

BEHAVIORAL HEALTH OVERSIGHT COMMISSION OF THE LEGISLATURE

FINAL REPORT June 2008

INTRODUCTION & PURPOSE

On April 14, 2004, then Governor Mike Johanns signed into law Legislative Bill 1083, the Nebraska Behavioral Health Systems Act. Introduced and championed by Governor Johanns and then Senator Jim Jensen, Chair of the Health and Human Services Committee, this historic legislation set out to reform Nebraska's behavioral health services by moving from an over-reliance on state-owned Regional Centers to creation or expansion of a continuum of services in the community.

Consistent with advances in research and treatment, evolving best practices, the legal and civil rights of those with mental illness or other disability as established in the U.S. Supreme Court *Olmstead* decision, and the advocacy of consumers, families, and professionals alike, LB1083 envisioned and mandated the provision of services closer to home, family, and support services and in the least restrictive setting. It also envisioned broadening access to federal Medicaid dollars by providing these services in the community, rather than on state institutional grounds.

As passed by the Legislature and signed into law (Nebraska Revised State Statutes Section 71-802), the purposes of the Nebraska Behavioral Health Services Act are:

1. Reorganize the statutes relating to the provision of publicly funded behavioral health services;
2. provide for the organization and administration of public behavioral health system within the department;
3. rename mental health regions as behavioral health regions;
4. provide for the naming of regional behavioral health authorities and ongoing activities of regional governing boards;
5. reorganize and rename the State Mental Health Planning and Evaluation Council, the State Alcoholism and Drug Abuse Advisory Committee; and the Nebraska Advisory Commission on Compulsive Gambling;
6. change and add provisions relating to development of community-based behavioral health services and funding for behavioral health services, and
7. authorize the closure of regional centers.

The Act, in Section 71-803 also sets forth the purposes of the public behavioral health system, which are to ensure (*bold emphasis added*):

1. The **public safety** and the **health and safety of persons with behavioral health disorders**;
2. **Statewide access to behavioral health services**, including, but not limited to, (a) adequate availability of behavioral health professionals, programs, and facilities, (b) an appropriate **array of community-based services** and continuum of care, and (c) integration and coordination of behavioral health services with primary health care services;
3. **High quality behavioral health services**, including, but not limited to, (a) services that are research-based and consumer-focused, (b) services that emphasize beneficial treatment outcomes and recovery, with appropriate treatment, planning, case management, community support, and consumer peer support, (c) appropriate regulation of behavioral health professionals, programs, and facilities, and
4. **Cost effective behavioral health services**, including, but not limited to, (a) services that are efficiently managed and supported with appropriate planning and information, (b) services that emphasize prevention, early detection, and early intervention, (c) services that are provided in the least restrictive environment consistent with the consumer's clinical diagnosis and plan of treatment, and (d) funding that is fully integrated and allocated to support the consumer and his or her plan of treatment.

LB1083 created the Division of Behavioral Health Services within the Department of Health and Human Services (HHS). This newly created Division was to partner with consumers, their families, the behavioral health regions, community-based providers, and other stakeholders to ensure that the implementation of LB1083 was inclusive, comprehensive, and reflective of local findings and recommendations on what services were needed to accomplish this significant undertaking. The Act addressed the roles and responsibilities of the Division and the newly renamed Regional Behavioral Health authorities, spoke to the development of community-based behavioral health services and the integrated funding of these services, and anticipated the closure of two regional centers as a result of the measures outlined. The Act also created in statute the Office of Consumer Affairs within the Division and an administrator of this office, as well as an integrated research and educational component within the behavioral health system.

Finally, the Act created the Behavioral Health Oversight Commission of the Legislature. Operating under the direction of the Health and Human Services Committee of the Legislature, the Commission was charged with overseeing and supporting implementation of the Nebraska Behavioral Health Services Act. Initial Commission members were appointed by the Chair of the Health and Human Services Committee in June, 2004. Consumers were active members of the Commission and advocated for the principles and practices of inclusion in all aspects of reform. The Oversight Commission held its first meeting on July 9, 2004 and has met on a regular basis throughout this four year period. Pursuant to the statute, the Commission expires on June 30, 2008. This document constitutes the final summary report, findings, and recommendations of the Behavioral Health Oversight Commission to the Health and Human Services Committee and the Legislature as a whole.

