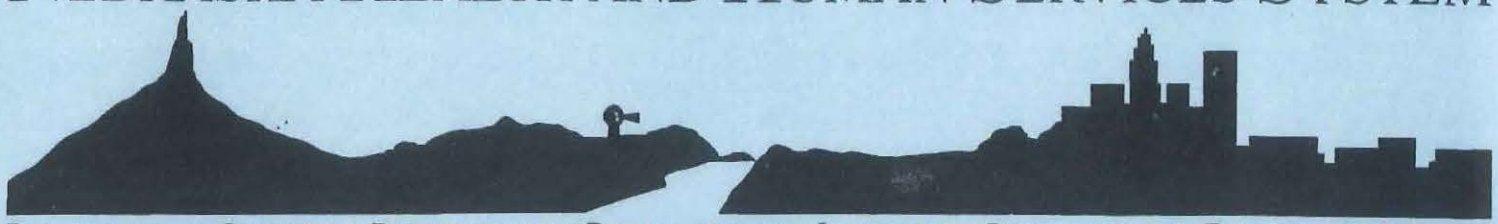
NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM



DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE • DEPARTMENT OF FINANCE AND SUPPORT

A Status Update on the Nebraska Health and Human Services System February, 1998

Based on recommendations from the *December 1, 1996 Report*

to Governor Nelson and the Nebraska Legislature

Nebraska Health and Human Services: Common Sense Solutions for a Healthy Nebraska

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The following information is presented as a status update on the implementation of recommendations and action steps outlined in the *December 1, 1996 Report*, required by the Nebraska Partnership Act, which passed in 1996.

The Nebraska Partnership Act created a Policy Cabinet to provide leadership for the Nebraska Health and Human Services System. Members of the HHSS Policy Cabinet are:

- Deb Thomas -- Policy Secretary
- Charles Andrews, MD -- Chief Medical Officer
- Jessie K. Rasmussen, Director -- Department of Health & Human Services
- Gina Dunning, Director -- Department of Health & Human Services Regulation & Licensure
- Jeff Elliott, Director -- Department of Health & Human Services Finance & Support

The reform of Nebraska's health and human services was the most far-reaching government reorganization project ever undertaken in Nebraska. The new System is about doing what works for the citizens of Nebraska. It's about providing better services that are simple, efficient, and make common sense. It's about providing cost savings and being accountable.

The Nebraska Health and Human Services System began on January 1, 1997. This review of activities-to-date shows the System is on course with its 30-month implementation plan.

Information compiled by
Communications & Legislative Services Division
Nebraska Health and Human Services System

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This status update follows the order and structure of the *December 1, 1996 Report*.

The page number where each action or recommendation was listed in the *December 1, 1996 Report* is included for ease in cross-referencing the two.

Setting A New Course

By January 1, 1997, Implementation/Transition Planning activities include:
(found on pg 9 in *December 1, 1996 Report*)

- **Initial proposed cost savings, due to a reduction in authorized positions over a 30-month period identified;**

  Status: Accomplished. The HHS System's 1997-99 biennium budget identified a total of $88 million in up-front cost savings as a result of the integration of five agencies into three. Reduction of 400 FTEs (full-time equivalent positions) amounted to $22.9 million of that total.

- **The ongoing work of the five sunsetting agencies will continue uninterrupted as the new structure is put into effect. Any changes in policy and procedure will be specifically communicated;**

  Status: Accomplished. Providing better services to more than 250,000 Nebraskans continues to be the main focus for any redesign activities. During 1997, the Central Office components of the three new agencies focused on getting an organizational structure in place to support delivery of those critical services. During the second phase in 1998, field services and programs are being redesigned, as appropriate, to be more effective and efficient, again with the focus on uninterrupted services.

- **Current five agencies are sunsetted and the new system, with its Policy Cabinet, Partnership Council and three new agencies officially comes into existence;**

  Status: Accomplished. The three new agencies are: Department of Health and Human Services, Department of Health & Human Services Regulation and Licensure, Department of Health and Human Services Finance & Support. They came into existence on January 1, 1997.

- **Policy Cabinet and Partnership Council appointments submitted for legislative approval and other key leadership positions appointed and/or filled;**

  Status: Accomplished. See Appendix A for list of Partnership Council members.

- **Coordinated legislative package drafted and submitted to the Unicameral on behalf of the new Health and Human Services System;**

  Status: Accomplished. See Appendix B, legislative bills passed during the 1997 Session.

- **Integrated budget and information technology plan submitted to the Governor and the Legislature for the 1997-1999 biennium;**

  Status: Accomplished. The Governor and the Legislature received one HHS System budget for the 1997-99 biennium. This budget included information about the information technology plan.

- **Employees in the Partnership agencies notified of their new agency assignments and provided with all relevant personnel-related information;**

  Status: Accomplished. Each employee in the five former agencies received a personal letter in December, 1996, stating their work location, job title and agency designation in the new HHS System that began January 1, 1997.

