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November 30, 2015

Legislative Performance Audit Committee releases report on the Nebraska Behavioral Health System

Committee to require a comprehensive needs assessment
and ongoing legislative oversight

An audit of the Nebraska Behavioral Health System, released Monday by the Legislative Performance Audit Committee, found the need for additional study of ways to reduce the behavioral health service gaps identified in the report. The Committee recommended additional study of the need for additional intermediate or "step-down" services for individuals being discharged from inpatient settings; exploring options for increased flexibility in funding; and whether the recommendations in an assessment completed by Tri-West consulting group for behavioral health Region 6, are applicable to service gaps in the other five regions.

The Committee criticized the Department of Health and Human Services, Division of Behavioral Health (Division) for failing to complete a comprehensive needs assessment required in behavioral health reform legislation (LB 1083, 2004), and said it will draft legislation to reinforce the requirement for such an assessment. The Committee will also introduce a legislative resolution to create an ongoing legislative behavioral and mental health oversight committee.

In its response to the draft audit report, the Department of Health and Human Services stated that it is important to note that efforts have been made to address the gaps mentioned in the report, but acknowledged there was much more work to be done.

Concerns about identifying service gaps remaining after the state's 2004 transition to community-based services, prompted the audit, which was authorized in February. The main audit questions were whether Behavioral Health Regions 1 through 5 have adult behavioral health service gaps similar to those identified for Region 6 in a January 2015 report released by Tri-West, and what DBH's role is in reducing or eliminating them.

Senator Dan Watermeier, Chairman of the Performance Audit Committee said, "The Committee believes additional attention is needed to improve behavioral health services by addressing the gaps identified in this report. A statewide assessment of needs, as required by LB 1083 more than 10 years ago, is critical for determining more precisely which services are needed in each region of the state. While the Division is taking some steps to identify those needs, additional legislative oversight is important in part because behavioral health services impact policy areas that are beyond the Department of Health and Human Services' purview, including corrections reform."

The report is available on the Legislative Performance Audit Office's website:
nebraskalegislature.gov/reports/audit.php

The DHHS Behavioral Health Division's Role in Reducing Service Gaps

Performance Audit Committee
Nebraska Legislature

November 2015

LEGISLATIVE AUDIT OFFICE
Nebraska Legislature
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I. Committee Recommendations

Audit Summary and Recommendations

In 2004, the Nebraska Legislature passed the Nebraska Behavioral Health Services Act (Act) to reform how the state provided behavioral health services. Key purposes of the Act were to provide for the administration of the public behavioral health system within the Department of Health and Human Services (DHHS); the development of community-based behavioral health services and funding within each behavioral health region; and the closure of regional centers.

In February 2015, the Legislative Performance Audit Committee directed the Legislative Audit Office (Office) to conduct initial research on the behavioral health system to identify specific service gaps remaining since the 2004 transition to community-based services. In the course of the Office's research, we became aware of a January 2015 assessment of the adult behavioral health system in Region 6 conducted by the TriWest consulting group. In its study, TriWest identified nine service gaps and made recommendations for improving them. This audit used these nine gaps as a basis for surveying the remaining five regions to assess the extent to which they existed in Regions 1 through 5 and as a starting point for the discussion of how to improve behavioral health services across the state.

Key findings of the audit include:

Problems most frequently raised by regional administrators:

- Need for longer authorization periods (the amount of time that Medicaid will pay for a client to receive services) for certain types of acute and long-term care and a corresponding need for additional "intermediate" services to serve individuals upon discharge from these settings
- Differences in the way services are authorized for Medicaid and non-Medicaid eligibility groups
- Potential need for additional inpatient beds allocated to each region at the Lincoln Regional Center (LRC)
- Need for increased flexibility in various funding sources

Survey results suggest that three of the TriWest service gaps are likely a problem in all five of the regions:

- Gap 3: Insufficient availability of integrated care for co-occurring disorder services
- Gap 7: Insufficient resources and supports to help people find an appropriate place to live
- Gap 9: Workforce shortages

The other six TriWest service gaps are likely a problem in at least three of the five regions. They are:

- Gap 1: Fragmentation and a lack of comprehensive system collaboration
- Gap 2: Insufficient access to care
- Gap 4: Insufficient availability of intensive community-based services
- Gap 5: Insufficient availability of Supported Employment
- Gap 6: Lack of a comprehensive Psychiatric Emergency System
- Gap 8: Unavailability of First Episode Psychosis care

Comprehensive needs assessment required by LB 1083 (2004) not completed.

Although the Division of Behavioral Health (Division) has made meaningful steps to improving behavioral health services across the state, it has not completed a statewide needs assessment.

Findings and Recommendations—Service Gaps

The specific findings relating to the service gaps identified by TriWest are listed starting on page iv.

Recommendation: The Legislative Performance Audit Committee will encourage additional study of ways to reduce the gaps identified in this report, through the needs assessment process discussed below.

Specific areas of study should include:

1. The need for additional intermediate, or step-down services, available to individuals discharged from inpatient settings. This should also include an evaluation of whether or not authorizations for hospital stays and other secure residential levels of care, including Assertive Community Treatment, are long enough and

whether there are sufficient beds available to each region at LRC. Current needs may be impacted by the prioritization of court-ordered placements and prison reform measures.

2. Exploring options for increased flexibility in funding behavioral health services so that funds can more easily be transferred between regions or services, as necessary, to accommodate changes in behavioral health trends or the unique needs of specific individuals.
3. The recommendations from the TriWest report for Region 6, listed at the end of this section, and whether those recommendations are applicable to service gaps in the other regions.

Findings and Recommendations—Needs Assessment

Finding: The Division has not completed the comprehensive needs assessment prioritized in its 2011 Strategic Plan, which is necessary for the development of a strategic plan that includes detailed goals and metrics.

Finding: Selected key stakeholders agree that the Division should conduct a statewide behavioral health needs assessment.

Finding: The Division is taking some meaningful steps to improve behavioral health services.

Finding: The Division's strategic plan for prevention services contains the type of detailed information that should be included in a comprehensive strategic plan for all behavioral health services.

Discussion: In the agency's response to the draft audit report, CEO Courtney Phillips states that "new leadership in place within DHHS has committed to this effort to initiate comprehensive statewide planning." Ms. Phillips also indicates that the agency has involved some of its federal partners in "developing and implementing both a needs assessment and a statewide behavioral health strategic plan." The Committee is encouraged by this commitment, but believes additional legislative oversight is needed to ensure that it is fulfilled.

Recommendation: The Performance Audit Committee will require the Division to conduct a comprehensive needs assessment or have such an assessment conducted by an outside

agency, similar to the assessment of Region 6 conducted by TriWest.

Recommendation: The Committee will introduce a resolution to create an ongoing legislative behavioral and mental health oversight committee to monitor the progress and resolution of these issues.

Service-gap Findings with TriWest Recommendations for Addressing the Region 6 Gaps

Gap 1: Fragmentation and a lack of comprehensive system collaboration.

Finding: In Regions 1, 5, and 6, fragmentation and a lack of comprehensive system collaboration are problems generally, and in Region 4 they are likely problems for individuals with both mental health diagnoses and developmental disabilities.

TriWest Key Recommendation for Region 6: Develop a high functioning, data-driven, collaborative structure focused on continuous quality improvement that represents all key partners in the mental health and substance abuse system. Addressing this gap is essential as it cuts across, or affects, all the other gaps.

Gap 2: Insufficient Access to Care.

Finding: Insufficient access to care is likely to be a problem in Regions 1, 3, 5, and 6.

TriWest Key Recommendation for Region 6: Move away from an appointments model and toward an "open-access" model through the use of a referral hub where providers coordinate to make sure that open slots are used as quickly as possible.

Gap 3: Insufficient availability of integrated care for co-occurring disorder services and services to people with complex needs.

Finding: For Regions 1, 3, 5, and 6, insufficient availability of integrated care for people with co-occurring disorders (such as mental illness and substance abuse) is a problem, generally. In Regions 2 and 4, it is likely a problem for individuals with both mental health diagnoses and developmental

disabilities. In Region 4 it is also likely a problem for individuals with mental health diagnoses who need primary care services.

TriWest Key Recommendation for Region 6: Develop academic and non-profit partnerships to ensure a system-wide plan for training of behavioral health providers for all levels of care, i.e., inpatient, outpatient, rehabilitation and residential, including peers, to treat individuals with co-occurring conditions.

Gap 4: Insufficient availability of intensive community-based services.

Finding: In Regions 1, 3, 5, and 6, insufficient availability of intensive community-based services is likely a problem.

TriWest Key Recommendation for Region 6: Add one to two additional ACT teams and ensure that they recruit the most difficult to treat individuals and that they are able to transition to less intensive services. Maintain Community Support levels of care.

Gap 5: Insufficient availability of Supported Employment.

Finding: In Regions 1, 3, 5, and 6, insufficient availability of Supported Employment is likely a problem.

TriWest Key Recommendation for Region 6: Work with vocational rehabilitation offices to increase the number of Supported Employment units, possibly by adding a vocation specialist to ACT teams.

Gap 6: Lack of a comprehensive psychiatric emergency system.

Finding: Region 6 reported the lack of a comprehensive psychiatric emergency system, and Regions 1 and 5 reported the lack of psychiatric emergency services as a likely problem. Region 2 reported that the lack of psychiatric emergency services is a likely problem only for children.

TriWest Key Recommendation for Region 6: The adult behavioral health services continuum needs to be assessed in order to determine whether Lasting Hope should take on the role as Psychiatric Emergency System by becoming more

medically capable, or whether another single site such as Immanuel Medical Center or the Nebraska Medical Center should function as the backbone structure of the PES. Alternatively, a coordinated group of inpatient and emergency services providers could establish agreements to meet these needs.

Gap 7: Insufficient resources and supports to help people find an appropriate place to live.

Finding: For Regions 1, 3, 5, and 6, insufficient resources and support for housing are likely problems. For Regions 2 and 4, availability of housing was identified as a likely problem.

TriWest Key Recommendation for Region 6: Identify alternatives for increasing PSH and ensure that it is permanent, including small, intensively staffed, semi-permanent group homes for people with complex needs that cannot live in the community otherwise. However, PSH must also be available to those people who do not need to live in an intensively staffed group home, but who are transitioning from a semi-permanent residence to more independent living.[1]

Gap 8: Unavailability of First Episode Psychosis care.

Finding: For Regions 1, 4, 5, and 6, lack of First Episode Psychosis care is likely a problem.

TriWest Key Recommendation for Region 6: Consider FEP as a pilot project first and track the success of the program to estimate clinical outcomes and long-term savings.

Gap 9: Workforce shortages.

Finding: For all regions, workforce shortages are a likely problem.

TriWest Key Recommendation for Region 6: Add residency slots for training psychiatrists; develop recruitment packages for psychiatric professionals, as well as retention incentives, e.g., student loan payoffs. Further develop public-academic partnerships to encourage psychiatrists, nurses and nurse practitioners toward the publicly funded system.

[1] It should be noted that the current Medicaid State Plan may need to be amended in order to provide for habilitation services. These are services that help individuals attain functional abilities they never had, contrasted with "rehabilitation services," which help people regain functional abilities lost through physical or mental illness or substance use disorder. TriWest report, pp. v and 59.

II. Legislative Audit Office Report

Legislative Audit Office Report

The DHHS Behavioral Health Division's Role in Reducing Service Gaps

November 2015

Prepared by
Dana McNeil
Clarence Mabin

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INTRODUCTION

In 2004, the Nebraska Legislature passed the Nebraska Behavioral Health Services Act (Act) to reform how the state provided behavioral health services.[1] Key purposes of the Act were to provide for the administration of the public behavioral health system within the Department of Health and Human Services (DHHS); the development of community-based behavioral health services and funding within each behavioral health region; and the closure of regional centers.

In February 2015, the Legislative Performance Audit Committee (Committee) directed the Legislative Audit Office (Office) to conduct initial research on the behavioral health system to identify specific service gaps remaining since the 2004 transition to community-based services. In the course of the Office's research, we became aware of a January 2015 assessment of the adult behavioral health system in Region 6 conducted by the TriWest consulting group. In its study, TriWest identified nine service gaps—including specific types of services that were needed in greater quantities as well as problems with service coordination—and made recommendations for improving them.

Because identifying *statewide* behavioral health service gaps was the Committee's goal, the Office proposed an audit scope which polled the remaining five regions regarding the prevalence of the Region 6 priority gaps and any others unique to their region. Consequently, the Committee approved the following scope statement in July 2015:

1. Describe the intent of the Legislature when it passed behavioral health reform (LB 1083).

2. Describe whether Behavioral Health Regions 1 through 5 have service gaps similar to those identified for Region 6 in the TriWest report or whether they have other types of adult behavioral health service gaps.

3. Describe the role of the Department of Health and Human Services Division of Behavioral Health in working to reduce or eliminate identified gaps.

[1] LB 1083; Neb. Rev. Stat. §§ 71-801 to 71-831.

Section I describes the legislative intent for behavioral health reform. Sections II and III describe service gaps identified by TriWest and through our survey, and Section IV discusses the Division of Behavioral Health's role in reducing those gaps.

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 does provide a reasonable basis for our findings and conclusions based on our audit objectives. The methodologies used are described briefly at the beginning of each section.

We appreciate the cooperation and assistance of DHHS, the regions, and external stakeholders during the audit.

SECTION I: Nebraska Behavioral Health Services Act

In this section, we describe the intent of the Legislature in adopting LB 1083 (2004), the Nebraska Behavioral Health Services Act (Act) based on the legislative history and other selected documents.

LB 1083 was prompted in part by a 1999 U.S. Supreme Court ruling. In *Olmstead v. L. C.*, the court held that the unnecessary institutionalization of people with disabilities constituted unlawful discrimination under the Americans with Disabilities Act. *Olmstead* required states to provide least-restrictive, community-based services for individuals if, among other considerations, the community-based services were appropriate for the individuals.

Broadly speaking, lawmakers intended the Act to be a blueprint for the overhaul of the state behavioral health system that would address the fragmentation caused by separate state and local behavioral health administrations. Lawmakers believed the Act would produce improved public behavioral health services and outcomes for consumers in Nebraska. The Act called for increased statewide access to high-quality, effective services. In keeping with the *Olmstead* decision, whenever appropriate, the services were to be provided in the least-restrictive environment and in community-based settings. The increase in community-based services was intended to reduce or eliminate the need for state regional centers (i.e. state psychiatric hospitals). The legislation also called for consumer involvement in the planning and delivery of services.