ACCOMPLISHMENTS / PROGRESS MADE

Upon the passage of the Act, the Department of Health and Human Services developed the “LB 1083 Behavioral Health Implementation Plan”, dated July 1, 2004. The state’s behavioral health regions also established local plans for developing community-based services with the participation of consumers, family members, professionals and local leaders and officials.

Since 2004, significant progress has been made in the implementation of LB1083 and the reformation of the behavioral health system intended by the Act. These include:

1. **30% increase in the number of individuals receiving behavioral health services in the community.** The number of persons served in the community grew by more than 9,000 from fiscal year 2004 to fiscal year 2007. This represents a 30 percent increase in the number of individuals receiving behavioral health services in the community. By providing community-based services, individuals that might have accessed the emergency system and perhaps would have been admitted to a regional center can now receive services closer to family and friends where their recovery may be quicker and more effective, and at much less risk of losing home and job.
2. **47% increase in admissions to identified community services.** The array and the capacity of community-based services has expanded significantly as a direct result of LB1083. Seven services were targeted as a priority for expansion in order to move patients from regional centers to the community. The total number of admissions to these services - Dual Residential, Assertive Community Treatment, Community Support for mental health and substance abuse, Short Term Residential, Day Rehabilitation, and Psychiatric Residential Rehabilitation - increased by 47% from FY2004 to FY2008. In addition, services such as Mobile Crisis Response Teams, Emergency Community Support, and even inpatient services in the community were developed or expanded.
3. **10% decrease in persons placed involuntarily in Emergency Protective Custody.** From fiscal year 2004 through fiscal year 2007, the number of persons placed in involuntary emergency protective custody (EPC) has decreased from 2,601 to 2,336. This is a 10 percent decrease over the four year period, and a 20 percent decrease from just six years ago. EPCs pose the risk of significant trauma to the individual needing behavioral health care, and utilizes significant resources of law enforcement. A decrease in EPCs is a significant indicator of increased access to community services.
4. **63% reduction in the number of involuntarily committed persons admitted to regional centers.** From fiscal year 2004 to fiscal year 2007, the number of involuntarily committed individuals admitted to regional centers decreased from 741 to 273, or 63%. This is another major indicator of the very real and positive impact of expanding both the array and the capacity of community-based services has had for Nebraska citizens with behavioral health disorders.
5. **Closure of 251 adult behavioral health beds at Hastings and Norfolk Regional Centers** consistent with the intent and purposes of the Legislature as stated in the statute.

6. **7.9% readmission rate to state regional center in Nebraska compared to 19.9% nationally.** The readmission rate within 180 days of discharge from a Nebraska regional center was 2 ½ times lower than the national rate in FY2007 and half that of the State's readmission rate in FY2004, providing evidence of the effectiveness of community services after discharge.
7. **Creation of an Office of Consumer Affairs and appointment of administrator within the Office; consumer positions created within each behavioral health region.** The Office of Consumer Affairs and administrator of this office were created by LB1083. The Office of Consumer Affairs incorporated two consumer liaisons who, for many years, had functioned within the Division to provide its consumer input internally. The administrator position was filled in January, 2006. The Division now contracts with each behavioral health region for a full time Behavioral Health Consumer Services Coordinator position.
8. **Peer support services are evolving across the State.** A number of providers have added peer positions. Consumers are advocating for peer driven, peer operated services with job descriptions and evaluation processes, many of which could be Medicaid approved for inpatient and community settings. These services are unique and emerging positions and disciplines in keeping with best practices and the intent of the New Freedom Commission. Consumers with provider support developed a peer support curriculum now offered for college credit by the University of Nebraska at Omaha This is consistent with the mandates of LB1083, and Nebraska's evolution into consumer driven best practices.
9. **Approximately \$26 million in ongoing operational funding has been moved from regional centers to the community.** These additional funds calculated to less than \$3,000 per person based on the 9,000 additional persons served in the community, compared to the \$125,000 or more per bed at the State regional center. The dollars moved funded the expanded community service continuum and the expanded capacity within that continuum.
10. **Mental health agencies receiving 'reform' dollars have earned and maintained national accreditation,** evidence of an ongoing commitment to quality, consumer focused, and results oriented services. This is a baseline standard of quality to which all community-based mental health services are held as a condition of eligibility for funding, and one which is also adhered to by many of the community substance abuse services.
11. **\$24.6 million dollars in private sector dollars raised as part of a public-private partnership formed in support of the goals of LB1083,** resulting in a new 64 bed crisis, acute, and sub acute resource in Omaha. This new physical resource is intended to significantly reduce the demand for Regional Center care for persons from Region 6 and, ultimately, help in the education and training of behavioral health professionals statewide. Such strong private sector support in behavioral health is virtually unprecedented, and brought widespread attention to our state and community.
12. **684 persons with serious mental illness receiving state housing assistance program through fiscal year 2007,** in recognition of the importance of safe, supportive, and affordable housing to the individual recovery process. This too, has drawn positive attention and praise from other parts of the country.