- **A "System Advocate" and a toll-free number in place to facilitate questions, concerns and complaints about the new System;**

  Status: Accomplished. The System Advocate can be reached at 1-800-254-4202, and assists individuals who aren't sure where to go with questions and concerns regarding the Health and Human Services System. During 1997, a total of 1,604 contacts were made with the System Advocate. The majority (96%) were telephone calls. Most contacts came from general citizens (592), clients (410) and state employees (222).

  Other contacts included providers, associations/organizations, legislators, local officials, government offices in other states, and community group. There were 906 requests for information, 474 expressing a complaint, 199 requesting help, 16 reporting abuse/neglect, 7 reporting fraud, and 2 making a suggestion.

- **Initial Cabinet-sponsored crosscutting teams created;**

  Status: Accomplished. The work teams proposed in the December 1, 1996, report were: Health Policy; Safety Policy; and Self-Sufficiency Policy; Strategic Planning; Community/State Partnerships. Crosscutting work teams did come together during 1997, but operated under different names. The work teams are:

  - Standards Work Team: Develop recommendations on defining system parameters ("who" will be served, "how" those individuals should best be served, and "to what end" the services are aimed.)
  - Financial Strategy Work Team: Develop recommendations on how best to align financial incentives with individual and system results.
  - Assessment/Information Work Team: Develop specifications for an integrated management information system that is capable of detailing precisely who and how many HHSS is serving at any given time.
  - System Management Work Team: Define responsibilities and system management capabilities needed for effective delivery of HHSS services.
  - Current Operations Work Team: Develop recommendations on integrating current services ,programs, and initiatives.
  - Network Development Work Team: Integrate the recommendations of the five work teams listed above, and develop recommendations on how best to integrate the work of the HHSS System.

- **Partnership agreements negotiated with three community/state "learning labs";**

  Status: Accomplished in two communities. The HHS System has signed agreements with the Panhandle and the Dakota County learning lab communities. Collaborative efforts continue in the Douglas/Sarpy County area, which was originally organized as the Health and Human Services Roundtable. Participants have reorganized as the Human Care Council. This group plans to partner with the state at a later date. During 1998, HHSS will continue to explore ways to partner with additional communities, through development of local integrated health and human services networks.

- **Discussion begun for state service management areas and operations pending results of public input.**

  Status: Accomplished After several months of review by Services Leadership Team, and input from community members, county officials, and employees throughout the summer/fall of 1997, six new Service Area boundaries were announced in October, 1997. Boundaries will become effective 4/1/98. Boundaries will be used by HHSS to organize/align work and resources, moving one step closer to an integrated service delivery system.

By June 30, 1997, at the end of the Implementation Initiation Phase, the following milestones will be achieved: (pg. 9)

- **1997 legislation passed to ensure smooth implementation of the new System and appointments confirmed**

  Status: Accomplished. See Appendix B, legislative bills passed during the 1997 Session.

- **Implementation of initial redesign recommendations (streamlining, service coordination, etc.) underway**

  Status: Accomplished and ongoing. Initial streamlining recommendations included merger of Emergency Medical Services Regulatory Boards (accomplished); redesign of behavioral health services (in the implementation phase); and integration of child welfare/juvenile justice services into the Protection and Safety Division (in progress).

- **Training designed to orient employees to the new System design, operations and culture change underway**

  Status: Accomplished and ongoing.

  - In 1996, approximately 300 employees from all five former agencies participated in three random surveys to determine if transition supports were meeting employee needs. In response, approximately 900 employees attended training between January and May, 1997, on organizational change and dealing with uncertainty, provided through the Methodist Employee Assistance Program. Methodist EAP training provided over 33 sessions for employees on organizational change, team building, burnout, conflict management.
  - HHSS Administrators received updates on various important areas during 1997, with the expectation that they would then take the information back to share with their employees.
  - A Resource Guide was prepared and distributed to all employees in January, 1997. This Resource Guide included organizational charts and descriptions of the primary functions for the three new agencies; phone numbers of some key contacts within HHSS so employees knew where to refer questions from the public; information about the HHSS web page; answers to frequently asked questions; information about how to order new letterhead; etc.
  - A second Resource Guide was distributed during February, 1998. Included was a listing of all HHSS employees, phone numbers, locations; culture principles; System TDD number; glossary of terms; Service Area map; list of key contacts in the HHS System.
  - A work group is developing a training curriculum and an orientation video that describes the culture/work expectations. Release is planned for late spring, 1998.

- **Opportunities expanded for communities to enter into partnership agreements with the State of Nebraska**

  Status: In progress through network development. A series of three information meetings were held in 18 locations across Nebraska in the fall of 1997. Several hundred Nebraskans had the opportunity to share information and make suggestions on how the community/state partnerships can best be realized through the network model.