Division of Behavioral Health

The Act created the Division of Behavioral Health (DBH or Division) within the Department of Health and Human Services and designated the Division "the chief behavioral health authority" for the state of Nebraska. The Division is responsible for directing the coordination and administration of the statewide public behavioral health system. Among other duties, DBH is responsible for:

- comprehensive statewide planning for the provision of appropriate, community-based and continuum-of-care services, and the encouragement and facilitation of the development of such services;
- development and management of data and information systems;
- coordination and oversight of the regional behavioral health authorities, including approval of the authorities' annual budgets; and
- administration of the state regional centers.

Behavioral Health Regions

The Act gives responsibility for local development and administration of services to behavioral health authorities in six geographic regions across the state. Formerly known as mental health regions, the areas were renamed behavioral health regions by LB 1083. Each regional behavioral health authority is governed by a board that consists of one county board member from each county in the region. Additionally, each region has an administrator and an advisory committee of consumers, providers, and interested parties. Figure 1.1 on page 5 shows the current behavioral health regions, and Table 1.2 on page 6 shows the counties in each region and the corresponding populations.

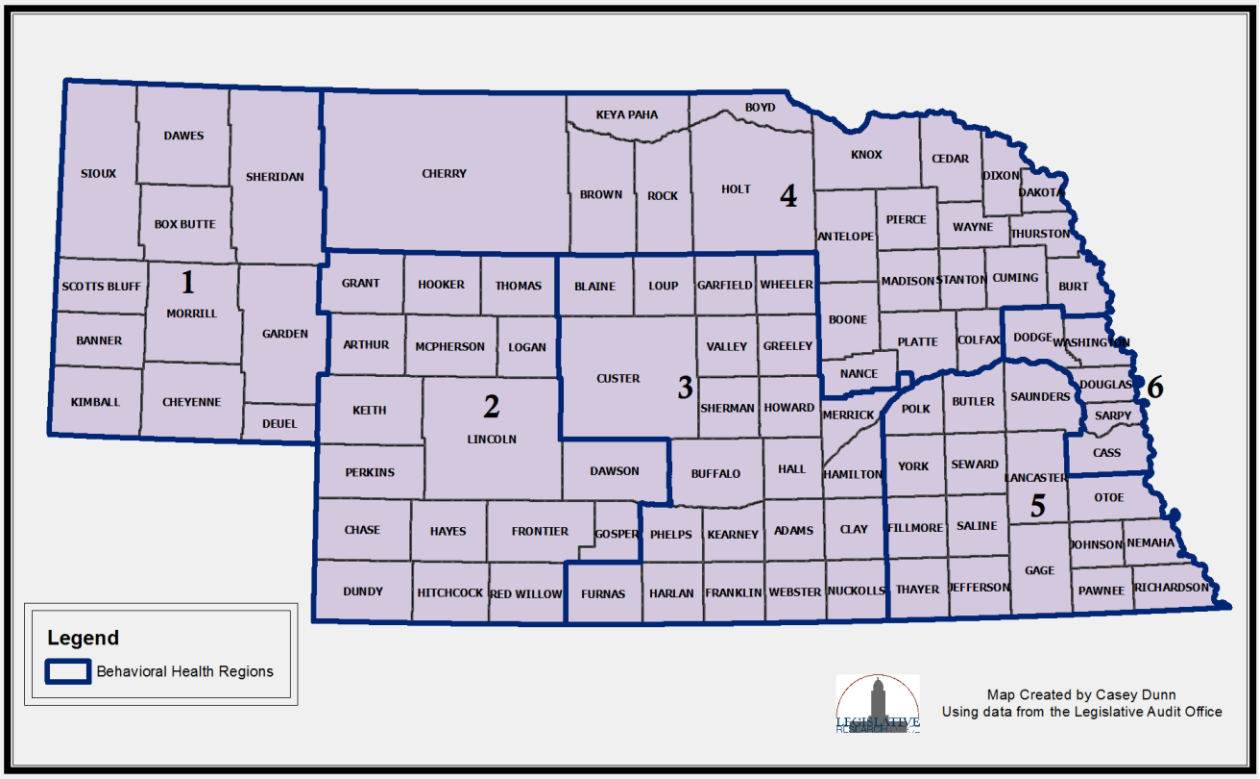
As prescribed by the Act, both the regional authorities and the state of Nebraska contribute to funding behavioral health services. Each county in a region is to provide funds for the operation of its behavioral health authority and for the provision of services. The Division manages all behavioral health services funds appropriated by the Legislature to ensure the statewide availability of an appropriate array of community-based services. The total funding amount contributed by regional counties is to equal one dollar for every three dollars provided to the regional authorities from the state General Fund.

Part of the intent of LB 1083 was to strengthen the Department of Health and Human Services' leadership of the behavioral health system and DBH's oversight of the six regional behavioral health authorities.

However, the Legislature did not intend for the Division to have control over the regions. DBH is responsible for comprehensive planning for the behavioral health system, while the regional authorities are responsible for providing an array of behavioral health services.

The Act created an Office of Consumer Affairs, which, among other duties, helps the behavioral health authorities plan and deliver services. The Act also created a Behavioral Health Oversight Commission (Commission), charged with overseeing and supporting implementation of LB 1083. The statutory authorization for the Commission was allowed to expire on June 30, 2009.

Figure 1.1 Behavioral Health Regions in Nebraska



Source: Department of Health and Human Services Web site.

Table 1.2 Counties and Population of Each Behavioral Health Region

Region	Counties	Population
1	Sioux, Dawes, Box Butte, Sheridan, Scotts Bluff, Morrill, Garden, Banner, Kimball, Cheyenne, Deuel	87,492
2	Grant, Hooker, Thomas, Arthur, McPherson, Logan, Keith, Lincoln, Perkins, Chase, Hayes, Frontier, Dawson, Gosper, Dundy, Hitchcock, Red Willow	100,932
3	Blaine, Loup, Garfield, Wheeler, Custer, Valley, Greeley, Sherman, Howard, Buffalo, Hall, Phelps, Kearney, Adams, Clay, Furnas, Harlan, Hamilton, Merrick, Franklin, Webster, Nuckolls	228,623
4	Cherry, Keya Paha, Boyd, Brown, Rock, Holt, Knox, Cedar, Dixon, Dakota, Thurston, Wayne, Pierce, Antelope, Boone, Nance, Madison, Stanton, Cuming, Burt, Colfax, Platte	207,137
5	Polk, Butler, Saunders, Seward, Lancaster, Otoe, Fillmore, Saline, Thayer, Jefferson, Gage, Johnson, Nemaha, Pawnee, York, Richardson	452,411
6	Dodge, Washington, Douglas, Sarpy, Cass	778,930

Sources: Neb. Rev. Stat. § 71-807 and email from DHHS, July 20, 2015, citing 2012 population estimates from the Regional Economic System, Bureau of Economic Analysis, U.S. Department of Commerce.

SECTION II: Problems Identified by Behavioral Health Regional Administrators

As part of the process of developing the scope of this audit, we interviewed the six regional administrators to begin to identify each region's primary service gaps. This Section contains a summary of four problems that were raised most frequently in our interviews. The information in this Section reflects the opinions of the regional administrators; we did not attempt to verify their comments. As with the survey results presented in Section III, we report this information as a starting point for the discussion of how to improve behavioral health services across the state.

The four problems are:

1. the need for longer authorization periods (the amount of time that Medicaid will pay for a client to receive services) for certain types of acute and long-term care and a corresponding need for additional "intermediate" services to serve individuals upon discharge from these settings;
2. differences in the way services are authorized for Medicaid and non-Medicaid eligibility groups;
3. the potential need for additional inpatient beds allocated to each region at the Lincoln Regional Center; and
4. the need for increased flexibility in the uses of various funding sources.

Authorization Periods and Intermediate Care Services

The majority of regional administrators were concerned that programs for clients with very high needs (such as inpatient hospitalization, secure residential placement, and Assertive Community Treatment[2]) have been reduced and that there are not enough intermediate residential services to care for individuals after discharge. Because of this, patients may go from acute to outpatient care without the benefit of an

[2] The ACT team provides high intensity services, available to provide treatment, rehabilitation, and support activities seven days per week, twenty-four hours per day, 365 days per year. The team has the capacity to provide multiple contacts each day as dictated by client need. The team provides ongoing continuous care for an extended period of time, and clients admitted to the service who demonstrate the continued need for treatment, rehabilitation, or support will not be discharged except by mutual agreement between the client and the team. 471 NAC 35-013.

intermediate level of care, such as a crisis stabilization unit or long-term transitional services, which integrates them into the community or provides long-term care for patients who require it. Additionally, the lack of intermediate care, or "step-down services," is more pronounced in rural areas that do not have the population to support fee-for-service basic services.

One of these programs was the Community Transition Program (CTP) at the Lincoln Regional Center, which the Department of Health and Human Services closed in 2009. According to the former program administrator, CTP assisted patients in transitioning from acute care to the community, and all individuals accepted to CTP were eventually discharged to less restrictive settings in the community. As discussed in Section III, many Region 5 patients who would have qualified for CTP are now either using a hospital bed, which means the state is paying for a higher level of care than necessary, or they are living in the community, which may create a community safety risk.

Medicaid and Non-Medicaid Client Inequities

The second problem identified is that differences in the way services are authorized for Medicaid and non-Medicaid eligibility groups sometimes create inequities in how each of these populations is served. DHHS contracts separately with Magellan Behavioral Health Services (Magellan) to manage the Medicaid and non-Medicaid populations served by the Division of Behavioral Health, but in some cases how services are managed differs between the contracts. One example is preauthorization of services, which is required under the Medicaid contract but not always required under the non-Medicaid contract.

Another area of concern is in the delivery of habilitation and rehabilitation services. Medicaid rules only allow for payment of services that are medically necessary.[3] This means that Medicaid does not cover *habilitation* services—which are services that will help maintain a patient to prevent relapse—but will cover *rehabilitation* services, which may be considered medically necessary. The result is that non-Medicaid clients can receive habilitative care, while Medicaid clients cannot. Providing habilitative care for individuals with behavioral health needs may be necessary to prevent relapsing

[3] See definition for medical necessity at 471 NAC 1-002.02A and 471 NAC 20-001.14 and 20-001.15 (for adult psychiatric services).

and increasing their cost of care. One region reported addressing this problem by assuming the cost of providing a non-Medicaid service to a Medicaid client when that service is not covered by Medicaid.

Allocation of Hospital Beds at the Lincoln Regional Center

A third problem identified by most of the regional administrators is the potential need for more treatment beds at the Lincoln Regional Center (LRC). LRC is the only state facility that provides secure residential services. Currently, each region is allocated a specific number of beds based on population, as shown in Table 2.1.

Table 2.1 In-Patient Beds at the Lincoln Regional Center Allocated for Each Region

Region	Number of Beds
1	3
2	4
3	9
4	8
5	36
6	30
Total	**90**

Source: Chart compiled by Legislative Audit Office based on interviews with regional administrators.

The administrators reported that the allocated number of beds may not always be enough, in part because court-ordered patients have priority for placement at LRC over others. If court-ordered patients fill the allocated beds, a region may need to find alternative placements for other patients who need secure treatment location. Some regions reported dealing with the need for additional secure hospital beds by contracting with hospitals for overflow, such as Region 4, which contracts with Richard Young Hospital in Kearney for overflow beds.

Another option for a region that needs an additional secure hospital bed is to "borrow" a bed allotted to another region. One administrator stated that they have been "lucky so far" and have not had to borrow beds from other regions. Other regions have had to work with community hospitals to take patients until a bed becomes available at LRC. In cases where

individuals are violent, this may necessitate adding staff and security.

Additionally, administrators noted that the prison reform efforts being discussed by the Legislature as this report was being written may also increase the need for additional LRC beds. Any diversion out of the correctional system of mentally ill and violent people could increase the need for secure treatment beds like those at LRC.

Lack of Funding Flexibility

Administrators in Regions 1, 3, and 5 cited a lack of flexibility in funding as an overall barrier to providing behavioral health services. The rigidity of the budget-and-contracting process makes it more difficult to respond to clients' needs because the regions must use historical data in order to predict future needs. Behavioral health trends change and sometimes funds cannot be shifted quickly enough. For example, problems can arise when an individual needs to receive services in a different region, including delays in shifting resources.

Additionally, regions were able to carry over unused funds until a few years ago. Having this ability would allow the investment of funds in other needed services, including intermediate services. One region stated that they can redistribute funds within the region to meet changing needs, but there can be a timing problem between actual distribution of the money and the contract period, which can significantly delay provision of the services. For example, for FY2014-15, although the Legislature re-appropriated unspent funds to the regions beginning July 1, 2014, at least one region was unable to access the funds until mid-January 2015.[4]

[4] Due to encumbrance certification requirements that occur in late August, DBH was not able to notify the regions of the amount of money available for each region until early October 2014. The regions were then required to submit a revised regional budget plan to include these additional funds which necessitated obtaining regional governing board approval prior to submission to DBH for its approval. Region 3 submitted its budget plan in late October 2014 and did not receive the fully executed FY2015 contract until early January 2015. The regions then had to amend its contracts with network providers to include the additional funds which took until mid-January 2015.

SECTION III: Statewide Behavioral Health Service Needs

This section addresses whether Regions 1 through 5 have adult behavioral health service gaps similar to those identified in a 2015 consultant's report on gaps in Region 6. To answer this question, we gathered information on each region's needs from the administrator and behavioral health advisory committee in each region.

We found that Regions 1 through 5 are likely to have behavioral health service gaps similar to those identified for Region 6. For Regions 1 and 5, all nine gaps are likely to be a problem. For the other four regions, between four and six of the gaps are likely to be problems.

We discuss the survey results in more detail following a description of the services gaps identified in the TriWest report.

TriWest Report on Region 6

Information for Region 6 comes from a 2015 report conducted by the TriWest consulting group. TriWest used two sources of information: stakeholder interviews and service capacity and utilization data. TriWest identified nine gaps in behavioral health services and proposed recommendations for addressing them. Following is a brief description of each gap.

Gap 1: Fragmentation and a lack of comprehensive system collaboration

According to the TriWest report, Region 6 has some system collaboration; but fragmentation and isolation between services, sometimes called "silo-ing," remain. The report said the system, at times, appears to be driven by agency needs rather than individual consumer needs. For example, not all Medicaid recipients neatly fit the Medicaid package of services. The rigidity of service packages can defeat their original purpose.

Gap 2: Insufficient access to care

The TriWest report states that the non-profit behavioral health providers are operating at full capacity and are over-run by referrals. Additionally, funding cuts to DBH and the regions in anticipation of the Affordable Care Act have

weakened the system. There are long wait lists/wait times to get medications and appointments with mental health providers.

