this response. We understand that in such a complex system, not all priorities will be shared and valued alike. The report serves as a basis for public discussion of the type of community based behavioral health system the citizens of Nebraska may want to develop and to fund in the future.

Very truly yours,



Scot L. Adams, Ph.D., Director
Division of Behavioral Health
Department of Health and Human Services

Legislative Performance Audit

Committee

Committee Members:
Senator John Harms, Chair
Senator Danielle Conrad, Vice Chair
Speaker Mike Flood
Senator Lavon Heidemann
Senator Arnie Stuthman
Senator Dennis Utter
Senator John Wightman

Legislative Audit Office
P.O. Box 94945, State Capitol
Lincoln, NE 68509-4945
402-471-2221

Section Staff:
Martha Carter, Legislative Auditor
Don Arp, Jr., Analyst
Clarence Mabin, Analyst
Dana McNeil, Analyst
Stephanie Meese, Legal Counsel
Sandy Harman, Committee Clerk

December 22, 2009

Mr. Scot Adams, Director
Division of Behavioral Health
Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Dear ~~Mr. Adams:~~
Scot

Thank you for your written response to the draft report titled *Community-based Behavioral Health: Funds, Efficiency, and Oversight*. There are three topics addressed in your report that contain new or different information from what our staff were told during the audit. We will need additional information on these topics as explained below.

Finding 4 and Discussion: Clarity of the responsibilities between the Division and the regions is likely harmed by the weaknesses in the Division's planning efforts identified by BHOC and the absence of updated regulations. Comprehensive planning for the delivery of an appropriate array of services across the state was a critical element of LB 1083's vision for shifting behavioral health care to community-based services. Similarly, properly promulgated regulations would provide uniform definitions and processes for the regions to follow.

Division Response (in part): DBH has had a contract with the University of Nebraska to facilitate a statewide strategic planning process since November, 2008. Additional considerations have caused the delay of this process, but not to the harm of the system. Some of these considerations have included an offer from the private sector to conduct a strategic planning process, national healthcare reform debate, and the downturn of the economy in the nation and Nebraska.

Audit staff comment: We were not told about this contract during the course of the audit.

Finding 18: Division staff do not compile or analyze program fidelity audit information to note trends in identified weaknesses for either specific providers or groups of providers.

Division Response: We believe that DBH staff do compile and analyze program fidelity information to note trends. Conversations about program performance form the heart of working agendas for the Division Quality Improvement Team (DQIT), Magellan Quality Improvement Team (MQIT), and Statewide Quality Improvement Team (SQIT). These data improvement teams involve regions, providers, consumers, and Magellan. Minutes with analysis therein are available. These teams have been working since 2007 and earlier under various other names.

Audit staff comment: This response is different from what we were told during the audit, when DHHS representatives told us that they do not look for trends in the program fidelity data. At a May 6, 2009, meeting, DHHS staff said that they would use a program fidelity audit to see if a region was struggling. Audit staff asked if DHHS analyzed the results of the audits in any way, to which the Division director said that this is a regional function and should be done on that level as problems with providers would impact whether their contracts are renewed through the regions. Audit staff also asked if the audit information was used to look at whether a Region has a tendency to pick bad providers. Division staff said that they are concerned about outcomes—how many people have been helped, served—and not about the process.

Finding 20 and Discussion: By not compiling consumer feedback from the annual conference and helpline, the Division is missing an opportunity to maximize consumer involvement in the behavioral health system. According to Division representatives, they review data from program fidelity audits and consumer outreach activities to identify immediate problems but do not compile and analyze the information to identify patterns or trends that develop over time.

Division Response: We believe that DBH compiles consumer data from the annual conference. Phyllis McCaul has done this.

Audit staff comment: During a May 6, 2009 meeting, audit staff asked Division staff if they gather input from consumers at the conference and report on it in any way. The Division director said that attendees fill out written evaluation forms, but said there's no formal report on the conference. Division staff made no mention of any compilations done by Ms. McCaul.

Additional Information Request

In order for us to determine whether changes need to be made to the draft report, please provide us with:

- all materials produced out of the Division's contractual relationship with the University;
- minutes and any other documentation of the analyses conducted related to program fidelity audits; and
- Ms. McCaul's most recent compilations of consumer feedback.