- **Capacity-building needs of communities assessed and technical assistance strategies developed**

  Status: In progress through network and Service Area development. The Services agency will hire six Service Area Administrators in February, 1998, to lead this effort and provide technical assistance to communities and local programs. Staff from the Office of Community Support are developing a technical assistance curriculum that will support community efforts. HHS System employees will be offered training in change management, team building, and other needed skills as they change the way they do business. Exploring distance learning opportunities as one way of enhancing technical assistance.

- **System-level outcomes and preliminary indicators validated with the Legislature and through a public process**

  Status: Accomplished. A listing of nine System results and 34 indicators was approved by the Policy Cabinet and distributed internally in December, 1997. This was a joint effort of the Performance Accountability Division in R&L and the Operations Research Team in F&S.

- **Plans for the creation of data collection and analysis capability to support outcome evaluation at the state and/or local level begun**

  Status: Accomplished. The Operations Research Team is in place and processes are being designed to capture appropriate and timely data. The Assessment & Information Strategies Integration Work Team has provided the Policy Cabinet with a strategic plan that would integrate HHSS data collection and analytic functions and facilitate the evaluation of System results.

- **Additional reengineering of work processes initiated**

  Status: In progress. The nine priority initiatives set out in the 1997-1998 Action Plan are the "work of the day" are all areas where reengineering is being considered where appropriate.
  Examples of reengineering activities done so far include: merger of investigative programs into one that supports the entire System; reducing a four year backlog of complaints in one year; redesign of adult behavioral health services; integration of child welfare and juvenile justice services into the Protection and Safety Division; combination of trust accounts for clients/state wards into the former DPI system, resulting in a simpler, more efficient accounting that meets necessary assurance of accountability and allowed elimination of one FTE; creation of a uniform process of adopting rules and regulations of the System, including a single public hearing for all changes and using in-house experts as hearing officers rather than contracting for those services; streamlining personnel policies of the five former agencies into one; consolidating payroll; bringing together of all training staff from the former agencies, focusing their efforts on specialty areas; bringing together all Information Systems staff to begin the important work of integrating and upgrading the HHSS information system.

- **Organizational structure and lines of authority to the work unit level established**

  Status: Ongoing. All three agencies will continue working together to refine organizational structure and lines of authority as new Service Area Administrators comes on line in April, 1998.

- **Human resource policies and procedures fully integrated**

  Status: Accomplished. Personnel policies from the five former agencies have been streamlined into one set of policies for the System. Payroll has been consolidated into one structure and other supports for these functions are being planned and accomplished.

- **State service management areas aligned based upon local input**

  Status: Accomplished. After several months of review by the Services Leadership Team, and input from community members, county officials, and employees throughout the summer/fall of 1997, six new Service Area boundaries were announced in October,1997. Boundaries become effective 4/1/98. Boundaries will be used by HHSS to organize/align work and resource, moving one step closer to an integrated service delivery system.

- **First integrated strategic plan for the new HHS System initiated**

  Status: Accomplished. The Policy Cabinet approved the System's 1997-98 Action Plan. This Action Plan identifies local integrated health and human service networks as the unifying strategy for responding to the health and human service needs of Nebraskans. The Action Plan also outlines nine priority initiatives that are the "work of the day" for the HHS System: Implementing Employment First welfare reform statewide; integrating child welfare/juvenile justice services; developing an integrated system of long-term care services; establishing a balanced and comprehensive behavioral health system; redesigning the professional credentialing process; making prevention an integral strategy throughout the system; expanding Medicaid managed care to rural Nebraska through Integrated Health Organizations; developing a statewide system of service coordination; and simplifying rules and regulations. (See Appendix C.)

- **Initial reduction of authorized positions realized**

  Status: Accomplished. The HHS System's 1997-99 biennium budget identified an up-front reduction of 400 FTEs amounting to $22.9 million. This reduction is real. On 12/1/96 the HHS System was budgeted for 6,259 FTEs. Eleven months later, 5,674 FTEs were filled. HHS System Leadership is serious about reducing the number of positions within the System, and is doing it through a thoughtful and responsible process. It is important to note that some of these vacant positions that provide frontline care in the 24-hour facilities, determine eligibility for services, or are technical in nature **must be refilled.**

Operating As A Unified Health and Human Services System

By June 30, 1999, the Implementation Completion Phase will see the following: (pg. 10)

- **Cost savings fully realized from implementation of restructuring and redesign recommendations**
  Status: Accomplished. At the end of FY 1997, $40.4 million lapsed from the HHS System back to the general fund. This is primarily due to savings of $40 million in the public assistance and Medicaid programs over the two-year budget period. Reduction of authorized positions was put in place up front, with the HHS System's biennium budget for 1997-1999 including a reduction of 400 FTEs for a savings of $22.9 million. Continued reengineering efforts will identify additional cost savings during the remainder of the transition period.