Gap 3: Insufficient availability of integrated care for individuals with co-occurring disorders and complex needs

TriWest states that Region 6, like most systems across the country, lacks in its capability to provide care to individuals with complex co-occurring problems—including people with both mental illness and substance use disorders and those with mental illness and physical health conditions.

Gap 4: Insufficient availability of intensive community-based services

The report found that intensive support is frequently necessary for individuals being discharged from inpatient units or for those who are trying to avoid admission. Assertive Community Treatment (ACT) teams have proven to be one of the best ways to treat this population. ACT is a multidisciplinary, team-based approach to providing intensive treatment, case management, supportive housing services, employment services, co-occurring mental illness and substance abuse treatment, and peer recovery services. While Region 6 provides ACT and other intensive and community-based services, it does not have enough capacity to be able to transition people from homelessness, criminal justice, and inpatient settings and support recovery.

Gap 5: Insufficient availability of Supported Employment

The TriWest report found insufficient resources for Supported Employment (SE), which is an evidence-based model used to help people with mental illnesses and other conditions choose, find, and maintain competitive employment. Nationally, individuals with serious mental illness have a 90 percent unemployment rate but 50 percent want help in finding work. In Region 6, about 2 percent of this population receives SE, which is slightly below the state level of about 3 percent and significantly below best practice levels of about 6 percent.

Gap 6: Lack of a comprehensive Psychiatric Emergency System

According to TriWest, a comprehensive Psychiatric Emergency System (PES) includes the following components: a 24/7 assessment center; a primary site for law enforcement; acute and sub-acute units; an adequate number of nurse practitioners; a peer diversion program; and transitional care coordinators. Most importantly, a PES has at least one reliable "one stop" location, where individuals experiencing a psychiatric emergency can access services.

Region 6 needs an assessment center that can provide care for individuals who have behavioral health issues and co-occurring physical problems such as diabetes, chronic health conditions, or acute medical emergencies.

Gap 7: Insufficient resources and supports to help people find an appropriate place to live

TriWest found that Region 6 needs more Permanent Supportive Housing (PSH) in addition to more long-term, semi-permanent residential alternatives for individuals with complex mental illness/substance use disorder/physical health issues, who need an intermediate level of care between secure residential and residential rehabilitation. PSH ensures that individuals with behavioral health conditions retain as much independence as possible, while also benefitting from secure housing. It is a "housing first" model which means that they don't have to achieve abstinence from substance abuse or mental illness stabilization in order to receive housing.

Gap 8: Unavailability of First Episode Psychosis care

According to TriWest, in Region 6 approximately 180 adults will experience their first psychotic episode each year[5], but there is no First Episode Psychosis program in the area. FEP care is an evidence-based program that provides illness management, medication education, collaborative decision-making, supported education and employment, family psycho-education and substance use disorder treatment. This early intervention approach can positively alter the illness

[5] According to the National Alliance on Mental Illness, "an episode of psychosis is when a person has a break from reality and often involves seeing, hearing and believing things that aren't real." http://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Psychosis, accessed November 11, 2015.

trajectory course for many, which may prevent the need for more intensive care later.

Gap 9: Workforce shortages

Region 6 has a shortage of behavioral health professionals, including psychiatrists, psychiatric nurses, nurse practitioners, other mental health professionals and bachelors-level staff who work in various community support, rehabilitation and residential programs. Additionally, there is a shortage of peer support workers (people who have achieved significant recovery from mental illness and support their peers in recovery).

Survey of Regions 1 Through 5

For regions 1 through 5, we surveyed the administrators and members of each region's behavioral health advisory committees, which are made up of both consumers and providers of behavioral health services. The survey asked whether the respondent believed each gap identified in the TriWest report was also a problem in his or her region. Respondents were asked to rate the significance of the gap in their region on a scale of 1 (not significant) to 5 (significant) and were encouraged to provide written comments and examples.

We received a smaller response to our survey than expected and due to that, as well as other reasons discussed at the end of this Section, we believe the differences between each rating (1 to 2, 2 to 3, etc.) should be interpreted with caution. For our purposes of identifying whether the service gaps identified in Region 6 are likely to be problems statewide, we summarized the ratings by defining ratings of 1 or 2 as indicating the gap is not likely a problem and defining ratings of 3, 4, or 5 as indicating it likely *is* a problem.

The survey results suggest that the behavioral health service gaps TriWest identified in Region 6 are not limited to that region. Three of the service gaps are likely a problem in all five of the regions we surveyed:

- Gap 3: Insufficient availability of integrated care for co-occurring disorder services;
- Gap 7: Insufficient resources and supports to help people find an appropriate place to live; and
- Gap 9: Workforce shortages.

The other six service gaps are likely a problem in at least three of the five regions we surveyed.

- Gap 1: Fragmentation and a lack of comprehensive system collaboration
- Gap 2: Insufficient access to care
- Gap 4: Insufficient availability of intensive community-based services
- Gap 5: Insufficient availability of Supported Employment
- Gap 6: Lack of a comprehensive Psychiatric Emergency System
- Gap 8: Unavailability of First Episode Psychosis care

Additionally, although this audit's scope was focused on adult behavioral health services, we included comments about children's services when they were made, since we know this is another area of concern to the Legislature and was being studied at the time this report was written.

Table 3.1, on page 17, shows the breakdown of each region's survey response. Table 3.2, on page 18, shows the likelihood that each gap is a problem in each region. Appendix B contains a more detailed discussion from the survey responses.

Likely Behavioral Health Service Gaps Statewide

A discussion of each service gap for all six regions begins on page 19. For each service gap we provide a map showing the regions that are likely to have a problem along with comments from the survey of Regions 1 through 5.

Table 3.1 Behavioral Health Gaps, Average Rating by Region

Gaps	Region 1 (5*)	Region 2 (11)	Region 3 (4)	Region 4 (1)	Region 5 (3)
1: Fragmentation/ lack of system collaboration	3	1	1	2 – generally 5 - collaboration with developmental disabilities	4
2: Insufficient access to care	4	1	3	2	4
3: Insufficient availability of integrated care for co-occurring disorder services and services to people with complex needs	4	2- mental health/ developmental disabilities	3	2 – mental health/substance abuse 4 – mental health/ developmental disabilities 3 – mental health/primary care	5
4: Insufficient availability of intensive community-based services	4	2	3	2	4
5: Insufficient availability of Supported Employment	4	1	3	1	5
6: Lack of a comprehensive psychiatric emergency system	4	1 - adults 3 - kids	2	2	3
7: Insufficient resources and supports to help people find an appropriate place to live	3	1- Support 3- Availability	3	2 – Support 5 - Availability	4
8: Unavailability of First Episode Psychosis Care	4	2	2	5	4
9: Workforce shortages	4	3	4	5	4

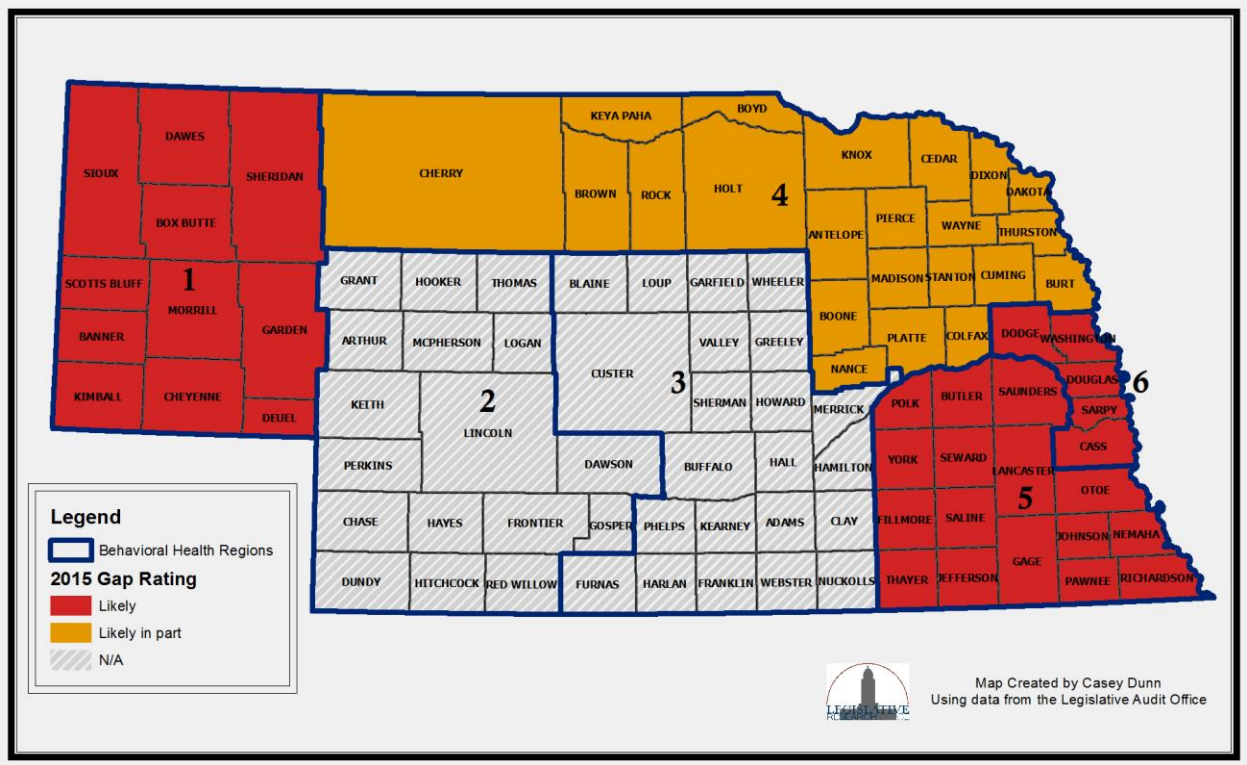
Source: Survey responses from Behavioral Health Regions 1-5 compiled by the Legislative Audit Office.
*Number of responses. Note that the Region 4 Advisory Committee and Administrator submitted one combined response.

Table 3.2 Likelihood that Region 6 Behavioral Health Service Gaps Also Exist in Other Regions

Gaps	Region 1	Region 2	Region 3	Region 4	Region 5
1: Fragmentation/lack of system collaboration	Likely			Likely for mental health with developmental disabilities	Likely
2: Insufficient access to care	Likely		Likely		Likely
3: Insufficient availability of integrated care for co-occurring disorder services and services to people with complex needs	Likely	Likely for mental health with developmental disabilities	Likely	Likely for mental health with developmental disabilities; and mental health with primary care	Likely
4: Insufficient availability of intensive community-based services	Likely		Likely		Likely
5: Insufficient availability of Supported Employment	Likely		Likely		Likely
6: Lack of a comprehensive psychiatric emergency system	Likely	Likely for children			Likely
7: Insufficient resources and supports to help people find an appropriate place to live	Likely	Likely in terms of availability	Likely	Likely in terms of availability	Likely
8: Unavailability of First Episode Psychosis Care	Likely			Likely	Likely
9: Workforce shortages	Likely	Likely	Likely	Likely	Likely

Source: Audit Office survey of Behavioral Health Regions 1-5.
Note: Shaded cells reflect a gap that the survey results suggested was unlikely to be a problem in a specific region.

Gap 1: Fragmentation and a Lack of Comprehensive System Collaboration



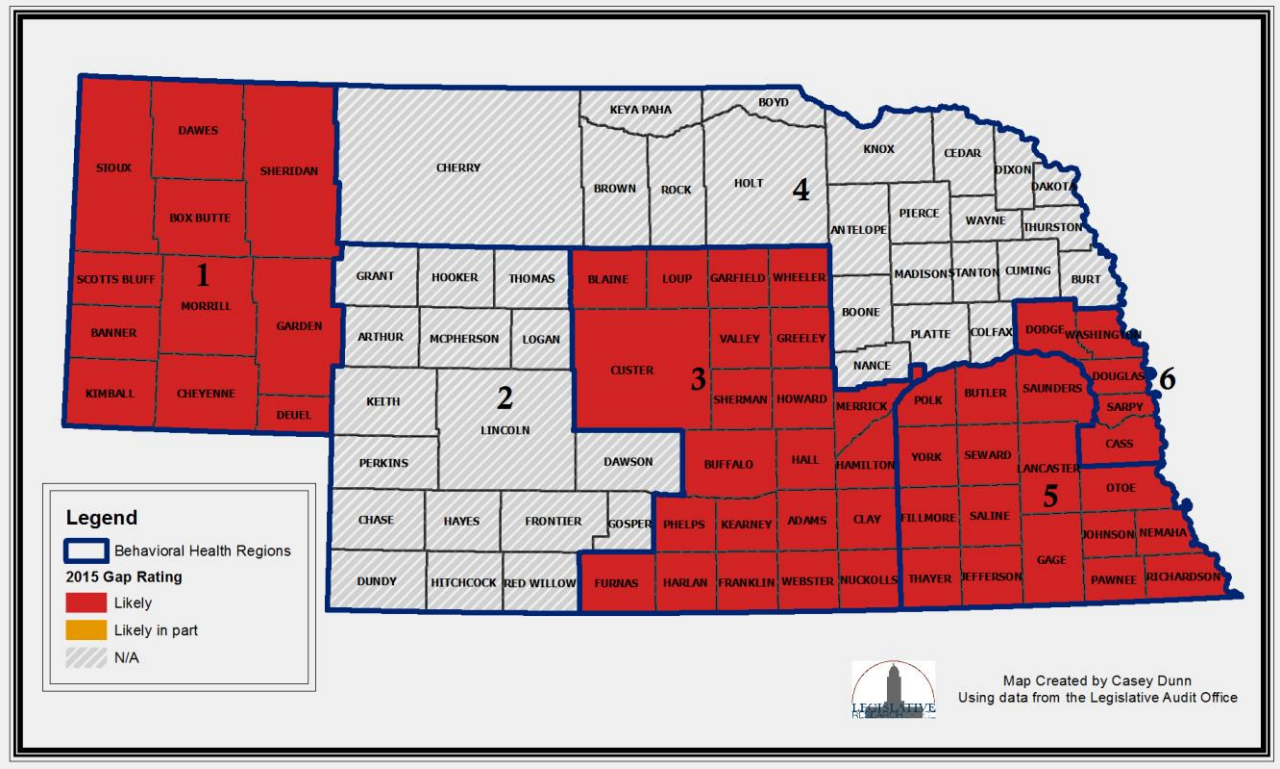
Source: Data from Audit Office survey, map created by the Legislative Research Office.

Finding: In Regions 1, 5, and 6, fragmentation and a lack of comprehensive system collaboration are problems generally, and in Region 4 they are likely problems for individuals with both mental health diagnoses and developmental disabilities.