Please also explain in your response why this information was not provided to us during the course of the audit.

We would appreciate receiving your response by January 8, 2009, if possible. If you have any questions, please contact me at 471-0072 or Don Arp at 471-0040.

Sincerely,



Martha Carter
Legislative Auditor

cc: Performance Audit Committee members

January 6, 2010

Martha Carter, Legislative Auditor
Legislative Audit and Research
State Capitol, Room 1201
Lincoln, Ne 68509



Dear Ms. Carter:

I write in response to your letter of December 22, 2009 seeking additional information on the Draft Report entitled, Community Based Behavioral Health: Funds, Efficiency and Oversight. Additional information that you requested is provided in attachments.

Your first topic involves planning efforts by the Division of Behavioral Health (DBH). The requested draft documents from the University concerning strategic planning are enclosed, as are other documents related to planning done by DBH, as Appendix A.

The topic of strategic planning was discussed with the Behavioral Health Oversight Commission and with regions during the past year. The issue also was discussed with the staff of the Legislative Performance Audit Committee (LPAC). We mentioned we had been preparing to engage overall strategic planning, though I do not recall if we discussed the relationship with the University specifically. We mentioned the original documents and plans from the implementation phase of LB 1083, which are still available on the DHHS web site. We also said that some of the regions have conducted their own strategic planning efforts. The DBH supports the regions' efforts to create plans that address their specific regional needs and resources. Thus, the Nebraska Behavioral Health System – the composite of the DBH, regions, network providers and consumers – has a wide variety of planning processes. Our discussions with LPAC staff were intended to illustrate that planning is conducted in many ways and levels.

My concern is that the word “harmed” seemed to have little solid basis, as no harm was identified.

The next topic in your letter involved the analysis of audit data. Additional information related to analysis of data is enclosed as Appendix B.

This issue may reflect a difference of understanding of the focus of audits specifically and the oversight function more generally. Audits are reviewed internally by staff. Significant information goes through the quality processes as noted in our response, such that the phrase “does not ... analyze...” seems to us to be inaccurate.

Martha Carter
January 6, 2010
Page 2

Additionally, I believe that I said the DBH is "...concerned about outcomes and LESS about the process," rather than "not" concerned as written in the draft report. I wish also to note that the examples I am cited as having said are not outcomes, but process objectives, and indicate that we did indeed talk about concern for process.

I thought it important to provide additional, specific, information to improve the Draft Report's accuracy.

Additional information in Appendix B complements that provided to LPAC staff during its interview process and nothing in this letter is intended to negate those comments.

I believe this issue highlights a fundamental dynamic at play. The interplay between the DBH and the regions is complex. At times we are a unified system, at other times we act competitively. Both relationships are appropriate depending on the specific situation and are sanctioned in statute. I believe the Draft Report presents an overly simplified approach to these dynamics, perhaps causing some misinterpretation of the issues noted herein.

The third topic you identify related to compilation of data from the annual consumer conference and helpline. Ms. McCaul's report is enclosed as Appendix C. I simply did not think of this report at the time of the interview. The larger topic at the time was whether or not consumers have input to the DBH as part of a balanced oversight and monitoring function described in LB 1083 and this had already been amply documented with your staff. In this light, the Finding was a surprise and caused me to review our files.

Thank you for your efforts to help us improve the publically-funded behavioral health system in Nebraska.

Very truly yours,

A handwritten signature in black ink, appearing to read "Scot L. Adams", written over a horizontal line.

Scot L. Adams, Ph.D., Director
Division of Behavioral Health
Department of Health and Human Services

Enclosures:

LEGISLATIVE AUDITOR'S SUMMARY OF AGENCY RESPONSE

This summary meets the statutory requirement that the Legislative Auditor “prepare a brief written summary of the response, including a description of any significant disagreements the agency has with the Section’s report or recommendations.”¹

On December 3, 2009, the Director of the Department of Health and Human Service Division of Behavioral Health (Director) submitted the agency’s response to a draft of the Performance Audit Section’s audit report. The Director’s response disagreed with a number of findings and other statements contained in the draft report. The response also included new information that had not been provided during the data gathering portion of the audit as well as some information that directly contradicted what we were told during that time. Following receipt of the Director’s response, we requested additional information on some of the new items and received that information on January 8, 2010.