- **Interim report to the Legislature on implementation and cost savings submitted**
  Status: Will be accomplished by June 30, 1999.

- **New state classification system piloted in HHS System**
  Status: In progress. The current state classification system is more than 25 years old and has grown to include 1,500 job classes – one for every 10 state employees. Beginning in March, DAS State Personnel will begin studying and redefining job classifications and their needed levels, and to ensure pay fairness for similar positions across agencies. Molly Anderson, DAS State Personnel, is leading this effort. One aim of the activities will be to group job classes together based on similarity of tasks, knowledge, skills, and abilities, resulting in fewer job titles that are less specific than the ones we had before.

- **Reports to the Governor and Legislature on the status of health and human services indicators issued annually**
  Status: Ongoing. The development of the nine HHS Systems Results and 34 Indicators establishes a baseline for data collection. This dynamic process will continue to evolve and the data collected will be refined over the biennium.

- **Aligning funding streams around outcomes (results-based budgeting) piloted in collaboration with the Legislature**
  Status: In progress. The Department of Finance and Support is taking the lead in developing a new Budget Framework for the HHS System for FY 2000-2001. This is a first step in aligning funding streams around outcomes for results-based budgeting. Work continues with the Governor's Budget Office, the Legislature's Appropriations Committee, and the Legislative Fiscal Office for the biennium budget that is due September 15, 1998.

- **Community/state partnership agreements in place across the state, and an increasing number of communities with the capability to manage resources systemically and be held accountable for outcomes. Some communities realizing savings which may be reinvested in preventive strategies**
  Status: In progress. Development of local integrated health and human service networks is underway. Recommendations call for either development plans showing a communities' readiness to form an integrated network, or contracts to be negotiated and signed for at least one network in each of the six Service Areas by the end of 1998.

- **State local service management in the field is effectively supporting communities with technical assistance and accessible services**

  Status: Ongoing. The Services agency hired six Service Area Administrators in February, 1998, to lead this effort and provide technical assistance to communities and local programs. Staff from the Office of Community Support are developing a technical assistance curriculum that will support community efforts. HHS System employees will be offered training in change management, team building, and other needed skills as they change the way they do business in order to provide better services.

Policy Cabinet

- **Five initial crosscutting teams will start up early in January, 1997 (pgs. 13-14)**

  Status: Accomplished. The work teams proposed in the December 1, 1996, report were: Health Policy; Safety Policy; and Self-Sufficiency Policy; Strategic Planning; Community/State Partnerships. Crosscutting work teams did come together during 1997, but operated under different names. The work teams are:

  - Standards Work Team: Develop recommendations on defining system parameters ("who" will be served, "how" those individuals should best be served, and "to what end" the services are aimed.)
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  - Current Operations Work Team: Develop recommendations on integrating current services, programs, and initiatives.
  - Network Development Work Team: Integrate the recommendations of the five work teams listed above, and develop recommendations on how best to integrate the work of the HHSS System.

Partnership Council

- **Beginning in the summer of 1997, a participative process for reviewing the advisory needs of the new agencies will be initiated, calling for recommendations by the end of 1997 (pg. 16)**

  Status: On hold. The Partnership Council has agreed to conduct this review of approximately 76 Boards and Commissions organized under the former five agencies. Recommendations may not be available until the fall of 1998.

A System Accountable for Outcomes

Performance Accountability Actions/Recommendations (pg. 17)

- **Establish a Division of Performance Accountability Management within R&L**

  Status: Accomplished. The Performance Accountability division is located in the Department of Regulation and Licensure.

- **Validate system-level outcomes and indicators**

  Status: Accomplished and ongoing. The HHS Finance & Support Operations Research Team evaluated several hundred suggested indicators against a set of criteria that included communication power, consistency and quality of data, cost of collecting data, ability to obtain data by geographic areas and ethnic groups, and comparability to indicators used in prominent national work efforts and in other states. Each of the 34 indicators validated referred back to these nine System results:

  - Nebraskans are free from abuse, neglect and exploitation;
  - Nebraskans are free from health risks related to a lack of compliance with environmental, professional or quality standards;
  - Nebraskans experience healthy pregnancies and births;
  - Nebraskans of all ages experience healthy lifestyles;
  - Nebraskans do not experience disease; disability/death due to lack of access to quality care;
  - Nebraskans live in supportive families and communities;
  - Nebraskans live as independently as possible;
  - Nebraskans have the resources needed to achieve self-sufficiency; and
  - Nebraskans are able to participate in and contribute to the political, economic and cultural life of the community.

- **Create the capability within F&S to collect data needed for outcome evaluation**

  Status: Accomplished and ongoing. The Operations Research Team is in place and processes are being designed to capture appropriate and timely data. The HHS System has the capability to collect data and has done so through 1996 for the nine System results. The HHSS Results and Indicators information issued in December, 1997, contains a set of 34 indicators for the nine System results. These indicators and data are a dynamic, ongoing work product and do not include analysis or interpretation. The indicators will establish a baseline for data collection, from which future reports can be prepared on the status of HHSS results and indicators in Nebraska.