Specific regional concerns include:

- Not all Medicaid recipients neatly fit the Medicaid package of services (Region 6);
- In more rural regions, distance can be a major contributor to fragmentation (Region 1);
- Some service definitions used to determine eligibility for behavioral health services may be overly restrictive (Region 3);
- A lack of collaboration between DBH and other DHHS divisions, such as Medicaid (Region 5); and
- A need for appropriate community placements for individuals discharged from the Lincoln Regional Center (Region 5).

Gap 2: Insufficient Access to Care



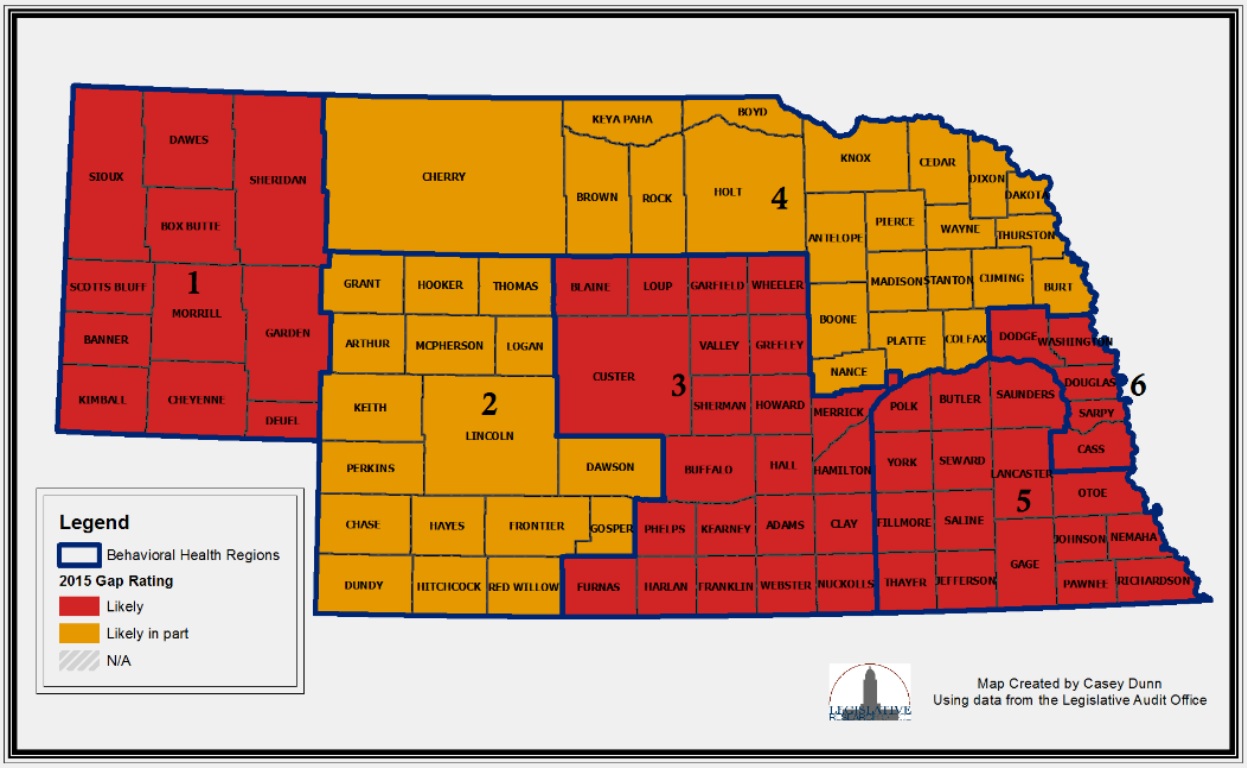
Source: Data from Audit Office survey, map created by the Legislative Research Office.

Finding: Insufficient access to care is likely to be a problem in Regions 1, 3, 5, and 6.

Specific regional concerns include:

- Non-profit providers cannot keep up with the demand for services (Region 6);
- In larger regions, distance and transportation costs can interfere with access (Region 1);
- Existing funding sources may not be adequate for larger regions that do not have a large enough consumer population to support some types of providers (Region 1);
- Need for additional long-term secure placements (Region 3);
- Need for transitional services for consumers after hospitalization (Region 5);
- Need for nursing homes willing to accept aging patients with behavioral health needs (Region 5); and
- Need for additional funding (Region 5).

Gap 3: Insufficient Availability of Integrated Care for Co-occurring Disorder Services and Services to People with Complex Needs



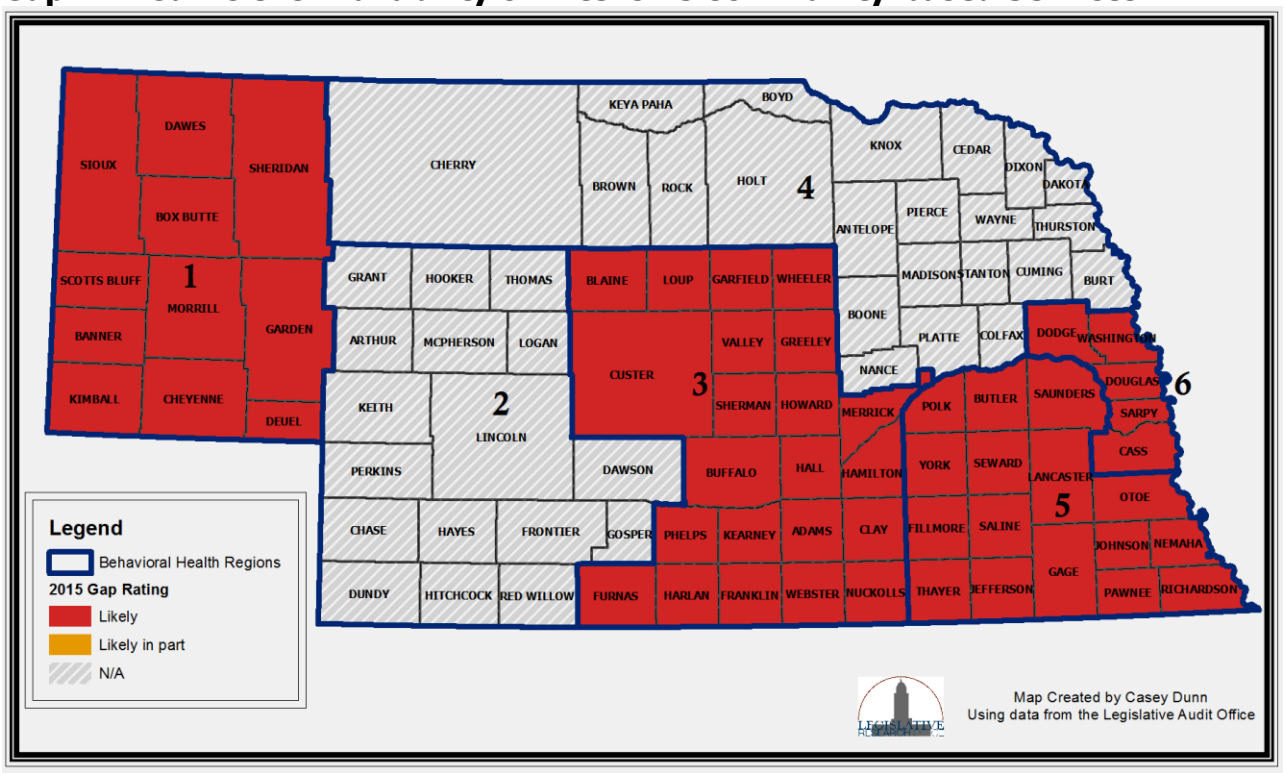
Source: Data from Audit Office survey, map created by the Legislative Research Office.

Finding: For Regions 1, 3, 5, and 6, insufficient availability of integrated care for people with co-occurring disorders (such as mental illness and substance abuse) is a problem, generally. In Regions 2 and 4, it is likely a problem for individuals with both mental health diagnoses and developmental disabilities. In Region 4 it is also likely a problem for individuals with mental health diagnoses who need primary care services.

Specific regional concerns include:

- State regulations, especially those relating to services for individuals with mental health diagnoses and developmental disabilities, create barriers (Region 2);
- A workforce shortage and inadequate funding for services to individuals with co-occurring problems (Regions 2, 3);
- Federal funding streams that do not allow or support more than one primary diagnosis (Region 3);
- Lack of electronic records standards allowing information to be shared (Region 5); and
- Difficulty finding placements for individuals with co-occurring disorders who are discharged from the Lincoln Regional Center (Region 5).

Gap 4: Insufficient Availability of Intensive Community-based Services



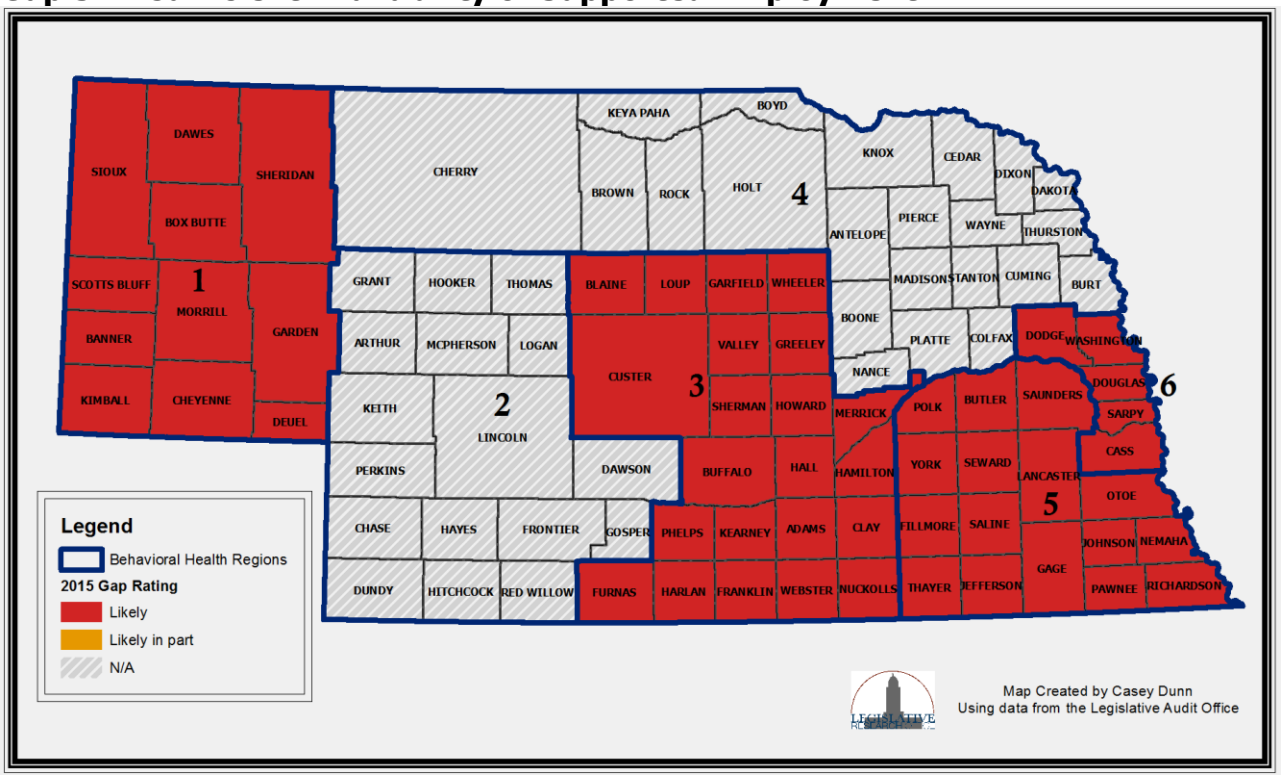
Source: Data from Audit Office survey, map created by the Legislative Research Office.

Finding: In Regions 1, 3, 5, and 6, insufficient availability of intensive community-based services is likely a problem.

Specific regional concerns include:

- Need for intensive services for individuals being released from inpatient units or trying to avoid such placements (Regions 5, 6);
- Rural regions do not have the population base to support residential services (Region 1); and
- Need for additional secure residential services (Region 3).

Gap 5: Insufficient Availability of Supported Employment



Source: Data from Audit Office survey, map created by the Legislative Research Office.

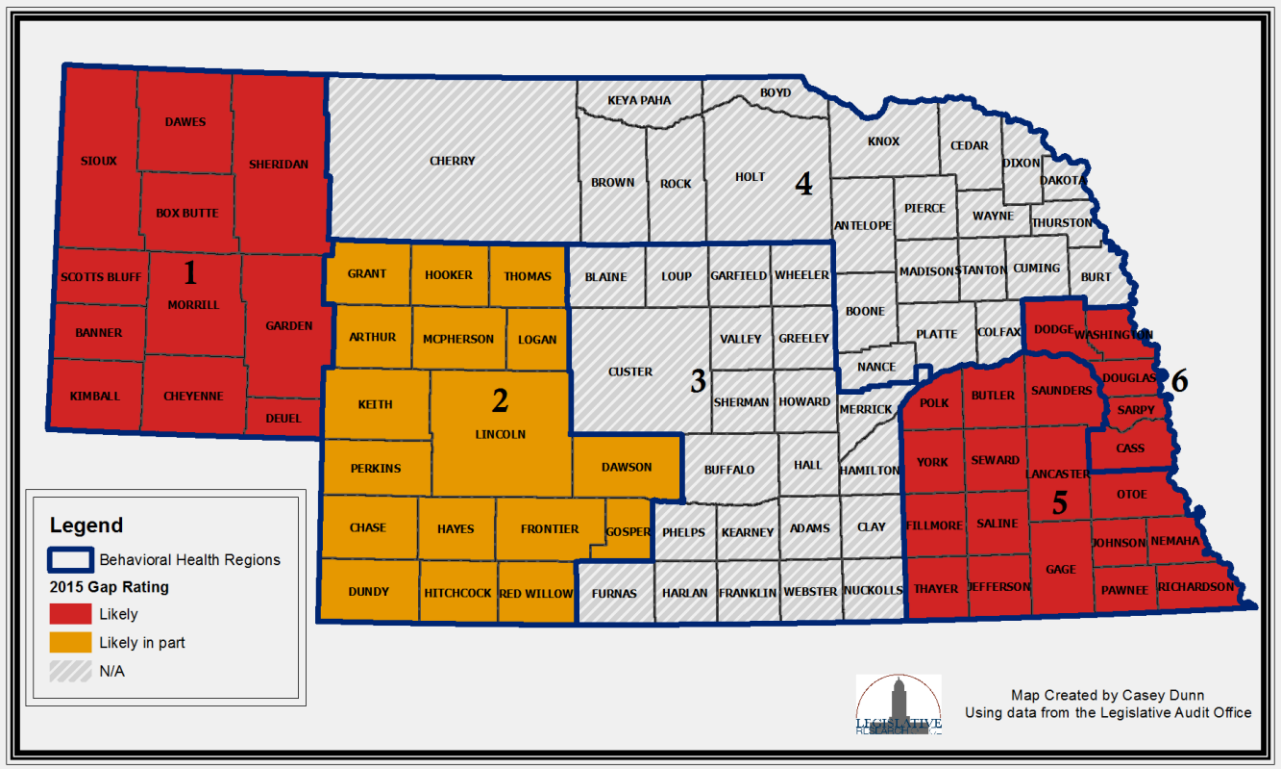
Finding: In Regions 1, 3, 5, and 6, insufficient availability of Supported Employment is likely a problem.[6]

Specific regional concerns include:

- Lack of funding (Regions 1, 2);
- Delays in application processing by the vocational rehabilitation program (Region 3);
- More opportunities for individuals who cannot work full-time (Region 3); and
- A possible lack of adherence to evidence-based models by DBH (Region 5).