Before discussing the remaining substantive issues, we note for the Committee that receiving new or contradictory information in the agency’s response to a draft report decreases the efficiency of the audit process. It causes additional work for both the agency and the audit staff that could have been avoided if the full and correct information had been provided during the data gathering phase of the audit.

A detailed response to each of the Director’s concerns is attached to this response. What follows is a description of the substantive areas in which remain in disagreement with the Director.

Need for a Strategic Plan and Up-to-Date Regulations

The draft report contained a finding that the absence of a statewide comprehensive strategic plan for service delivery and out-of-date regulations “likely harmed the clarity of responsibilities between the Division and the regions.” The Director disagreed with this finding, citing a lack of evidence to support it. However, the draft report cited (1) representatives of some behavioral health regions, one of whom suggested that the absence of a strategic plan “creates a void in vision, direction, and leadership” and (2) the final report of the Behavioral Health Oversight Commission, created by the Legislature to oversee implementation of LB 1083, which criticized the absence of a “comprehensive statewide plan for behavioral health services.”

In addition, although we did not raise this issue in the draft report, the manner in which the Division closed the Lincoln Regional Center Community Transition Program (CTP) also demonstrates the lack of clarity caused by the absence of a comprehensive statewide strategic plan and current regulations. The Director has publicly stated that the closing of CTP was long envisioned by the Department as part of the LB 1083 implementation. Had a comprehensive statewide plan for services been in place, it presumably would have included the expected closing of this program, allowing consumers and providers to plan accordingly. In-

¹ Neb. Rev. Stat. sec. 50-1210.

stead, the closing came as a surprise to many. In addition, had the regulations been updated, there might well have been less confusion about whether or not the treatment provided through CTP constituted a “service” and if it triggered a requirement for legislative notification.²

In his written response, the Director explains that the proposed regulations have been subject to considerable public input. Specifically, he states that:

DBH has coordinated its efforts with the Division of Medicaid and Long-Term Care (DMLTC) so that DBH and DMLTC regulations are considered jointly for the public to focus its attention to the relationship between both sets. The regulations in DBH have been revised five times to address issues raised by stakeholders and further meetings continue to coordinate with the DMLTC regulations to provide consistency across the agency.

Audit staff appreciate the importance of obtaining input in developing regulations but question whether the formal rulemaking process—which requires a public hearing and the Attorney General’s approval of an agency’s interpretation of the statutes—should be delayed almost six years beyond a statute’s enactment. The absence of official regulations for several years leaves those who must comply with the law without the detailed guidance regulations are intended to provide.

Director’s Discretion

The draft report also contain a finding (#6) that in one instance a previous Director had essentially waived statutory competitive bidding requirements when a provider stopped providing services while still under contract. The report noted that such a deviation does not appear to be authorized under the Nebraska Behavioral Health Services Act. Audit staff recommended that if the Legislature wants the Director to make such exceptions in emergency cases, it should authorize it explicitly.

The Director disagreed with this finding, stating that “DHHS could not find a prohibition in statute for the Director's actions. Sections 71-805, 71-806 and 204 NAC Chapter 2 grants the Director broad accountability to “integrate and coordinate the public behavioral health system.””

We disagree with the Director’s interpretation that the broad authority to “integrate and coordinate the public behavioral health system” allows the director to bypass statutory controls on competitive bidding. Taken to the extreme, this interpretation would allow a Director to avoid *any* statutory requirement simply by claiming that the violation was necessary for the integration and coordination of the system. We stand by our recommendation that if the Legislature’s believes the Director should have such authority, it should adopt legislation to explicitly grant it.

² Additional issues related to closure of the CTP program are discussed in the report “HHS Statutory Compliance in Closing the Lincoln Regional Center Community Transition Program.”