FINDINGS & RECOMMENDATIONS

The Department of Health and Human Services has declared to this Commission and in a state wide media advisory and press conferences that, while behavioral health “reform” may be an ongoing process, Nebraska can “close the chapter” on implementation of LB1083 with the distribution of legislatively mandated funds in May, 2008, a planned disbursement of \$3.5 million from the regional center budget to community budget in fiscal year 2009, and the termination of the Oversight Commission on June 30, 2008.

The Commission finds that while much has been accomplished including the milestones noted above, the disbursement of funds and termination of this body cannot and should not close the chapter, or derail the focus on full implementation of LB1083. The Nebraska Behavioral Health Services Act remains the law of this State, and the transfer of dollars or the sun setting of a commission does not change State responsibilities under this law. In addition, The American with Disabilities Act, and its application to persons with disabilities under the *Olmstead* decision which requires that inappropriate, long-term treatment in state institutions be minimized, also remains the law for all in the United States, therefore precluding “closing the chapter” on many of the fundamental tenets of the Nebraska Behavioral Health Services Act.

The Commission understands that focusing on the movement of funds from the regional centers to the community was, out of necessity, the first step in behavioral health reform. Expanding community-based services depended on first providing the funding to develop and deliver those services. But even if all funding had been accounted for and was fully integrated - and it has not been - LB 1083 does not stop there. The statute clearly outlines multiple, additional principles and responsibilities that have yet to be accomplished.

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

- Consumer involvement in all aspects of service planning and delivery
- Development of a consumer focused culture that is driven by the needs of consumers.
- A plan for integrating the administration of behavioral health programs
- A comprehensive statewide plan for behavioral health services
- Development and management of a data and information system.
- A quality improvement plan
- Services that are research based, focus on recovery, and include peer support
- A methodology for measuring consumer, process, and system outcomes
- Development of plans for developing the behavioral health work force
- An integrated rate setting methodology
- Development and implementation of peer support services

- Recommendation #1:** The Commission recommends that the Department fulfill the mandate of the Act which stipulates “consumer involvement in all aspects of service planning and delivery.” Suggested approaches include: -
- a. Publically take the position that new treatment approaches and attitudes have developed. To transform the mental health system, efforts need to be made to implement these innovative approaches in Nebraska.
 - b. Fund the increase of leadership development, advocacy skills, and board and committee participation, at multiple levels so that all who wish can be involved, and there is “no wrong door”.
 - c. Identify and incorporate existing “real world” opportunities, and create the additional opportunities for consumer voice that are required for this mandate. No government employed consumer is the voice of consumers, or represents consumers. Their charge is to help consumers develop their own voice, regardless of where they may be in their recovery.
 - d. Develop meaningful and good faith mechanisms for creating individual recovery plans, self-determined care, shared decision making and other recovery mechanisms as well as service definitions to be included in the Medicaid State Plan.
 - e. Provide for consumer driven integrated peer support with the cost of these positions included in the rates paid for the service.
 - f. Continue to measure and demonstrate the increase of consumer advocacy and inclusion at all levels of the system.
 - g. Provide funding and training necessary to enable consumers to develop meaningful consumer outcomes and measure those in system level research.
 - h. When individuals have both a mental illness and an addiction, they must have specific “integrated treatment”. Comprehensive training in integrated treatment approaches must be provided to all members of treatment teams, including peers.
 - i. The Office of Consumer Affairs (OCA) needs to be accountable to consumers. Oversight by consumers is needed:
 - to ensure broad based participation by consumers.
 - to ensure regular, consistent, creditable, and comprehensive reports of OCA activities.
 - to demonstrate strategic planning including the development of specific goals and objectives.
 - To develop a budget for consumer projects and demonstrate fiscal accountability.