[6] The TriWest report defines Supported Employment as an evidence-based model used to help people with mental illnesses and other conditions choose, find, and maintain competitive employment.

Gap 6: Lack of a Comprehensive Psychiatric Emergency System



Source: Data from Audit Office survey, map created by the Legislative Research Office.

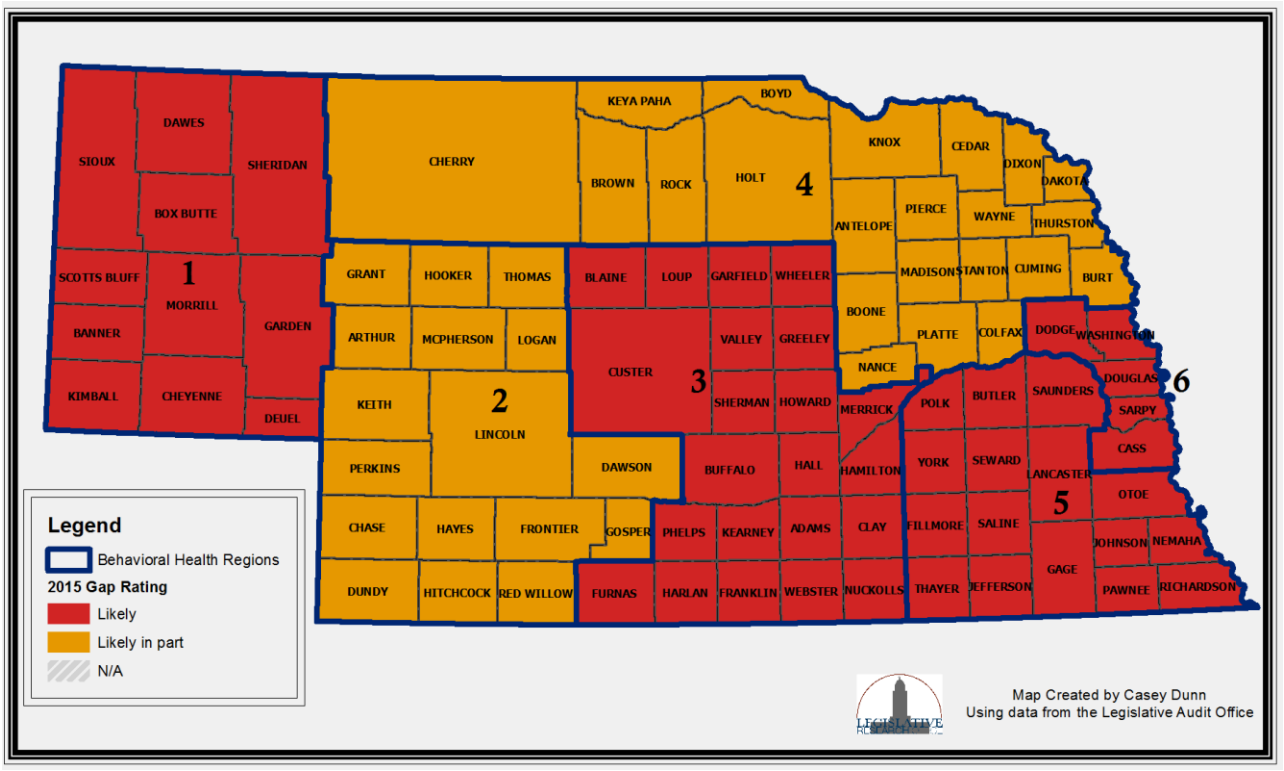
We note that the survey responses from Regions 1 through 5 did not provide a rating or comments about a *psychiatric emergency system, or PES,* as used by TriWest in its evaluation of Region 6. (PES is defined on page 13.)Instead, survey respondents addressed the need for *psychiatric emergency services* within their particular region *in general*. This distinction is reflected in the finding and regional comments.

Finding: Region 6 reported the lack of a comprehensive psychiatric emergency system, and Regions 1 and 5 reported the lack of psychiatric emergency services as a likely problem. Region 2 reported that the lack of psychiatric emergency services is a likely problem only for children.

Specific regional concerns include:

- Need for an assessment center (Region 6);
- Shortage of providers to care for individuals released from hospitals (Region 1);
- Need for psychiatric emergency services for children (Regions 1, 2);
- Lack of reimbursement for voluntary admissions, which could avert crises (Region 3);
- Lack of third-party oversight for treatment needs of individuals committed to Lincoln Regional Center under the Mental Health Commitment Act (Region 5); and
- Lack of services in rural areas (Region 5).

Gap 7: Insufficient Resources and Supports to Help People Find an Appropriate Place to Live



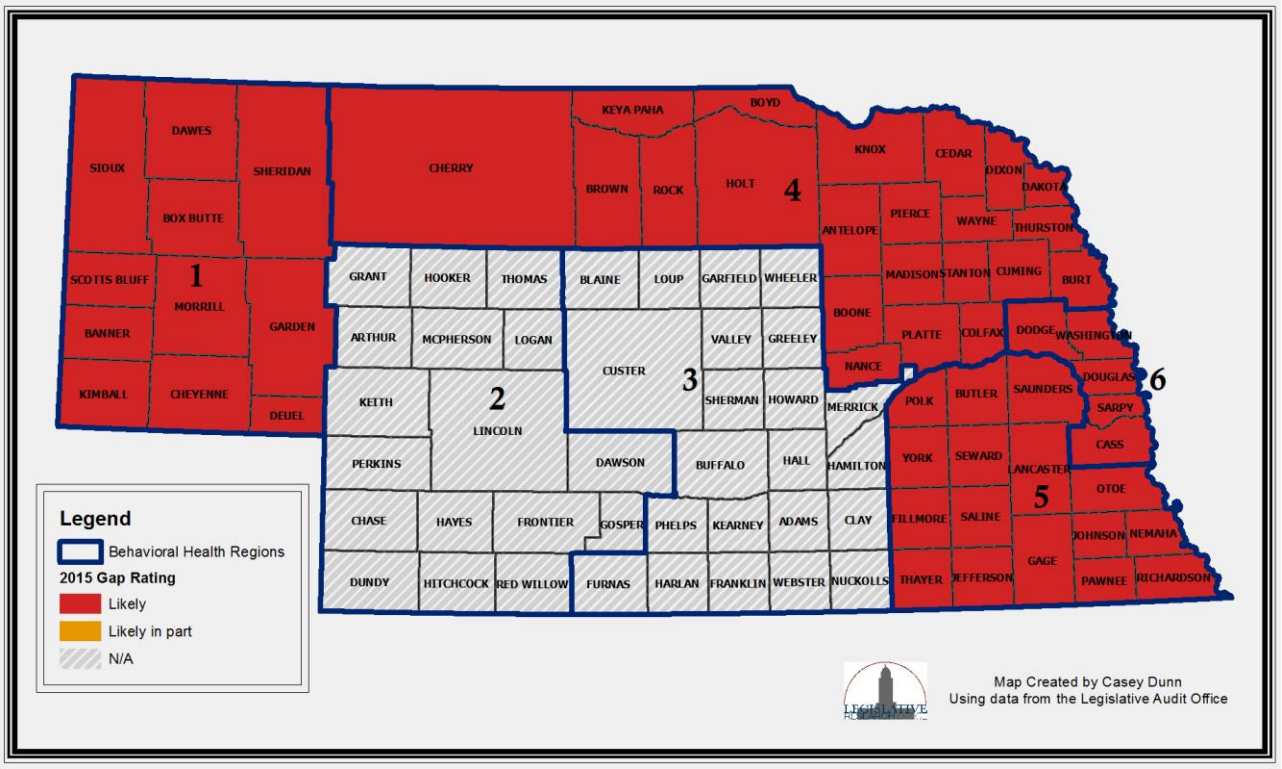
Source: Data from Audit Office survey, map created by the Legislative Research Office.

Finding: For Regions 1, 3, 5, and 6, insufficient resources and support for housing are likely problems. For Regions 2 and 4, availability of housing was identified as a likely problem.

Specific regional concerns include:

- Need for additional Permanent Supportive Housing, which ensures that individuals with behavioral health conditions retain as much independence as possible, while also benefitting from secure housing. (Region 6);
- Rural areas need homeless shelters, transitional housing and better rental housing (Region 1);
- Need for rental assistance available for individuals with a mental health diagnosis, to be available to individuals who also have substance use disorders (Region 3); and
- Need for additional funding for rental assistance (Region 5).

Gap 8: Unavailability of First Episode Psychosis Care



Source: Data from Audit Office survey, map created by the Legislative Research Office.

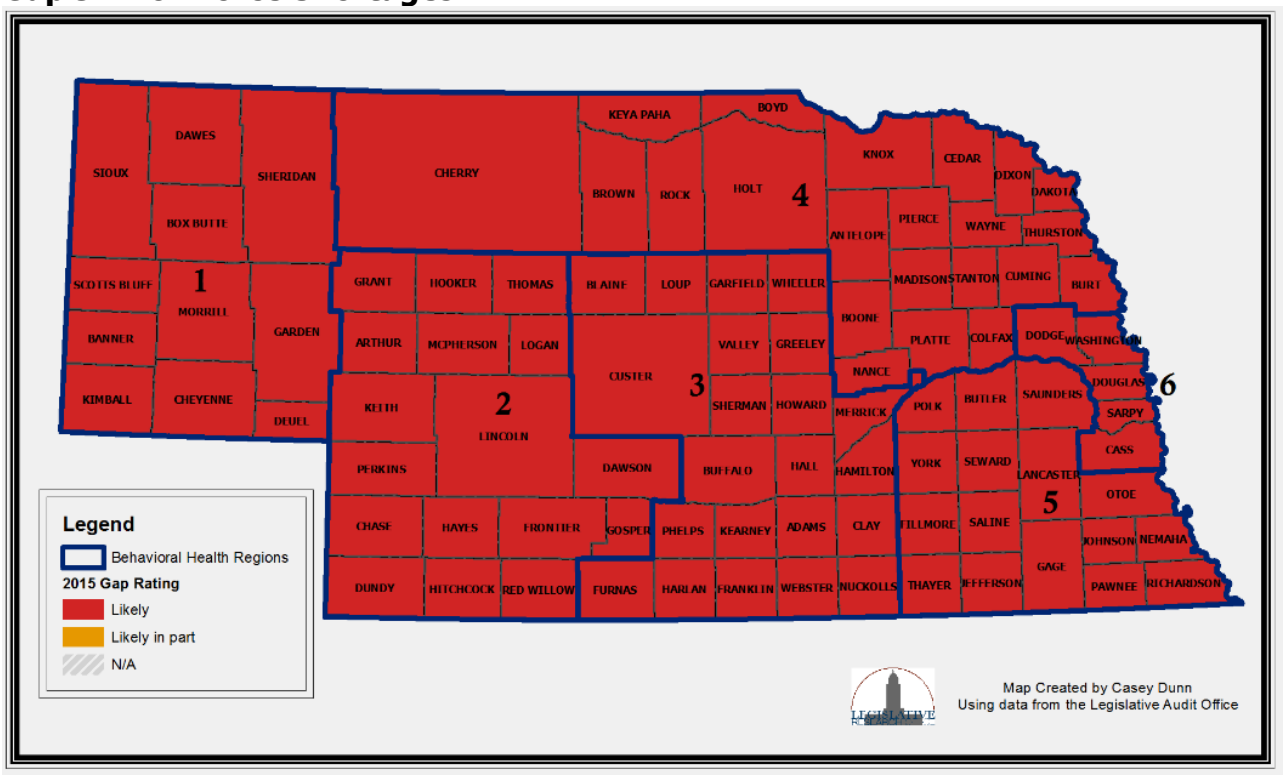
Finding: For Regions 1, 4, 5, and 6, lack of First Episode Psychosis care is likely a problem.[7]

Specific regional concerns include:

- Need for a First Episode Psychosis program (Region 6);
- Rural regions need these services, especially for youth (Region 1); and
- Two regions are participating in a pilot project to provide these services using existing providers (Regions 3, 6).

[7] First Episode Psychosis care is an evidence-based program that provides illness management, medication education, collaborative decision-making, supported education and employment, family psycho-education and substance use disorder treatment.

Gap 9: Workforce Shortages



Source: Data from Audit Office survey, map created by the Legislative Research Office.

Finding: For all regions, workforce shortages are a likely problem.

Specific regional concerns include:

- Shortages are greater in rural regions and may be more difficult to fill because available wages may be less than those available in more populated regions (Regions 1, 2, 3, 4); and
- In addition to the need for providers with behavioral health specialties, there is also a need for more peer support workers (Regions 3, 5).

Survey Methodology

Due to time limitations for this audit, we chose to survey a small number of individuals. We believe the regional administrators and behavioral health advisory committees (which include both service providers and consumers) are key stakeholders in their regions, well-qualified to provide us with a credible indication of whether the particular service gaps are likely to exist in their region. We received responses from all regions, but they varied both in terms of the number of responses we received from each region[8] and the level of detail provided.

At the same time, the pool of people surveyed was small, and we received fewer responses than we had expected. We had hoped for more responses from members of the behavioral health advisory committees so we could highlight the perspectives of providers and consumers, but received too few responses to do so.

Additionally, the survey did not specifically define the terms "not significant" and "significant," so it is difficult to know whether the scores used by one region are comparable to the other regions' scores. Consequently, the results reported should be understood as *suggesting* whether or not the service gaps are likely to exist, not concluding that they do exist.