- **Issue annual reports to the Governor, Legislature and public on the status of health and human services outcomes and indicators in Nebraska**

  Status: Ongoing. The HHS System Results and Indicators establish a baseline for data collection. Reports will be prepared as data is collected and refined.

- **Develop and implement a process for outcome-based performance evaluations as part of the System's new performance management process**

  Status: Changing focus. A report was submitted and reviewed by the Policy Cabinet, which has advocated a change of focus. A beginning compilation of the data for the approved indicators without analysis, interpretation or recommendations has been accomplished.

- **Assist in building capacity in communities around outcome accountability in preparation for entering into partnership agreements with the state**

  Status: In process. HHS Regulation & Licensure's Performance Accountability staff worked with the Office of Community Support (OCS) staff to develop a tool to use to build this capacity. The OCS's technical assistance team has been working with lab communities and family preservation teams to accomplish this, with the expectation that this process will expand in 1998. The OCS is developing a technical assistance curriculum that will be available to parties interested in developing local integrated health and human services networks.

- **Support outcome-based, crosscutting policy teams at the Cabinet level to utilize performance accountability data as the basis for strategic planning and budgeting and resource allocation.**

  Status: Accomplished. The Performance Accountability Division has participated in each of the six cross-cutting Integration Teams and in other work groups looking at the coordination of resource allocation, strategic planning, and budgeting. Integration teams incorporated members from each of the three agencies to optimize the different perspectives in the development of "new ways" of doing business for HHSS.

Working In Partnership With Communities

Actions/Recommendations (pg. 19)

- **Establish an area for Community Support and Service Management Areas within the new Department of Health and Human Services with responsibility for providing technical assistance to communities**

  Status: Accomplished. The Office of Community Support (OCS) reports to the Services' Chief Deputy Director, as will the six new Service Area Administrators. OCS staff is involved in development of Service Areas and local networks.

- **Continue working with three "learning lab" communities to implement partnership agreements**

  Status: Accomplished in two communities. The HHS System has agreements with the Panhandle and the Dakota County learning lab communities. Collaborative efforts continue in the Douglas/Sarpy County area. Originally organized as the Health and Human Services Roundtable, participants have reorganized as the Human Care Council. This group plans to partner with the state at a later date. During 1998, HHSS will continue to explore ways to partner with other communities also, through development of local integrated health and human services networks.

- **Expand partnership opportunities to additional communities across the state during 1997**

  Status: Ongoing. A series of three information meetings were held in the fall of 1997 in 18 locations across Nebraska. Several hundred Nebraskans had the opportunity to share information and make suggestions on how services can be improved through community/state partnerships, which can best be realized through the network model.

- **Initiate capacity building to develop the competencies of state employees and communities for new partnership agreements**

  Status: Accomplished. The Services agency hired six Service Area Administrators in February, 1998, to lead this effort and provide technical assistance to communities and local programs. HHS System employees will be offered training in change management, negotiating, and team building.

- **As a partner with communities, the state will support "local service networks" to organize services in a more integrated way**

  Status: Ongoing. The Services agency has recommended a model for local networks, and will be working with communities throughout the rest of 1998 to assess readiness and develop local integrated health and human services networks.

Department of Health and Human Services

By June 30, 1997: (pg. 28)

- **Complete orientation and training of employees to the new department and the new Health and Human Services System**

  Status: Accomplished and ongoing.

  - In 1996, approximately 300 employees from all five former agencies participated in three random surveys to determine if transition supports were meeting employee needs. In response, approximately 900 employees attended training between January and May, 1997, on organizational change and dealing with uncertainty, provided through the Methodist Employee Assistance Program. Methodist EAP training provided over 33 sessions for employees on organizational change, team building, burnout, conflict management.
  - HHSS Administrators received updates on various important areas during 1997, with the expectation that they would then take the information back to share with their employees.
  - A Resource Guide was prepared and distributed to all employees in January, 1997. This Resource Guide included organizational charts and descriptions of the primary functions for the three new agencies; phone numbers of some key contacts within HHSS so employees knew where to refer questions from the public; information about the HHSS Web page; answers to frequently asked questions; information about how to order new letterhead; etc.
  - A second Resource Guide was distributed during February, 1998. Included was a listing of all HHSS employees, phone numbers, locations; culture principles; System TDD number; glossary of terms; Service Area map; list of key contacts in the HHS System.
  - A work group is developing a training curriculum and an orientation video that describes the culture/work expectations. Release is planned for late spring, 1998.