Recommendation #2: The Commission recommends the Department establish an information system for all persons receiving state-funded behavioral health services. To provide for more effective

management of the behavioral health system and to ensure more accountability for system performance, an information system that provides accurate and timely information to providers, the region, and the state is critical. This should be a state developed system to preclude the possibility of periodic changes in the contractor.

The Commission finds that the work force shortage is a crisis not being adequately addressed by the Department. There are an inadequate number of psychiatrists and other mental health and substance abuse professionals to provide the services consumers need. This is true in both urban and rural settings across Nebraska. Both education and training are needed to grow the work force and to expand training recovery principles and evidence-based practices.

Recommendation #3: The Commission recommends the Department develop a comprehensive, statewide workforce development and funding plan by December, 2008 in collaboration with consumers, physicians, provider/employers, and academic institutions representing all levels of the behavioral health workforce.

The Commission finds that the current and future role of the State regional center(s) is undefined. Defining the role of the state regional center system was a recommendation of the Oversight Commission early in the reform effort, and was not completed by the Department. Without a clearly defined role, it is difficult, if not impossible, to have a fully integrated behavioral health system, to utilize these resources in the most effective and efficient manner possible, or to have consistency across the State. As of the writing of this report, the behavioral health services provided by the Regional Centers are used differently by various regions. All Region 5 patients needing acute care for example, receive these services from Lincoln Regional Center, where other Regions look to the Regional Centers to provide sub acute or longer term secure services.

Recommendation #4: The Commission recommends the formation of a task force comprised of consumers, providers, physicians, regional administrators, a representative of the Regional Centers, and a representative of the Department to study and define the role of the regional centers. Because much of the responsibility for managing regional emergency systems and creating the continuums of care needed to serve persons needing behavioral health services rests with the regions, the task force should be chaired by a regional administrator. The report and recommendations should be completed by December, 2008.

Recommendation #5: The Commission recommends the Department, utilizing current funding appropriated to the Regional Centers, or the Legislature through additional appropriation to Program 38, provide the funding necessary for Behavioral Health Region 5 to develop acute and sub-acute capacity in the community, and discontinue utilization of Lincoln Regional Center for this purpose. Region 5

is the only region that did not receive funding as part of the reform effort to contract for inpatient beds in the community.

Recommendation #6: The Commission recommends the transfer of all funding at the regional centers (Program 365) devoted to providing capacity for behavioral health patients to the regions (Program 38) effective in fiscal year 2010. Regions would be required to contract with the regional centers on an annual basis for the capacity they plan to use. This process would provide for greater accountability for the effective management of the system by both the regional centers and the regions

Recommendation #7: The Commission recommends that all state operated Regional Centers be required to seek and continuously maintain national accreditation as a baseline measure of quality of care for the patients it serves. Department statements that accreditation is not worth the cost are in direct contradiction of its placement of such a requirement on community mental health providers for both Division and Medicaid funding. Accreditation provides consumers and family members with some external validation that at least minimum quality standards are being met. This recommendation is also consistent with the requirements of mental health providers within the community and is viewed as necessary for the ongoing integration of services between community and state hospital into one system as envisioned by LB1083.