Despite these limitations, the survey responses give policymakers reason to believe that the service gaps identified by TriWest are problems in parts of the state beyond Region 6. Additional study will be needed to better describe the extent of the problems in each region and to identify ways of resolving them.

[8] For example, in one region the administrator and advisory committee submitted one combined response while in another the administrator and each advisory committee member submitted individual responses.

SECTION IV: Division of Behavioral Health Role in Addressing Service Gaps

This section addresses the role of the Division of Behavioral Health (DBH or Division) in working to reduce or eliminate service gaps identified in this report. To answer this question, we reviewed documents relating to the implementation of LB 1083 and interviewed the DBH division director and staff as well as two advocates for behavioral health services.

We found that a key role for DBH in reducing the service gaps identified in this report is to conduct a statewide needs assessment, which it should have completed as part of the implementation of LB 1083. While the Division is taking some meaningful steps to improve services, as discussed at the end of this section, a statewide picture of existing needs is essential to ensure that state and regional entities, as well as consumers, providers, and policymakers are working to address problems systematically rather than in a piecemeal fashion.

Division of Behavioral Health Responsibilities

As discussed in Section I, in passing LB 1083, the Legislature envisioned a major reform of the state's behavioral health services, including significant development of community-based services and increased cooperation between DBH and the regions. One of the Division's specific responsibilities in the reform was to conduct "comprehensive statewide planning" to provide for the "appropriate array" of community-based behavioral health services. Although not specifically required by LB 1083, a needs analysis is a common first step in developing a strategic plan, which DBH itself recognized and planned for in its 2011 strategic plan, as discussed in more detail below.

Need for a Comprehensive Statewide Services Plan

LB 1083 required the Department of Health and Human Services (DHHS) to create an implementation plan. DHHS prepared that plan, which included 108 "deliverables," or products, which the plan stated "must be completed in order

to achieve the reform" envisioned by the Legislature.[9] One of those products was a "comprehensive statewide plan." However, the 2009 final report of the legislative Behavioral Health Oversight Committee noted that many of the promised deliverables—including the statewide plan—had not been completed. A 2010 Legislative Performance Audit Committee report noted that there was still no plan.

In 2011, the DBH released a strategic plan for the period 2011 to 2015. The plan included history of behavioral health services in Nebraska and identified broad goals, strategies, and outcome measures that DBH believed would lead to the improvement in behavioral health services intended by the Legislature when it enacted LB 1083.

The strategic plan describes the Division's role in identifying and resolving service gaps across the state. For example, under Strategy 1: Insist on Accessibility, the Division sought to:

> 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 service, and cost.

The division also committed to an outcome measure, designated as *Leadership Initiative #1*, for "Publication and implementation of standards for access for each area (mental health, substance abuse, problem gambling) and each service." Perhaps most importantly, DBH stated it would partner with the regions to "assure that a full and comprehensive needs assessment is complete as a baseline for accountability."

Updates to the plan in 2012 and 2014 described steps the Division had taken to improve services but, as of the writing of this report, the Division has neither developed the standards described above nor conducted the comprehensive needs assessment. The 2014 progress report on the strategic plan did include some statistics that could be incorporated into a full needs assessment (*see Appendix B for an example from that progress report*).

[9] Note about report terminology: in 2004, the agency currently referred to as the Department of Health and Human Services was called the Nebraska Health and Human Services System. For simplicity and ease of understanding, we use the current name.

Finding: The Division has not completed the comprehensive needs assessment prioritized in its 2011 Strategic Plan, which is necessary for the development of a strategic plan that includes detailed goals and metrics.

Stakeholder Input

We contacted representatives of several organizations that represent or advocate for persons who use behavioral health services to get their opinions on the Division's role in addressing behavioral health service gaps. Representatives of two organizations provided us with sufficient information to include in this report: the executive director of the Nebraska Association of Behavioral Health Organizations; and the president of CenterPointe, a treatment facility for individuals with mental health and substance use disorders.

Both stakeholders said that the extent of the services gaps, as well as the overall effectiveness of the behavioral health care system, is not known because the state has apparently no means to assess the system. They believe that a statewide behavioral health needs assessment is needed. They also suggested that better data collection and tracking is required in order to identify gaps, their location, and how they should be funded.

Finding: Selected key stakeholders agree that the Division of Behavioral Health should conduct a statewide behavioral health needs assessment.

Selected Division of Behavioral Health Actions to Reduce or Eliminate Service Gaps

In discussing behavioral health services gaps, the DBH Division Director told us of a number of efforts the Division has underway to help reduce and eliminate the gaps.

Revise the Strategic Plan

The existing strategic plan expires at the end of 2015, and DBH plans to begin the process of revising it in 2016. In the interim between strategic plans, DBH has developed a bridge document which will be posted on the DHHS web site after it has been shared with stakeholders, sometime in November

2015. Additionally, the Division and regions are developing a financial blueprint to gain an understanding of where behavioral health dollars are currently being spent.

Conduct Gap Analysis

DBH has hired a consultant to work with the regions to identify top gaps and barriers to filling those gaps, how the system can make best use of funding, and what is being done now to address the gaps. This work will provide both a regional and statewide perspective.

Improve Inter-agency and Inter-divisional Cooperation

DBH is working more closely with: 1) other DHHS divisions, including Medicaid and Long-term Care, and Children and Family Services; 2) the behavioral health regions; and 3) other state entities including the Department of Correctional Services and the Administrative Office of Probation to address behavioral health needs systematically and reduce fragmentation. According to the Division Director, DHHS has established a cross-division solutions team that meets weekly to develop service plans for people with complex needs. The Director also noted that new leadership of DHHS and other agencies has brought about a greater spirit of cooperation. (Auditors' note: the change in leadership followed the 2014 election of a new Governor.)

Finding: The Division is taking some meaningful steps to improve behavioral health services.

Prevention Services Strategic Plan

Finally, DBH issued a strategic plan focusing specifically on prevention services, covering 2013 to 2017. That plan was developed in cooperation with the Substance Abuse Prevention and Treatment Block Grant. The prevention strategic plan contains specific goals and benchmarks for its performance indicators. For example, the plan states that: "The State of Nebraska will reduce the prevalence of underage drinking by high school students to less than 35% by June 30, 2017." The baseline used for assessing improvement is that underage drinking by high school seniors in 2011 was 41 percent, and the plan includes a table comparing rates of

underage drinking in Nebraska and in the United States for previous years. The type of information included in the Prevention Strategic Plan could be used as a model for a more comprehensive strategic plan for all behavioral health services.

Finding: The Division's strategic plan for prevention services contains the type of detailed information that should be included in a comprehensive strategic plan for all behavioral health services.

APPENDIX A: Survey

On a scale of 1 to 5, with 1 being the lowest score (gap is not a significant problem) and 5 being the highest (gap is a significant problem), please rate the presence of each gap in your region and provide additional narrative, examples and data to explain, if possible.

If a gap does not apply to your region, please indicate accordingly and explain why.

Gap 1: Fragmentation and a lack of comprehensive system collaboration.

Rating: (1-5 or N/A)

Narrative/Examples/Data:

If not applicable, why:

Gap 2: Insufficient access to care.

Rating:

Narrative/Examples/Data:

If not applicable, why:

Gap 3: Insufficient availability of integrated care for co-occurring disorder services and services to people with complex needs.

Rating:

Narrative/Examples/Data:

If not applicable, why:

Gap 4: Insufficient availability of intensive community-based services.
Rating:

Narrative/Examples/Data:

If not applicable, why:

Gap 5: Insufficient availability of Supported Employment.

Rating:
Narrative/Examples/Data:

If not applicable, why:

Gap 6: Lack of a comprehensive psychiatric emergency system (PES).

Rating:

Narrative/Examples/Data:

If not applicable, why:

Gap 7: Insufficient resources and supports to help people find an appropriate place to live.

Rating:

Narrative/Examples/Data:

If not applicable, why:

Gap 8: Unavailability of First Episode Crisis Care.

Rating:

Narrative/Examples/Data:

If not applicable, why:

Gap 9: Workforce shortages.

Rating:

Narrative/Examples/Data:

If not applicable, why:

Please describe any additional service gaps that apply to your region and provide examples and supporting data, if possible.

APPENDIX B: Survey Comments by Region

For each service gap, we start with the Region 6 finding, which gives a brief description of the gap. The other regions' comments follow. Survey respondents were asked to rate each gap on a scale of 1 to 5, with 1 being the lowest score (gap is not a significant problem) and 5 being the highest (gap is a significant problem). Rating in this appendix reflect the average of the ratings received.

Gap 1: Fragmentation and a lack of comprehensive system collaboration

Region 6 - Region 6 has clinical level collaborative processes and pockets of system collaboration, but fragmentation and isolation between services, sometimes called "silo-ing," remain. The TriWest report said the system, at times, appears to be driven by agency needs rather than individual consumer needs. For example, not all Medicaid recipients neatly fit the Medicaid package of services. The rigidity of service packages can defeat their original purpose.

Region 1 - Fragmentation and lack of system collaboration were rated 3 out of 5 for significance in Region 1. One provider stated that there was good communication through the advisory committee but that distance was a major contributor to fragmentation.

Region 2 - Respondents rated this gap as very low in Region 2.

Region 3 -System collaboration among all behavioral health stakeholders was rated 1 out of 5 for significance in Region 3. Regular meetings are held with providers, state probation administration, the DHHS, DBH leadership, law enforcement, county attorneys and mental health board members and "[t]here is a strong spirit of collaboration." From the provider perspective, they have been able to coordinate high risk discharges and admissions to ACT and psychiatric residential rehabilitation. Additionally, discharge and crisis planning meetings are held for specific high utilizers and hospital discharges to coordinate their care.

However, one respondent cited overly restrictive service definitions for community-based services as a system-wide barrier to receiving services. Service definitions are used to determine eligibility for behavioral health services. When consumers are denied authorization for services they have previously received (e.g., day rehabilitation, community support, ACT), it is difficult to find alternatives for care that provide for *habilitation or maintenance* of the individual. Many consumers do not have family or community support which could help provide this care. Service definitions are written narrowly to include only a very specific population.

Region 4 - In general, Region 4 rated Gap 1 as 1 out of 5 for significance, stating that there is excellent collaboration within the criminal justice system and that other community providers work well together to meet individuals' needs. One exception was fragmentation within the developmental disabilities system which was rated as a very significant problem; it is difficult to obtain and maintain services for people with these needs, especially for those requiring emergency services.

Region 5 - Two major problems were identified under Gap 1 from Region 5. The first was the lack of collaboration between the Medicaid and Behavioral Health Divisions within DHHS. One respondent stated that this creates fragmentation because data is not shared and decisions impacting providers are made independently of each other. The second major problem relates to community placements after discharge from the Lincoln Regional Center (LRC), the state's psychiatric hospital. These individuals often have histories of severe mental illness, medication

non-compliance in the community, danger to self or others, substance abuse, and criminal backgrounds, which can make finding a placement difficult.

An additional complication is that regional community providers are allowed to choose whether they will accept people who are being discharged from LRC. If no placements are available, this results in longer stays at LRC. The former Region 5 psychiatric residential rehabilitation program, known as the Community Transition Program or CTP[1], accepted all LRC discharges requiring psychiatric residential rehabilitation. Currently, if there is no place in Region 5 to discharge patients, they must go to another region for psychiatric residential rehabilitation services. Other regions can also refuse to accept these individuals. If they are accepted, they may be discharged to a city outside the patient's city of origin where they may have no support system.

Gap 2: Insufficient access to care

Region 6 - Non-profit behavioral health providers are operating at full capacity and are over-run by referrals. The TriWest report states that funding cuts to DBH and the regions in anticipation of the Affordable Care Act have weakened the system. There are long wait lists/wait times to get medications and appointments with mental health providers.

Region 1 - Region 1 is largely rural and survey responses noted that services are minimal (but perhaps less so in Scotts Bluff county), and that distance and transportation costs are sometimes prohibitive. Another issue is funding. According to the Regional Administrator, since Region 1 is the least populated region, it only receives five percent of the state budget for behavioral health services. Because this region does not have the population to support reimbursement of some services on a fee-for-service basis, it would be helpful if these services could receive capacity access guarantee reimbursement. This funding mechanism allows providers to be reimbursed for operating expenses, in addition to fee-for-service reimbursement based on the number of units provided.[2] Residential and crisis services for youth, intermediate levels of residential care, and recovery housing are a few of the services that would benefit from capacity access guarantee funding so that consumers are not forced to travel to another part of the state to receive services.

Region 2 - Overall, there is sufficient access to care in Region 2. Responses noted there were sometimes for residential care, but in these situations interim care is provided. One respondent singled out nursing home care for consumers with behavioral health needs as lacking and another cited transportation in the rural areas as being an issue.

Region 3 - Access to care was rated 3 out of 5 for significance in Region 3, particularly for long term consumers who need a secure residential treatment setting. According to the regional administrator, the length of time being authorized for secure residential care by Magellan[3] has been shortened, resulting in a significant service gap for this population. Secure residential services are necessary for patients who are transitioning from hospitalization to community-based services and to help prevent hospital (re)admission. It is difficult (and sometimes dangerous) to try to maintain individuals needing higher levels of care (e.g., those with a chronic pattern of self-harm, hospitalization, impulsiveness and those with developmental disabilities or lower IQ) in non-secure residential settings, for example in ACT. This may put staff and other

[1] The Community Transition Program was a unique setting where patients could practice their social skills in a hospital but not be treated like a sick person. It was a way of gradually teaching an individual to become a functioning member of society in a safe environment, which requires special training for staff.
[2] Fee-for-service reimbursement occurs after the units are provided.
[3] Magellan is under contract with the Department of Health and Human Services to provide authorization for the care of Nebraska Behavioral Health System consumers.

residents at risk. Moreover, physicians are reluctant to admit patients with these types of needs to ACT because they are afraid they will not be admitted to higher levels of care should they require it.

Other specific access to care service gaps identified were: medication management for individuals who are committed by a mental health board for outpatient treatment and therapeutic community, or residential service for substance dependent consumers. Wait lists exist to receive these services, as well as for short term residential treatment for persons with co-occurring mental health and substance abuse issues.

Region 4 - Overall, Region 4 respondents believe there is good access to care. However, there are fewer services in the western counties.