Attachment: Additional Information Relating to the Agency Response to the Draft Behavioral Health Audit Report

Line #	Draft Report Language	DHHS Response Letter	Audit Staff Response
1		Third, I would note that while the title of the draft report suggests a review of the entire community-based system, the report touches only upon the regions and DBH. The 2010 appropriation to DBH is approximately \$170 million. Program 03 8, Aid, is approximately \$100 million. Of this, approximately \$75 million is with the regions. The remainder (25%) is spent on other community-based services, which is not addressed in your report.	The title accurately reflects the review conducted, which was dictated by the concerns of the Committee relating to DHHS and the regions.
2	Finding #2: Although regions do not require service providers to account separately for funds spent on administrative costs and service costs, larger providers in three regions do report separate figures.	With regard to Finding 2, all agencies which receive an independent financial audit will separate out administrative costs from program costs for that agency according to generally accepted accounting principles. Thus, it is not accurate to note that these are not identified. Each agency and each region has this information, and while it may not be aggregated, there is not a business reason to do so.	This response directly contradicts what we were told by a representative of each region during the audit. A few regions told us that noted that larger providers make this distinction; however others noted there is no requirement in budget plan guidelines to differentiate between the administrative costs and service costs of the providers. And although DHHS believes there is no “business reason to do so,” aggregating information that allows for a comparison between budgeted administrative costs versus actual administrative costs over time could provide for the detection of improper administrative fees and provide a safeguard that money allocated for services is not being depleted by administrative costs.
	Finding 4 regarding strategic planning.	Further, DBH has had a contract with the University of Nebraska to facilitate a statewide strategic planning process since November, 2008. Additional considerations have caused the delay of this process, but not to the harm of the system. Some of these considerations have included an offer from the private sector to conduct a strategic planning process, national healthcare reform debate, and the downturn of the economy in the nation and Nebraska.	Department representatives did not mention this contract during the audit. After learning about it in the Division’s response to the draft audit report, we requested, and the Division provided, additional information it. We note that the contract simply provides for the University to facilitate “strategic planning meetings”; it contains no objective for development of a comprehensive strategic plan.

Line #	Draft Report Language	DHHS Response Letter	Audit Staff Response
	<p>Finding #10: The Division was not compliant with the contractual requirement to audit regionally provided services on a yearly basis. One of the six regions had no services purchased audits between 2005 and 2008.</p> <p>Finding #11: This noncompliance also raises questions about the effectiveness of the Division's review and monitoring of the audit timeline submitted with regional budget plans.</p>	<p>With regard to Finding 10 & 11, I would like to note that all FY 2010 audits have been scheduled with regions. Staff reductions during prior years did hamper the DBH capacity to perform all of its assigned functions, notably, 5 (all managers) of 27 positions (including support positions) were eliminated between 2005 and 2008, exactly the period of behavioral health reform implementation. At the same time, funding to regions increased by nearly 50%. Workloads and resource trends were in opposition to one another. Recent reorganizations have helped. Present budget reductions increase the need for DBH to give priority to all functions expected of it, focusing attention onto the most important areas.</p>	<p>The Division's plan to accomplish of the statutorily required reviews in FY 2010, which we support, does not alter the fact that those requirements were not met in the past.</p>
	<p>Finding #12: Some regions' policies for conducting services purchased audits varied inappropriately from the Division's policies.</p>	<p>With regard to Finding 12, we believe the audits met minimum standards yet we do not require uniformity. This is not to say that any one of these approaches is "inappropriate" or wrong. The majority of services audits are complete. Regions are in compliance. Nothing of substantial concern was reported.</p>	<p>The variation in audit standards reported in the draft report were allowing two regions to use an error rate that was <i>double</i> the rate used by the other four regions, and allowing one region to use a policy that contained no sanction policy. We continue to believe that these are, in fact, inappropriate variations and despite the Director's statement to the contrary, he provides no good reason why these elements should not be uniform.</p>
	<p>Finding #18: Division staff do not compile or analyze program fidelity audit information to note trends in identified weaknesses for either specific providers or groups of providers.</p>	<p>With regard to Finding 18, we believe that DBH staff do compile and analyze program fidelity information to note trends. Conversations about program performance form the heart of working agendas for the Division Quality Improvement Team (DQIT), Magellan Quality Improvement Team (MQIT), and Statewide Quality Improvement Team (SQIT). These data improvement teams involve regions, providers, consumers, and Magellan. Minutes with analysis therein are available. These teams have been working since 2007 and earlier under various other names.</p>	<p>This response directly contradicts what DHHS representatives told us during the audit. At a May 6, 2009, meeting, DHHS staff told us that they would use a program fidelity audit to see if a region was struggling. Audit staff asked if DHHS analyzed the results of the audits in any way, to which the Division director said that this is a regional function and should be done on that level as problems with providers would impact whether their contracts are renewed through the regions. Audit staff also asked if the audit information was used to look at whether a Region has a tendency to pick bad providers. Division staff said that they are concerned about outcomes—how many people</p>