- **Engage all Health and Human Services field employees in team building, joint planning, and program redesign activities**

  Status: Ongoing. Methodist EAP training provided over 33 sessions for employees on organizational change, team building, burnout, conflict management. Staff and Partnership Development is working on training for new employees. Prior to hiring six Service Area Administrators in February, 1998, three individuals from the Services Leadership Team (Dennis Loose, Dennis Mohatt, and Bryan Samuels) took a lead role in facilitating integration activities. These individuals will work extensively with the six new Service Area Administrator, who will be leading capacity building efforts to develop team building, planning, and reengineering competencies in state employees.

- **Define work responsibilities of Health and Human Services state service management area leaders**
  Status: Accomplished. A job description was developed for the Service Area Administrator position. SAA responsibilities include: performing a leadership role in development and strategic planning for community-based service integration activities; serving on and representing the state's interest in local networks; serving as an agent of change as the cultures of five former agencies come together; working with management and staff system-wide to unify and integrate HHS operations in their respective Service Area; coordinating development, implementation, and monitoring of agency programs and policies; supervising local state-operated programs; conferring and improving working relationships with key local officials, local agencies and other interested groups to obtain necessary support for HHS program priorities and goals.

- **Define process and timeline to define state service management areas by July 1, 1997.**
  Status: Accomplished. Services leadership developed a timeline and a process to obtain input from county officials and employees during the summer of 1997, culminating with announcement of the geographic boundaries in October, 1997. These Service Area boundaries go into effect on April 1, 1998.

- **Begin implementation plan specific to major areas of work: Prevention, Service Coordination, Community/State Partnerships, and Service System**
- **Continue work in existing priority redesign areas: Welfare Reform, Long-Term Care Project, Behavioral Health, Child Welfare and Juvenile Services Merger.**
  Status: Accomplished and ongoing. The areas listed above are included as part of the nine priorities in the HHS System Action Plan for 1997-98. These nine HHS System priority initiatives are the work of the day for employees in the System:
  Implementing Employment First welfare reform statewide; integrating child welfare/juvenile justice services; developing an integrated system of long-term care services; establishing a balanced and comprehensive behavioral health system; redesigning the professional credentialing process; making prevention an integral strategy throughout the system; expanding Medicaid managed care to rural Nebraska through Integrated Health Organizations; developing a statewide system of service coordination; and simplifying rules and regulations.

- **Complete planning for organization and staffing in Central Office components**
  Status: Completed. All three agencies have developed an organizational structure for their Central Office components.

- **Develop structure and working relationships regarding Medicaid related functions and responsibilities among the three agencies**
  Status: Ongoing. The three agencies have agreed on placement of Medicaid-related functions. This continues to be refined as HHSS implements Medicaid managed care in rural areas of the state.

By June 30, 1999: (pg. 28)

- **Implement structure revisions and unified program strategies as they are completed**
  Status: Accomplished and ongoing. Examples include integration of Office of Rural Health into Preventive Health and Public Wellness; Office of Minority Health and Human Services under Administration; and child welfare/juvenile justice services into the Protection and Safety Division.

- **Develop and implement plan to address existing statutory regional boundaries**
  Status: Reviewed and dropped. Development of the six Service Areas did not effect Area Agency on Aging, Mental Health/Substance Abuse, or Developmental Disabilities regional boundaries that are in statute.

Implementation Plan for Service Coordination

By January 1, 1997: (pg 32)

- **Distribute Service Coordination definition and model to Service agency staff**
  Status: Accomplished. Recommendations made to Services Leadership Team in a June 30, 1997 report. Approximately 4,500 cases having more than one caseworker have been identified and are being assessed, in order to identify a primary case manager.

- **Form interagency implementation planning group under Services leadership**
  Status: On temporary hold, pending determination of Service Coordination Plan components.

- **Develop Implementation Plan**
  Status: On temporary hold, pending determination of Service Coordination Plan components.

- **Identify current clients with multiple service coordinators, identify duplications.**
  Status: Accomplished in Developmental Disability areas. In the developmental disabilities area, 4,500 cases had two or more case managers – one from former DPI and one from former DSS. We are now in the process of assessing how best to designate one person with primary responsibility for coordinating each case.

By June 30, 1997: (pg. 32)

- **Develop criteria for primary Service Coordinator assignments**
  Status: Accomplished in Developmental Disability/Medicaid Waiver area. Recommendations made to Services Leadership Team in June 30, 1997 report.

- **Assign primary Service Coordinators**
  Status: Accomplished in Developmental Disability/Medicaid Waiver areas; further system-wide review and comment needed in other areas.

- **Develop Service Coordinator and Eligibility Consultant qualifications/classifications**
  Status: Ongoing.

- **Review program rules and regulations for consolidation and revision**
  Status: Accomplished in Developmental Disability/Medicaid Waiver areas; further system-wide review and comment needed in other areas.

- **Work with F&S to determine data and information system needs**
  Status: Ongoing. The implications of technology exchange are being reviewed.