The Commission finds that behavioral health patients not committed under the provisions of LB1199 (2006), the Sex Offender Commitment Act should not be served at the Norfolk Regional Center. The recent shift of patients from the Lincoln Regional Center to the Norfolk Regional Center is inconsistent with the intent of both the Nebraska Behavioral Health Services Act and the Sex Offender Commitment Act. LB 1083 provides for the closure of regional centers and the Norfolk Regional Center should be closed to behavioral health patients. The fact that sex offenders are served in the same building and the treatment of the building as a high security area should preclude behavioral health patients from being served there.

Recommendation #8: The Commission recommends the immediate cessation of the Department's practice of moving patients from the Lincoln Regional Center to the Norfolk Regional Center. The Commission further recommends that future plans for the Norfolk Regional Center not include capacity for behavioral health patients and that a goal be set to move all behavioral health, i.e. all patients at NRC not committed under the provisions of LB1199, to the community or, if necessary, to Lincoln Regional Center by no later than June 30, 2009 and preferably sooner.

Recommendation #9: The Commission recommends the development and funding of two 16 bed, secure, longer stay capacity residential facilities to facilitate the accomplishment of the discharge of all behavioral health patients from Norfolk Regional Center as outlined above. These two facilities are in addition to the secure residential facility being developed in Region 6. The Commission recommends that efforts be made to locate one of these additional facilities in the Region 5 area and one in the Region 4 area, but neither should be on state regional center grounds; Region 6 may also be considered as a location. The Commission further recommends that the services be developed, sized, and accredited in a manner that is consistent with becoming a Medicaid eligible service under the State plan. (See recommendations below.)

The Commission finds that the cost of services provided at Hastings Regional Center are excessive and unjustified relative to the intent and mandates of the Nebraska Behavioral Health Services Act. The costs of providing adolescent services at Hastings Regional Center in fiscal year 2008 are over \$250,000 per bed based on licensed capacity of 40 residential beds are approximately \$265,000 per bed. According to the information provided by the Department, over \$10 million is being spent this fiscal year on these residential chemical dependency treatment beds. The per bed cost skyrockets to over \$350,000 per adolescent when based on actual census. This added to maintaining an adult behavioral health unit for one patient, with a reported 70 staff positions at a \$3 million cost call into question the Department's management of scarce resources and accountability to taxpayers, as well as its adherence to the Legislative mandate in LB1083 to transfer available funds and services to the community.

Recommendation #10: The Commission recommends closing the adolescent chemical dependency unit and the 14 person unit for developmental disabilities at the Hastings Regional Center at the earliest possible date and no later than June 30, 2009, and moving all commensurate behavioral health funding to the community consistent with the requirements of the Nebraska Behavioral Health Services Act.

The Commission finds that there has been a lack of transparency and accountability by the Department in the reporting of financial information to the Commission. Funding for both the expansion of community-based services as well as "one-time," reappropriated funding was available to the Department to distribute on July 1, 2007. In meetings with the Commission and other public forums, Department leaders stated that the funds identified through this Commission would be distributed in October, then in January, and then in April. It was not until the Legislature, in response to their constituents, passed specific language requiring the distribution of those funds, that funds were disbursed to the behavioral health regions in May, 2008. Further, the Commission remains concerned that not all dollars required to be transferred to the community under the provisions of the statute LB1083, or the appropriations bill passed in April, 2008 (LB959) has been fully reconciled, and will not be until after this Commission expires.

The Commission finds that, upon review of financial records of the Department requested by the Commission, certain administrative costs were inappropriately being allocated to the behavioral health aid program (Program 38), and that there had been no identified process put into place for identifying and remedying such errors on a regular and timely basis.

Recommendation #11: The Commission recommends both a financial and performance audit of the operations the Division of Behavioral Health for purposes of providing an opportunity to start with a “clean slate” and resolve any ongoing disagreements as to funding. For example, administrative costs are currently being paid from aid funds. Appropriations to Program 38 (behavioral health funds) are intended to provide for behavioral health services in the community. The cost of the contract with Administrative Services Organization (Magellan) to perform administrative activities is currently being paid from Program 38 and there are other administrative expenditures inappropriately assigned to the program that should be corrected.