Line #	Draft Report Language	DHHS Response Letter	Audit Staff Response
			have been helped, served—and not about the process.
	Finding #19: The Division's lack of formal data analysis was noted as an area of concern in a 2007 review by the federal Center for Substance Abuse Treatment.	With regard to Finding 19, the 2007 Corrective Action Plan noted a multitude of actions that were the result of analysis in this area. The State is not now within a Corrective Action relationship with CSATISAMHSA. This Finding is dated.	The report was cited to show a trend in DHHS practice.
	Finding #20: By not compiling consumer feedback from the annual conference and helpline, the Division is missing an opportunity to maximize consumer involvement in the behavioral health system.	With regard to Finding 20, we believe that DBH compiles consumer data from the annual conference. Phyllis McCaul has done this.	This response directly contradicts what DHHS representatives told us during the audit. During a May 6, 2009, meeting, audit staff asked Division staff if they gather input from consumers at the conference and report on it in any way. The Division director said that attendees fill out written evaluation forms, but said there's no formal report on the conference. Division staff made no mention of any compilations done by Ms. McCaul.
	Recommendation: The Division should develop a plan for increasing its analysis of audit results and consumer input. If such analysis cannot be conducted on all data every year, the Division should ensure that each type of data is analyzed at least every other year.	With regard to the Recommendation for these Findings, the DBH continues to increase still further the level of consumer involvement in these and other activities in the wake of the hiring of Carol Coussons de Reyes, the new Administrator for the Office of Consumer Affairs in May, 2009. DBH wishes to note that a Quality Improvement Team has been established within the past 2 years. Its activities relate to regions, Magellan, providers, consumers, regional centers, and the federal government. All quality processes are coordinated within this team. From these processes, we see improvements to data - its collection, analysis, and distribution - on an ongoing basis.	Again, the audit response was the first mention of this quality improvement team.

Note: Concerns raised relative to findings 4 and 6 are addressed in the memo that accompanies this table.

Performance Audit Committee Reports: 1994 to 2010

- Department of Health and Human Services: Statutory Compliance in Closing the Lincoln Regional Center Community Transition Program (November 2009)
- Department of Economic Development's Job Training Grant Program: Statutory Compliance (November 2009)
- The State Foster Care Review Board: Authority, Conflicts of Interest, and Management Practices (December 2008)
- Personal Services Contracts: An Examination of Compliance and Oversight (October 2008)
- The Nebraska Information Technology Commission: An Examination of Statutory Compliance and the Project Review Process (November 2007)
- The Nebraska Lottery's Implementation of LB 1039 (February 2007)
- The State Department of Education's Student-based Teacher-led Assessment and Reporting System (February 2007)
- The Lincoln Regional Center's Sex Offender Services Program (August 2006)
- The Public Employees Retirement Board and the Nebraska Public Employees Retirement Systems: An Examination of Compliance, PIONEER, and Management (August 2006)
- The Nebraska Medicaid Program's Collection of Improper Payments (May 2005)
- The Lincoln Regional Center's Billing Process (December 2004)
- Nebraska Board of Parole (September 2003)
- Nebraska Department of Environmental Quality: Administering the Livestock Waste Management Act (May 2003)
- HHSS Personal-Services Contracts (January 2003)
- Nebraska Habitat Fund (January 2002)
- State Board of Agriculture (State Fair Board) (December 2001)
- Nebraska Environmental Trust Board (October 2001)
- Nebraska Department of Roads: Use of Consultants for Preconstruction Engineering (June 2001)
- Department of Correctional Services, Inmate Welfare Fund (November 2000)
- Bureau of Animal Industry: An Evaluation of the State Veterinarian's Office (March 2000)
- Nebraska Ethanol Board (December 1999)
- State Foster Care Review Board: Compliance with Federal Case-Review Requirements (January 1999)
- Programs Designed to Increase The Number of Providers In Medically Underserved Areas of Nebraska (July 1998)
- Nebraska Department of Agriculture (June 1997)
- Board of Educational Lands and Funds (February 1997)
- Public Service Commission: History of Structure, Workload and Budget (April 1996)
- Public Employees Retirement Board and Nebraska Public Employees Retirement Systems: Review of Compliance-Control Procedures (March 1996)
- Leaking Underground Storage Tank Program (December 1995)
- School Weatherization Fund (September 1995)
- The Training Academy of the Nebraska State Patrol and the Nebraska Law Enforcement Training Center (September 1995)
- Nebraska Equal Opportunity Commission (January 1995)
- The Interstate Agricultural Grain Marketing Commission (February 1994)