- **Work with F&S to develop and provide training for staff, clients, and community members on new Service Coordination processes and self-directed services**
  Status: On hold, pending determination of plan components.

By June 30, 1999: (pg. 33)

- **Continue implementation of new Service Coordination process**
  Status: Ongoing. Services Coordination has made the greatest strides in the areas of developmental disabilities and Medicaid Waiver services. Approximatley 4,500 cases with two or more case managers were identified; program rules and regulations are being reviewed for consolidation and revision; criteria has been developed for primary Service Coordination assignments; a single assessment document has been developed and is being field tested; the implications of technology exchange are being reviewed.

- **Work with R&L Performance Accountability to establish quality assurance/outcome measures**
  Status: Ongoing.

Implementation Plan for Prevention
By January 1, 1997: (pg 35)

- **Distribute Prevention Strategies report to other Partnership teams and community agencies to acquaint people with the report and help ensure a prevention focus at the policy development level.**
  Status: Accomplished and ongoing. HHSS Administrators will receive the Prevention Strategies report at the March 5, 1998, management meeting. Two national prevention experts will share their perspectives on prevention with the Administrators, who are expected to take that information back to their employees. The entire day will focus on prevention, and on developing concrete strategies that each manager can take back to his/her work area and put in place.

- **Ensure representation on the Partnership Council with expertise in primary prevention**
  Status: Accomplished. Four out of the 15 Partnership Council members – or almost one-third of the Council's membership – have expertise in primary prevention.

- **Identify primary prevention specialists to lead technical assistance teams. Identify prevention opportunities in all agency programs.**
  Status: Accomplished. The Prevention Strategies report outlines these specialists and opportunities. HHSS Administrators discussed the Prevention Strategies report at a March 5, 1998, management meeting. The entire day focused on prevention, and on developing concrete strategies that each manager can take back to his/her work area and put in place.

- **Establish organization goals and strategies to create a "prevention culture" throughout the new Health and Human Services System. Establishment of policies and procedures to ensure prevention programs remain coequal with intervention and treatment/rehabilitation programs.**

  Status: Accomplished. The Policy Cabinet has endorsed creation of a "prevention culture" throughout the HHS System, and is working on the policies and procedures necessary to ensure success. There is recognition that both prevention and intervention strategies are needed in order to achieve the outcomes of health, safety, and self-sufficiency. HHS System administrators heard national prevention experts at an all-day training session in March, 1998, aimed at making the focus on prevention specific to the administrators' areas of responsibility. The entire day focused on prevention, and on developing concrete strategies that each manager can take back to his/her work area and put in place.

By June 30, 1997: (pg. 35)

- **Establish prevention domains for focus of prevention services attention**

  Status: Accomplished. Prevention domains include children and the HHS System's major initiatives (i.e. long-term care, behavioral health, Employment First). The Services agency has organized the Office of Preventive Health and Public Wellness, headed by Bruce Rowe. This Office includes the following areas of responsibility: Disease Prevention and Control; Family Health; Health Promotion and Education; and the Office of Rural Health.

- **Appoint a primary prevention advisor to serve the Policy Cabinet with specific responsibility to ensure that prevention opportunities are fully explored and developed**

  Status: Accomplished. Bruce Rowe in Services has been designated as that prevention advisor. He is Director of the Office of Preventive Health and Public Wellness in the Services agency.

By June 30, 1999: (pg. 35)

- **Develop policies and procedures to require preventive focus in all managed care contracts**

  Status: Ongoing. There are numerous efforts in this area. Managed care plans are expected to include health education (smoking cessation, benefits of exercise, etc.) There is evidence of prevention activities in medical records of managed care providers, noting such things as immunizations, breast/cervical cancer screening, working with parenting skills, wearing seat belts. Another example is the Services Diabetes program, which is working with Medicaid managed care Quality Assurance staff to develop consistency in plans.

- **Provide effective in-service training for primary care providers on integrating primary prevention activities into their practices**

  Status: Ongoing. Managed care providers are expected to do prevention training for physicians, as set forth by the National Commission for Quality Assurance (requires prevention and clinical management activities)

- **Complete comprehensive inventory of services/programs/initiatives related to selected prevention domains**

  Status: Ongoing. Most communities have directories of services and programs available to their citizens. Another example is the comprehensive resource directory developed by Options Mental Health.

Department of Regulation and Licensure

Coordination with the Health and Human Services System
Implementation Plan (pg. 40)
By January 1, 1997:

- Agency leadership assignments made:
  Status: Accomplished. Administrators have been hired for the Divisions of Performance Accountability Management, Credentialing, Regulatory Analysis and Integration, and Investigations. Public Health Assessment has an interim director.

- Service area coordinators and Regulation and Licensure facilitators designated;
  Status: Accomplished and ongoing. Service Areas have been defined and will become effective April 1, 1998. A structure for administration is under development. Service Area Administrators were hired in February, then Service Area coordinators will be selected to carry out the work of integration in the field. Regulation and Licensure facilitators have not been designated as yet. The System Advocate has been serving as the facilitator who helps citizens access the services they need and links customers with appropriate parts of the HHS System.