The Commission finds that there is a significant disparity in the manner in which the state portion of Medicaid costs for behavioral health services are being funded as compared to physical health services. The Legislature directly appropriates to the Medicaid budget (Program 348) the state match portion for physical health services. While a portion of the match for behavioral health services is directly appropriated, the Commission finds that an increasing amount of match dollars are being transferred from the Division of Behavioral Health budget (Program 38) to the Medicaid budget (Program 348) without Legislative approval or oversight. The Department plans to expand this internal transfer further in fiscal year 2009 by including additional services to be matched by Program 38 funds. By matching Medicaid funded behavioral health services in such a manner, funding and access to services for very low income, non-Medicaid eligible patients are disproportionately reduced. The Department has not enacted any similar reduction for non-Medicaid patients requiring physical health services.

Recommendation #12: The Commission recommends parity and equality of treatment for Nebraska citizens in the funding of Medicaid services for physical health conditions and behavioral health conditions. Specifically, it recommends that the administrative practice of utilizing Program 38 funds as a match for an increasing number and span of Medicaid eligible behavioral health services be immediately ended. Further, the Commission recommends that the Legislature and Governor be fully informed of this disparity in treatment, and that the state match for behavioral health services be directly appropriated to the Medicaid budget, as it is for physical health services.

Recommendation #13: The Commission recommends that the State Medicaid plan be revised to include all behavioral health services developed to date

and those planned for development as part of this reform effort, including secure residential services, intensive community support services, dual diagnosis services, intensive residential rehabilitation services, emergency community support, crisis response, and peer support services.

The Commission finds that the cost of providing sex offender services at the Norfolk Regional Center is high when compared to other states. Notwithstanding the Department's stated position that all beds at Norfolk Regional Center are licensed psychiatric hospital beds, the Commission views the treatment of behavioral health patients committed under the LB1199 processes as substantially different in focus, length of stay, and therefore cost than that of patient needs contemplated under the Nebraska Behavioral Health Services Act. A *New York Times* report dated March 3, 2007, compares the cost of delivering sex offender treatment in 18 states including Nebraska. The average annual cost per sex offender ranged from \$32,000 in Texas to \$166,000 in California. The average cost recorded for 17 states (excluding Nebraska) was \$93,743. The median cost was \$88,000. The costs in Kansas and Iowa were \$69,070 and \$70,000 respectively. The planned cost for delivering services at the Norfolk Regional Center (more than \$13 million and 120 beds) was \$114,000 per bed. The actual cost at the current census of 87, which includes behavioral health patients, is \$157,183 per patient.

Recommendation #14: The Commission recommends that the Department contract for an independent study to identify and report back findings and recommendations for Legislative consideration relative to various treatment models and comparative effectiveness and costs for programs to deal with committed sex offenders.

The Commission finds that its effectiveness in overseeing implementation and fulfillment of the purposes and mandates of LB1083 was greatly furthered by (a) its structure as a body reporting to, and having the direct participation and access to members of the Legislature, (b) its broad composition and representation of multiple stakeholders; and (c) its public meetings and wide-spread public dissemination and sharing of the reports, findings, data, and analysis considered. The Commission notes that the replacement Oversight Commission is structured as an advisory committee to DHHS, with membership appointed by the Governor. Representation of stakeholders, particularly by consumers of behavioral health services, is significantly curtailed as compared to this Commission, as is independent recourse available should DHHS and the Commission disagree on process, findings, or direction.

Recommendation # 15: The Commission recommends that, upon expiration of the replacement Commission effective June 30, 2009, the Legislature establish a subsequent oversight body structured in a manner that assures (1) independence from the Department of Health and Human Services; (2) broad stakeholder representation inclusive of consumers of behavioral health services; (3) participation and/or direct access to members of the Legislature or Legislative committee; and (4) public meetings and wide-spread web posting

and other public dissemination of reports, findings, analysis and recommendations.

Adopted by majority vote of the Behavioral Health Oversight Commission on June 20, 2008.

Jim Jensen
Chair, Behavioral Health Oversight Commission