Nebraska State Legislature

SENATOR TIM GAY

District 14
1001 Hogan Drive
Papillion, Nebraska 68046

Legislative Address:
State Capitol
PO Box 94604
Lincoln, Nebraska 68509-4604
(402) 471-2730



COMMITTEES

Chairperson - Health and Human Services
Transportation and Telecommunications

May 19, 2010

Senator John Harms, Chairman
Legislative Performance Audit Committee
Nebraska Legislature
Nebraska State Capitol
1445 K Street
Room 2017
Lincoln, NE 68509

Dear Senator Harms,

We are in receipt of the report dated April 2010, Committee Report, Vol. 16, No. 3 entitled "Community-Based Behavioral Health: Funds, Efficiency and Oversight". Thank you for conducting a thorough audit of several areas in the behavioral health system.

Of particular interest is the recognition, in numerous areas of the report, of the lack of a strategic plan on the part of the Department of Health and Human Services Division of Behavioral Health. We echo these concerns and would like to take this opportunity to update you on our involvement in trying to further the strategic planning process.

Rhonda Hawks served as the Chair of the Behavioral Health Oversight Commission (BHOC) from July 1, 2008 through June 30, 2009. (See Final Report of BHOC attached.) The charter which was adopted in August of 2008 for the BHOC was to "provide a Strategic Vision for behavioral health for the state of Nebraska recognizing limited resource availability and the importance of an environment of recovery for all behavioral health consumers." During its term, the BHOC adopted three areas of strategic focus which are highlighted in the document. It is our view that in the absence of a strategic plan by the Department of Health and Human Services Division of Behavioral Health we would continue to experience the problems identified in the performance audit report.

When the BHOC report was distributed in June, 2009, Rhonda Hawks, Howard Hawks and Ken Stinson offered to mobilize the private sector to provide financial resources and professional support by seeking out and paying for those with expertise and objectivity to

facilitate a strategic planning process that would lead various stakeholders in a discussion of what we have and what we need, per the guidelines offered by the BHOC.

To further the strategic planning process, Open Minds, a consulting firm that is well regarded for its national expertise in behavioral health, was hired by the Behavioral Health Support Foundation (a private sector foundation whose principals are the Stinsons and Hawks). Open Minds conducted a Consensus Panel process during the period of December, 2009 through its conclusion in March, 2010. A broad group of stakeholders invited to participate in the Consensus Panel included 26 representatives of these varied groups:

- Consumers (2);
- All Regional Program Administrators (6);
- State Division of Behavioral Health and Medicaid representatives (2);
- Community-Based Agency Leaders (12);
- UNMC Psychiatrist (1);
- Hospital Executives (2);
- Private Sector Leader (1).

The Consensus Panel was led by the CEO of Open Minds and focused on priorities within the behavioral health system across the state of Nebraska and garnered critical input, lively discussion and support from the Consensus Panel. Voting was utilized to agree on the three top priorities that should be the focus of a strategic plan:

1. Assure accountability of the behavioral health system by developing performance measurement for best use of funding. In this way, programs that have the most successful outcomes are funded; thus, “the most bang for the buck” services are maintained.
2. Develop standards for timely access to behavioral health services for all Nebraskans. What are acceptable wait times to enter various services? This analysis results in more efficient use of services; there may or may not be a shortage of services; some collaborations may result from this analysis to streamline delivery of services to consumers.
3. Optimize the use of available funding for the behavioral health services by initiating regulatory reform to reduce redundant costs and burdens in the delivery system. This is meant to capture the cost savings associated with eliminating duplicative audits; inconsistency in credentialing of staff between federal and state standards, etc.

The information compiled through this process is in the Nebraska Behavioral Health System Strategic Planning Report commissioned by the Behavioral Health Support Foundation prepared by Open Minds dated March 15, 2010. The report is included for your information.