Region 5 - Funding was identified as an underlying barrier to access to care in Region 5, which impacts service availability and capacity throughout the system. Specific care needs include:

- Increased transitional services where relationships are built with community providers prior to community placement of hospital discharges. Community providers are expected to both accept patients to their care and work with them after discharge.
- Increased supportive housing services and assisted living facilities that are sanitary and livable.
- Increased assisted living options statewide; currently Region 5 (Lincoln) accepts individuals from other regions due to the lack of facilities in other parts of the state.
- Increased services for persons with co-occurring mental health and developmental disabilities diagnoses.
- In general, a need for more long-term options because some patients will never make significant improvements in functioning.
- Nursing homes willing to accept aging patients who also have behavioral needs, especially aggression and medical non-compliance. Specialized wards may be necessary.[4]

Gap 3: Insufficient availability of integrated care for co-occurring disorder services and services to people with complex needs

Region 6 - Region 6, like most systems across the country, lacks in its capability to provide care to individuals with complex co-occurring problems, either co-occurring mental illness and substance use disorders or co-occurring mental illness and physical health conditions.

Region 1 - Unavailability of services for individuals with co-occurring disorders is problematic, again primarily due to distance, the lack of behavioral health professionals and the way providers are compensated. However, one respondent did rate this gap as less significant, noting that efforts to educate providers have resulted in more services for these individuals.

Region 2 - Region 2 respondents said state rules and regulations are a barrier to the integration of services for individuals with co-occurring disorders, particularly mental health and developmental disabilities. Also, lack of funding for this population is an issue.

Region 3 - An insufficient number of beds for individuals with co-occurring disorders was rated 3 of 5 for significance in Region 3. Catholic Charities of Columbus currently provides four beds

[4] Some regional administrators also commented on the need for nursing homes willing to take the seriously mentally ill who require nursing home level of care but are unable to assimilate into that environment due to their aggressive behavioral issues.

under a contract with the region and there is usually a wait list. There is also a workforce shortage for providers treating co-occurring disorder patients, which further decreases capacity to serve these individuals and increases the wait list.

Federal mental health and substance abuse prevention and treatment block grants also create barriers to funding services to patients with complex needs. These are two distinct funding streams that require separate tracking. Outpatient programs may be funded with both types of grants which then requires providers to designate a primary diagnosis (i.e., mental health or substance abuse) and bill the corresponding funding stream. This conflicts with best practice treatment guidelines which dictate that one diagnosis is not primary over the other, and that behavioral health needs are treated in an integrated setting. This also acts to distort data, in terms of numbers of people served with a co-occurring disorder diagnosis.

Another issue faced by individuals with dual diagnoses is that they are often required to have 30 days of medications with them before they can be admitted to short term residential care. Since money is frequently a problem for these patients, it would be helpful if the medications could be provided for them within the facility.

Other gaps cited include: (1) narrow and restrictive financial eligibility criteria can be a barrier to collaborating with primary care clinics; (2) the region's medically supported detox program cannot serve people with opioid dependence; (3) outpatient providers need a separate case management worker; currently services for this population do not get reimbursed for case management which is additional work beyond providing therapy; and (4) provider education is needed to promote the understanding that the existence of co-occurring disorders is the norm; rarely is there a distinct split between mental health and substance abuse. Provider training in the treatment of these individuals is also needed.

Region 4 **-** Co-occurring services for individuals with mental health and substance abuse needs are good, however co-occurring services for individuals with complex physical needs (requiring primary care) are sometimes difficult to find. Co-occurring services for individuals with developmental disabilities are often unavailable.

Region 5 **-** Broadly speaking, the Region 5 Administrator identified the lack of electronic health record standards that allow interagency and inter-discipline sharing of information and the separate funding streams that are either mental health or substance abuse, as being barriers to services for individuals with co-occurring disorders. Moreover, there is no definition for co-occurring disorders in the DHHS Behavioral Health Services regulations.[5]

More specifically, placement is again difficult for patients discharging from LRC who have co-occurring disorders and require residential treatment. Selection interviews are too intense and rigorous. Increased coordination with parole/probation to ensure appropriate supervision, in addition to their co-occurring needs, is required. Often, what the court wants in terms of monitoring and supervision is not possible because it does not exist in the community or is otherwise impossible to coordinate. This may result in patients remaining at LRC for longer periods of time.

[5] Title 206, Nebraska Administrative Code.

Gap 4: Insufficient availability of intensive community-based services

Region 6 **-** Intensive support is frequently necessary for individuals being discharged from inpatient units or who those who are trying to avoid admission. ACT teams have proven to be one of the best ways to treat this population.[6] While Region 6 provides ACT and other intensive and community-based services, it does not have enough capacity to be able to transition people from homelessness, criminal justice and inpatient settings and support recovery.[7]

Region 1 **-** Again, the low population of this area makes the development and provision of residential services difficult. One provider noted that there were more services in Scottsbluff but less in other towns. Another respondent cited the specific need for detox services and day programs.

Region 2 **-** Intensive outpatient substance abuse programs are available in three locations in Region 2. The number of consumers needed for certain other intensive services is insufficient to support providers. However, community services can adjust to be as intensive as needed. An additional issue is the distance some clients need to travel to access services due to the sparse population.

Region 3 **-** Since ACT is available in Region 3, this issue is not as significant a problem as in other regions. However, as mentioned previously, secure residential services are needed for individuals needing longer periods of care than that currently being authorized by Magellan.

Region 4 **-** Intensive community based services are available for clients.

Region 5 **-** Step-down services from higher intensive levels of care are lacking. This results in consumers staying in more costly, high-end services longer than necessary. More psychiatric residential rehabilitation and ACT is needed; community support services have a limited number of encounters and for some individuals, this is insufficient.

Gap 5: Insufficient availability of Supported Employment

Region 6 **-** There are insufficient resources for Supported Employment (SE). Nationally, individuals with serious mental illness have a 90 percent unemployment rate but 50 percent want vocational assistance. In Region 6, about 2 percent of this population receives SE, which is slightly below the state level of about 3 percent and significantly below best practice levels of about 6 percent.

Region 1 **-** Lack of funding was again cited as a reason that SE services are insufficient in this region. Currently, the only SE program in Region 1 is in Scottsbluff. Obtaining employment is limited by distance because many individuals do not have transportation and public transportation is not available.

Region 2 **-** Most respondents agreed that SE is readily available in Region 2. One commented that lack of funding was an issue affecting SE in rural areas.

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[6] The report defines ACT as "A multidisciplinary, team-based approach to providing intensive treatment, case management, supportive housing services, employment services, co-occurring mental illness and substance abuse treatment, and peer recovery services." p. 3

[7] For example, Region 6 has only one ACT team compared to Denver, with eight. TriWest report, pp. iv and 52.

Region 3 - Despite ample SE capacity, there are significant delays in vocational rehabilitation's process of admission which delays people from starting employment. A concern was that vocational rehabilitation (VR) limits its services to individuals who are able to work full time; development of a program for persons with severe and persistent mental illness who want to work fewer hours would be helpful. SE in Region 3 would benefit from better coordination.

Barriers to SE exist for individuals with co-occurring disorders, and specifically in the length of time it takes to begin services once a referral is made to VR. For example, for someone with behavioral health needs who is also participating in drug court, the delay in admission to VR may prevent them from participating in SE due to conflicting timeline requirements in drug court. It was noted by the Region 3 Administrator that the region has developed a process with DBH in which SE providers can bypass VR when the admission process is a barrier and begin to provide services immediately. This has helped to alleviate this problem. Additionally, VR has sometimes been inconsistent in their eligibility determinations for persons with substance use disorders.

Region 4 - SE is available to those seeking this service.

Region 5 - SE is very limited; consumers need to be able to access services ranging from a structured workshop to independent employment. One respondent suggested that there has been no adherence to evidence-based models by DBH, so the funding does not support quality SE practices. Another suggested that vocational rehabilitation does not have a good reputation of working with individuals with mental health needs.

Gap 6: Lack of a comprehensive Psychiatric Emergency System (PES)[8]

Region 6 - According to TriWest, a comprehensive Psychiatric Emergency System (PES) includes the following components: a 24/7 assessment center; a primary site for law enforcement; acute and sub-acute units; an adequate number of nurse practitioners; a peer diversion program; and transitional care coordinators. Most importantly, a PES has one or a few reliable "one stop" locations, where individuals experiencing a psychiatric emergency can access many types of services. Region 6 needs an assessment center which can provide care for individuals who have behavioral health issues and co-occurring physical problems such as diabetes, chronic health conditions or acute medical emergencies.

Region 1 - Respondents commented that individuals are being released from hospitals too soon, that there is a shortage of mental health professionals equipped to provide this level of care, and that, while the adult system is working well, emergency services for youth and families are lacking.

Region 2 - Respondents rated the emergency psychiatric system for adults very highly, noting that there is adequate access to medications, transportation and hospitalization and "one number to call." Another noted there has been significant improvement in this area. Psychiatric emergency services for children were rated as being a more significant problem (rated 3 out of 5) by some respondents. One respondent stated that children need to be transported out of Region 2 for hospitalization.

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[8] Responses from the regions addressed *psychiatric emergency services* within their particular region *in general*, and did not provide a rating or comments about a *psychiatric emergency system, or PES,* as used by TriWest in its evaluation of Region 6. Consequently, in our summary of Region 6, we refer to a PES and in our summary about the regions', we refer to emergency psychiatric services or the system, generally.

Region 3 - Survey respondents rated its psychiatric emergency system fairly well, stating that Region 3 has two psychiatric hospitals to which individuals requiring emergency protective custody (EPC) can be admitted, crisis response teams, and a crisis stabilization unit located in Grand Island. The region has worked hard to develop this system. However, law enforcement may "EPC" an individual, or admit them to a hospital, rather than contact crisis response to evaluate whether hospitalization is necessary. Region 3 continues to raise awareness of this issue with law enforcement.

More specific issues were: (1) the need for a crisis stabilization unit for youth that could be accessed by the school system, child welfare, primary care, behavioral health, probation and law enforcement; and (2) the need for reimbursement for voluntary commitments to a psychiatric hospital for those who realize their symptoms are creating a safety issue for themselves and those around them. Lack of reimbursement for voluntary admissions creates a disincentive to getting treatment sooner, which could avert a crisis. Allowing reimbursement would save money in the long run because it would result in shorter lengths of stay, fewer symptoms, and stabilization of the consumer in a shorter amount of time.

Region 4 - This gap was rated 2 out of 5 for significance; Region 4 has crisis response teams throughout the area and has emergency community support available to individuals who require this service. Region 4 contracts with Faith Regional Hospital (Norfolk), Richard Young (Kearney), and Great Plains (North Platte) for inpatient care in order to increase access to care for its residents so that, for example, a Cherry County resident can go to North Platte rather than Norfolk to receive services.

Region 5 - Two major issues were cited regarding the psychiatric emergency system in Region 5. The first is that LRC lacks an "authorizing environment," which is a third party who monitors and authorizes treatment for patients who have been committed under the Mental Health Commitment Act. An authorizing environment ensures accountability that the level of care continues to demonstrate medical necessity. Other facilities providing inpatient psychiatric care are required to have each individual authorized by Magellan for treatment on a regular basis. The second problem identified was the lack of services in rural communities which makes crisis planning difficult.

Gap 7: Insufficient resources and supports to help people find an appropriate place to live

Region 6 - Region 6 needs more Permanent Supportive Housing (PSH)[9] in addition to more long-term, semi-permanent residential alternatives for individuals with complex mental illness/substance use disorder/physical health issues, who need an intermediate level of care between secure residential and residential rehabilitation.

Region 1 - One respondent noted a lack of funding at the county level for this type of assistance. One simply stated that "there are no places to live. We need homeless shelters, transitional housing and decent rental housing in general." Another individual stated that housing was not a significant problem because there are sufficient funds through the housing assistance fund, but noted that availability of community housing fluctuates.

[9] PSH ensures that individuals with behavioral health conditions have the most independent level of secure housing they can. It is a "housing first" model which means that they don't have to achieve abstinence from substance abuse or mental illness stabilization in order to receive housing. TriWest, p. 58.

Region 2 - Housing *support* is not a significant problem in Region 2 (rated 1 out of 5 for significance), however, housing availability is a problem (rated 3 out of 5).

Region 3 - Region 3 coordinates the housing assistance program which provides rental assistance to adults with serious mental illness who have extremely low income. Over the past five fiscal years, this program has served an average of 129 individuals per year with an average annual income of $4976. However, a gap still exists for persons with substance use disorders because the program does not serve these individuals. Additionally, income eligibility guidelines are very low; more individuals would benefit if the income eligibility threshold was higher. One consumer commented that "affordability creates anxiety for me and I then feel pressured to give up needs to pay rent." Demand for housing has increased and although Hastings has supported housing for individuals with serious mental illnesses, there are often wait lists. Quality of independent housing varies; homeless shelters in Hastings and Kearney do a good job, but are often full.

Region 4 - Supports available to assist persons in housing (i.e., community support, medication management, Section 8/HUD vouchers) are readily available, but in some areas waiting lists for vouchers exceed one year. However, availability of suitable housing is a significant problem (rated 5 out of 5 for significance). Individuals seeking housing tend to have a sporadic rental history and inconsistent income, which are common to persons who have been recently hospitalized or who are in treatment but are not disabled. Housing alternatives need to be able to accommodate these issues.

Region 5 - Housing was identified as a significant problem in Region 5 (rated 4 out of 5 for significance). Additional funding for rental assistance was specifically cited. Patients admitted to LRC on a Mental Health Board commitment are homeless and having housing upon release from LRC is necessary to achieve stabilization. Housing is particularly difficult for consumers with legal histories or registered sex offenders.

Gap 8: Unavailability of First Episode Psychosis care

Region 6 - In Region 6, approximately 180 adults will experience their first psychotic episode each year, but there is no First Episode Psychosis (FEP) program in the area. FEP care is an evidence-based program that provides illness management, medication education, collaborative decision-making, supported education and employment, family psycho-education and substance use disorder treatment. This early intervention approach can positively alter the illness trajectory course for many, which may prevent the need for more intensive care later on.

Region 1 - One respondent stated that due to the culture of the area, many first episodes remain unknown to all but those closest to the individual experiencing the psychotic episode, although education programs are helping to increase awareness. FEP services are needed in Region 1, particularly for youth, but some services are available at Regional West Medical Center.

Region 2 - A majority of the comments regarding FEP care noted that care was available, but that this was dependent on a referral being made. A lack of community awareness was consistently mentioned as being a significant problem in Region 2.

Region 3 - Region 3 is currently participating in a FEP pilot project that implements the Coordinated Specialty Care Team model, described in the following table. Region 3 has worked with DBH, Magellan, the Division of Children and Family Services, the Department of Education, and Region 6 Behavioral Healthcare to research and plan this evidence-based program that can

be implemented within existing workforce and funding resources. Implementation is targeted for late fall, 2015.