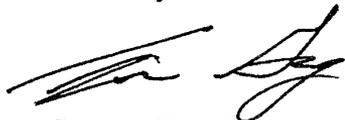
In April, with input from several members of the Health and Human Services Committee and the Legislative Performance Audit Committee, Senator Gay introduced an interim study, LR 513. LR 513 directs the Health and Human Services Committee of the

Legislature to address the Division's completion of a strategic plan including the three focus areas highlighted above.

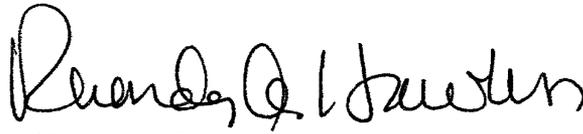
After several conversations, we have concluded both our respective goals could be met with the assistance of the Behavioral Health Support Foundation who has agreed to engage Open Minds to fully develop the three focus areas of a strategic plan as established by the Consensus Panel. We believe this is a great example of public/private partnerships that aim to help the state determine funding and service delivery priorities in a challenging economic environment.

If you have any questions, please call either Senator Gay at 402-643-2739 or Rhonda Hawks at 402-691-9518.

Sincerely,



Senator Tim Gay
Chair, HHS Committee



Rhonda A. Hawks
Principal, Behavioral Health Support
Foundation

CC.: Governor Dave Heineman
Kerry Winterer, CEO DHHS
Senator Kathy Campbell
Senator Annette Dubas
Senator Jeremy Nordquist
Martha Carter, Legislative Auditor



**Scope of Work
Create A Regulatory Reform Initiative To Reduce
Administrative Costs
For The Behavioral Health Support Foundation**

June 7, 2010

Following the recent Nebraska Behavioral Health System's strategic planning initiative, the *OPEN MINDS* team identified the need to create a regulatory reform initiative to reduce administrative costs throughout the Nebraska Behavioral Health System. The focus of this initiative is to assure that regulatory rules, as established in administrative rule and statute, be coordinated as much as possible and that duplicative or uncoordinated and conflicting rules are modified.

This proposal outlines an approach and methodology for identifying specific rules and regulations that could be streamlined to reduce the administrative costs of the Nebraska Behavioral Health System without negatively affecting quality.

Proposed Workplan & Timeline

In order to establish regulatory reform that supports the delivery system, the *OPEN MINDS* team will convene the Nebraska Consensus Panel and facilitate a discussion to develop a master list of high cost regulations and legal requirements and will prioritize that list in terms of system costs. This information will be analyzed to determine whether DBH and/or Medicaid rule changes are needed for Nebraska and whether legislative action is required.

The following page outlines *OPEN MINDS* proposed approach, methodology, and timeline to conducting this initiative.

Project Activity	Estimated Timeline
1. <i>OPEN MINDS</i> will develop a communication for stakeholder public comment on regulatory reforms that would specifically result in system savings and efficiencies- request that representatives from DBH, provider organizations, regional directors and psychiatrists submit at least two issues related to regulatory relief	June 18, 2010
2. <i>OPEN MINDS</i> will summarize submissions from stakeholders to prepare for on-site meeting on regulatory reforms that would specifically result in system savings and efficiencies	June 25, 2010
3. <i>OPEN MINDS</i> will facilitate a one-day on-site meeting with the Nebraska Consensus Panel to review the summary of regulatory issues and prioritize regulatory reform recommendations. These recommendations would likely fall into three categories: <ul style="list-style-type: none"> ▪ Medicaid regulatory changes for consideration ▪ DBH regulatory changes for consideration ▪ Legislative initiatives for consideration ▪ Licensing and credentialing 	July 14, 2010
4. <i>OPEN MINDS</i> will develop a summary report on regulatory reform including: <ul style="list-style-type: none"> ▪ A listing of areas of regulatory duplication ▪ Proposed Medicaid regulatory changes ▪ Proposed Division of Behavioral Health regulatory administrative rule changes ▪ Legislative initiatives requiring statutory changes 	July 23, 2010
5. <i>OPEN MINDS</i> will convene a half-day meeting with the Nebraska Consensus Panel to review the final summary report.	August 5, 2010

Engagement Fees:

The estimated cost of creating system regulatory reform and legislative initiatives is \$34,000, including expenses.