FEP Coordinated Specialty Care Program Enrollment Criteria

Age Criteria	Male or Female, age 15-25
Diagnostic Criteria Using DSM-IV Diagnoses	295.90 Schizophrenia; 295.40 Schizophreniform Disorder; 295.70 Schizoaffective Disorder; 297.1 Delusional Disorder; 298.8 Brief Psychotic Disorder; and 298.9 Psychotic Disorder NOS
Symptom Duration	First psychotic episode of any duration so long as the individual has taken antipsychotic medication for psychosis for a cumulative period of no longer than twelve months
Exclusionary Criteria	Diagnosed with an intellectual disability Other diagnoses excluded: psychotic disorder due to a general medical condition, substance-induced psychotic disorder, depressive disorder, and bi-polar disorder Families of individuals 18 and younger must agree to participate
Anticipated Length of Treatment	Minimum of two years or an earlier natural point if the individual is stable on medication, non-psychotic, employed or in school, and the family agrees to discharge
Pilot Size	8-10 participants per team in the first year

Region 4 - First Episode Psychosis care is not available in Region 4.

Region 5 - A significant amount of training, funding and service development would have to occur in order to develop FEP Care in Region 5. As mentioned previously, pilots currently exist or are being developed in Regions 3 and 6. One respondent was concerned that there was no peer support specialist on the team, according to the 2016-17 draft pilot project plan, and that the draft supported a philosophy of intervention with families, rather than making them part of the team.

Gap 9: Workforce shortages

Region 6 - Region 6 has a shortage of behavioral health professionals, including psychiatrists, psychiatric nurses, nurse practitioners, other mental health professionals and bachelors-level staff who work in various community support, rehabilitation and residential programs. Additionally, there is a shortage of peer support workers.[10]

Region 1 - Workforce shortages are a significant problem in Region 1 (rated 4 out of 5) due to its inability to hire and retain mental health professionals at competitive wages. One respondent summed it up as "we educate and they leave."

Region 2 - Respondents commented on the prevalence of behavioral health workforce shortages in rural areas and especially for levels of care between residential and community-based supports.

[10] Those who have achieved significant recovery from mental illness and who now support their peers in recovery. TriWest report, pp. v and 62.

Region 3 - Workforce shortage in Region 3 is significant (rated 4 out of 5), as it is throughout most of the state and nation across all behavioral health professional classifications. It is difficult for hospitals to recruit and retain psychiatrists; outpatient providers have trouble recruiting therapists; and residential programs have challenges in recruiting and training technical staff. As discussed previously, co-occurring diagnosis residential service providers are sometimes forced to reduce their capacity because they cannot fill critical staff positions. Peer support workers are also needed, although one respondent cited the current peer support certification program as a positive example of workforce training.

Region 4 - Workforce shortages are a significant problem in Region 4 (rated 4 out of 5) for all levels of behavioral health professionals.

Region 5 - Workforce shortages exist at every professional level in Region 5. Peer support was singled out by one respondent as needing more development in the region to encourage hiring by employers at a living wage. Research has demonstrated the benefit of using peer support in treatment.

APPENDIX C: Example from 2014 Strategic Plan Progress Report

Currently, the plan states four "foundational 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.
2. The division will use financing mechanisms which support innovative service content, technology and delivery structures (e.g., telehealth; in-home acute services; peer support services).
3. The division will reduce the reliance on the Lincoln Regional Center for general psychiatric services.
4. The division will explore an effective system to safely manage sex offenders in outpatient settings.

The plan then lists the strategies the division will use to make progress towards these goals: 1) Insist on Accessibility; 2) Demand Quality; 3) Require Effectiveness; 4) Promote Cost-Efficiency; and Create Accountable Relationships. Under each strategy, the report lists actions taken by the division and some descriptive statistics related to it. So, for example, the entire listing of statistics for the Accessibility strategy is as follows.

2014 Strategic Plan Progress Report
ACCESSIBILITY

- The 2013 Behavioral Health Consumer Survey reveals that 88.9% of consumers felt services were available at times that were good for them. 81% indicated they were able to get all the services they thought they needed.
- There are about 62,000 adults in Nebraska with a serious mental illness.
- Drug and alcohol abuse affects over 134,000 adults in Nebraska.
- In Fiscal Year 2013 over 20,000 individuals received mental health services and close to 14,000 received substance abuse disorder services
- In Fiscal Year 2013 the Division of Behavioral Health funded services for 31,984 individuals. Mental Health services were provided to 1,549 youth experiencing serious emotional disorders.
- Males comprised 55% of all consumers seeking services. The largest age group served was individuals aged 21-44.
- In 2013 the Professional Partner Program in Nebraska served 1,252 youth and young adults ages 2 through 25 diagnosed with an emotional and/or behavioral disturbance.
- In Fiscal Year 2013 there were 589 priority consumers waiting for substance abuse services statewide. The average wait time fell below the federal established benchmark.
- The Lincoln Regional Center had 189 total admissions in calendar year 2013 compared to 172 for 2012. Median length of stay was 147 days in 2013 compared to 181 days for 2012.

Auditor's notes

While this listing does provide some information about the accessibility of services, it is not as useful as it could be. It would be more useful to know not just how many people received a service, but whether there is evidence that the service reduced or resolved the problems.

Similarly, while consumer satisfaction is important, it is equally, if not more important to know how many people are on waiting list for needed services. It would also be useful to know additional information such as the population(s) who received the survey; number of responses; and something about the characteristics of those who responded such as age, gender, diagnosis, and services accessed or attempted to access.

III. Fiscal Analyst's Opinion

State of Nebraska

LEGISLATIVE COUNCIL

www.nebraskalegislature.gov

Legislative Fiscal Office
PO Box 94604, State Capitol
Lincoln, NE 68509-4604

October 14, 2015

Martha Carter, Legislative Auditor
Nebraska Legislature
P.O. Box 94604, State Capitol
Lincoln, NE 68509

Dear Martha:

This letter is written in response to your request for an opinion as to whether the Department of Health and Human Services (HHS) can implement the recommendations of the Legislative Performance Audit Committee regarding the audit of the Division of Behavioral Health within the current appropriations provided to the department. The following comments are provided relative to each of the recommendations in the report.

Recommendation: "**The Legislative Performance Audit Committee should consider initiating additional study of ways to reduce the gaps identified in this report.**" The recommendation goes on to mention specific areas of study. The recommendation for further study has no immediate fiscal impact for HHS. If further study of the specific areas identified in the report such as the need for additional intermediate or step-down services or more beds at the Lincoln Regional Center is initiated and ultimately recommended, then there will likely be a fiscal impact for the department to provide funding for additional services.

Recommendation: **"The Performance Audit Committee should consider whether to require the Division of Behavioral Health to conduct a comprehensive needs assessment or whether to have such an assessment conducted by an outside agency, similar to the assessment of Region 6 conducted by TriWest."** The Behavioral Health Support Foundation, a private entity, paid about $165,000 from July 2014 through February 2015 to TriWest to complete an assessment of behavioral health services for adults in Region 6. The assessment included data gathering on

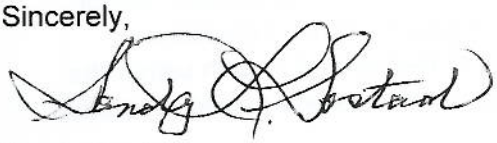
available services, usage of current services and the identification of gaps in existing services. Interviews were conducted with about twenty-seven key individuals to assess needs and services.

If a like statewide assessment is completed, it is assumed the Division of Behavioral Health will need to contract for such a study since it would require a significant amount of staff time to develop the study, gather and report data on services, interview and summarize comments of providers and stakeholders and prepare an assessment report. If the assessment done in for Region 6 is any indication of cost, a contracted statewide comprehensive needs assessment may cost in excess of $350,000. The Division of Behavioral Health could only absorb the cost of a needs assessment within its existing budget by reducing aid to behavioral health providers or reducing administrative expenses.

Recommendation: **"The Committee may want to consider appointing an ongoing behavioral health oversight committee to monitor the progress and resolution of these issues."** The Behavioral Health Oversight Commission was established to monitor the implementation of behavioral health reform pursuant to LB 1083 (2004). The commission was composed of twenty members and was funded through the budget of the Legislative Council. The bill terminated the commission on June 30, 2008. Initially, the commission met frequently to monitor the implementation of the act. Expenditures for the commission totaled $30,167 in FY 2004-05 and $41,492 in FY 2005-06. The funding in subsequent years was $9,230 in FY 2007 and $7,235 thereafter until the commission terminated.

There will be a fiscal impact to pay the expenses of persons on a Behavioral Health Oversight Commission. The Division of Behavioral Health may be able to absorb the reimbursement of commission member expenses within its existing budget if the commission is relatively small and if it is not required to meet on a monthly basis.

Sincerely,



Sandy Sostad
Program Analyst, Legislative Fiscal Office

IV. Background Materials

BACKGROUND MATERIALS

The "background materials" provided here are materials (in addition to the Office's report) that were available to the Committee when it issued the findings and recommendations contained in Part I of this report. They include:

- The agency's response to a draft of the Office's report; and
- The Legislative Auditor's summary of the agency's response.

Department of Health & Human Services
DHHS
NEBRASKA

State of Nebraska
Pete Ricketts, Governor

November 4, 2015

Martha Carter
Legislative Audit Office
P.O. Box 94604, State Capitol
Lincoln, EN 68509

Dear Ms. Carter:

This letter is in response to your performance audit report entitled "Service Gaps in the Nebraska Behavioral Health Regions and the DHHS Behavioral Health Division's Role in Reducing Them." Below is our response that we would like included in the published version of your report.

With the new CEO and leadership team in DHHS, the Division of Behavioral Health (DBH) will have support to assert its role as the Chief Behavioral Health Authority as legislatively intended. The FY 16-17 appropriation and carryover funding will provide an opportunity to address some identified needs.

In past years, DBH has completed focused needs assessments to prioritize needs and align strategic and quality improvement efforts. The assessment included internal sources such as utilization of service data, waitlist and capacity information to assess access to care for priority populations, outcomes related to stable housing, employment, justice involvement, substance use and retention in services, consumer and partnership surveys. It also evaluated data from external sources such as the NSDUH, TEDS and URS, SAMHSA BH Barometer. These assessments are reviewed with the State Advisory Committees on Mental Health and Substance Abuse. We appreciate the scope of the assessment and look forward to a more inclusive data driven needs assessment which will enable a deeper analysis for identifying solutions.

Our ability to accurately assess our needs and develop a comprehensive plan of action will require significant input among a broad group of stakeholders, as well as close collaboration within DHHS divisions. As the largest funder of behavioral health services for adults and children, Medicaid plays a critical role in these efforts. Medicaid also contracts directly with providers while DBH contracts with the Regional Behavioral Health Authorities. The new leadership in place within DHHS has committed to this effort to initiate comprehensive statewide planning. Over the last few months, we have built stronger bonds between our Divisions and are committed to much closer collaboration to make these efforts successful.

We appreciate the finding that DBH has taken meaningful steps. DBH will further investigate the barriers caused by state regulations including service definitions. In recent months, DBH has worked with Regions to align funding priorities with gaps, identify barriers and improve innovation/flexibility to meet needs. DBH is reviewing its budget planning process to ensure it achieves a balance of flexibility and innovation with accountability. It is important to note that efforts have been made to address the gaps mentioned in the report. We acknowledge there is much more work to be done. For example, contracted regions and providers have completed a baseline assessment of co-occurring capability. Improvement in capability will be assessed on an ongoing basis to identify progress in serving individuals with co-occurring needs. This is done through utilization of a standardized tool, the COMPASS EZ, and reviewed in our

quality improvement process. In addition, DBH began the FEP workgroup prior to the initiation of the Triwest report. We are pleased to share that Regions 3 and 6 will begin pilots in the next couple of months. Related to the workforce gap, we meet regularly with BHECN. As we move forward, regardless of innovation and comprehensive service planning, having enough trained and competent licensed and unlicensed providers in the behavioral health workforce is critical. Continued partnership with BHECN who receives funding for workforce development is key to successful outcomes. Because stable housing is a key to a person's recovery, DBH has contracted with Technical Assistance Collaborative to assist with a five year housing strategic plan.

DBH appreciates the Committee utilizing an existing needs report. The Committee may also recognize some limitations. DBH has reviewed the survey and will plan to build upon the Committee's assessment process by engaging an outside consultant to develop scientific, valid, reliable methodology. The needs assessment will serve as the foundation for building a strategic plan that builds upon strengths and identifies measureable goals and strategies.

As indicated during the audit, DBH plans to utilize a document that will bridge the 2011-2015 plan until a new strategic plan is complete in late 2016. We have engaged SAMHSA, NASMHPD, and NASADAD and requested technical assistance with developing and implementing a needs assessment and statewide behavioral health strategic plan. We envision a strengths-based approach to addressing gaps and meeting with our surveying stakeholders across the state. We agree that the Prevention Strategic Plan format is a model format. We agree that working with partners is essential to moving the system forward.

The Department would like to thank you and your staff for your work on this audit. If you have any questions or comments on our responses, please contact the Internal Audit Administrator, Garet Buller.

Sincerely,

Courtney N. Phillips, MPA
Chief Executive Officer
Nebraska Department of Health and Human Services

Legislative Auditor's Summary of Agency Response

This summary meets the requirement of Neb. Rev. Stat. § 50-1210 that the Legislative Auditor briefly summarize the agency's response to the draft performance audit report and describe any significant disagreements the agency has with the report or recommendations. In addition to the agency response, we asked for comments from the behavioral health regions we surveyed in the audit. We received comments from regions 1, 2, 3, and 4.

Findings and Draft Recommendations

Neither the Department of Health and Human Services (DHHS) nor the regional administrators who responded had specific disagreements with the performance audit findings or draft recommendations. DHHS stated that it is revising its strategic plan, which will be released in late 2016. The agency has involved its federal agency partners to provide technical assistance and noted that it is committed to developing the strategic plan with "significant input among a broad group of stakeholders, as well as close collaboration within DHHS divisions." The agency also indicated that it will engage an outside consultant to develop a "scientific, valid, reliable methodology" for its needs assessment, which will serve as "the foundation for building a strategic plan that builds upon strengths and identifies measurable goals and strategies."

The Audit Office believes that these steps are appropriate and have the potential to lead to the kind of strategic plan envisioned by the Legislature when behavioral health services reform was initiated in 2004. However, we continue to believe that additional legislative oversight, perhaps in the form of a short-term special committee, is warranted to ensure that plan does, in fact, address all of the Legislature's concerns.

Other Comments

Each of the regional administrators suggested technical corrections to the portion of the report relating to his or her region. We made all of the suggested changes but because they were not substantive, we did not attach the comments to this report.