- Team leaders for ongoing redesign work identified;
  Status: Accomplished. All employees have been assigned to their working divisions, and Team Leaders have been identified.

- Regulation and Licensure employees will be notified of their divisional assignments.
  Status: Accomplished. Each employee in the five former agencies received a personal letter in December, 1996, stating their work locations, job title, and agency designation in the new HHS System that began January 1, 1997.

By June 30, 1997:

- Orientation and training of employees to the new agency and new System will be completed;
  Status: Accomplished and ongoing.
  - In 1996, approximately 300 employees from all five former agencies participated in three random surveys to determine if transition supports were meeting employee needs. In response, approximately 900 employees attended training between January and May, 1997, on organizational change and dealing with uncertainty, provided through the Methodist Employee Assistance Program. Methodist EAP training provided over 33 sessions for employees on organizational change, team building, burnout, conflict management.
  - HHSS Administrators received updates on various important areas during 1997, with the expectation that they would then take the information back to share with their employees.
  - A Resource Guide was prepared and distributed to all employees in January, 1997. This Resource Guide included organizational charts and descriptions of the primary functions for the three new agencies; phone numbers of some key contacts within HHSS so employees knew where to refer questions from the public; information about the HHSS web page; answers to frequently asked

questions; information about how to order new letterhead; etc.

- A second Resource Guide was distributed during February, 1998. Included was a listing of all HHSS employees, phone numbers, locations; culture principles; System TDD number; glossary of terms; Service Area map; list of key contacts in the HHS System.
- A work group is developing a training curriculum and an orientation video that describes the culture/work expectations. Release is planned for late spring, 1998.

- **Organizational design and staffing work within divisional units and planning for implementation will be completed.**

  Status: Accomplished. The five divisions of the Department of Regulation and Licensure have been organized according to work function and staffed appropriately. Those divisions are: Credentialing; Investigations; Performance Accountability; Public Health Assessment; and Regulatory Analysis & Integration.

Streamlining the Way Work Gets Done

Reducing EMS certification categories (pg. 41)

Action/Recommendation:

- **Introduce legislation in January 1997 to reduce the number of categories for emergency medical services certification of personnel from eleven to five and simplify the list of categories for EMS licensing services from eleven to four.**

  Status: Accomplished. LB 138 was passed by the Legislature and signed by the Governor. The legislation consolidated the classification of out-of-hospital emergency care providers into four categories: first responders, emergency medical technician, emergency medical technician-intermediate, and emergency medical technician-paramedic.

Merger of EMS Regulatory Boards (pg. 41)

- **Introduce legislation in January 1997 to create a single Board of Emergency Medical Services**

  Status: Accomplished. LB 138 was passed by the Legislature. The bill created the Board of Emergency Medical Services and abolished the Board of Ambulance Advisors and the Board of Advanced Emergency Medical Care.

Unlicensed Assistive Personnel (pg. 42)

- **Introduce legislation in January 1997 to address: Medication Assistant Registry for persons who have met minimum competency standards to provide medications according to the Five Rights (the right person gets the right drug in the right dose via the right route and at the right time). The Legislature will address competency criteria defined by state with provisions for competency assessment to be done at community/provider level. It will also repeal statutes and/or regulations related to Care Staff Members and Medication Assistants to eliminate duplication.**

  Status: Accomplished. LB 783 is still pending before the Health and Human Services Committee. After input from interested parties, it is expected that it will be possible to pass this bill during the 1998 Session.

Credentialing Providers, Programs and Facilities (pg. 42)

Actions/Recommendations:

- **Implement One Stop/One Shop model for credentialing with these essential components: single resource centers, facilitators, universal application form, master information system; unique identifier, consistent credentialing and practice standards, universal definitions and terms, and local waiver with state approval.**

  Status: In progress. Recommendation B3 of the Nebraska Credentialing 2000 Study states that there should be created a unifying mechanism for all facility regulation activities of state government. LB 1016 has been introduced in the 1998 Session to create a foundation for this model. Also, LB 1108 asks for funding for a new licensing information system.

Inspecting Programs and Facilities (pg. 43)

Actions/Recommendations:

- **The new Health and Human Services agencies continue the internal and external dialogue with staff, providers, and consumers about how inspections are conducted.**
- **The Health and Human Services System will use the following approaches to conducting inspections to minimize duplication and reduce the burden on those inspected: accreditation, consumer/provider/licensure process, single inspector, coordinated team of inspectors/single report, coordinated multiple inspections.**

  Status: Accomplished and ongoing. Public forums in various parts of the state were held to obtain public input about the credentialing/licensure process including inspections. An assessment of the current system was conducted by five work teams composed of providers, consumers, and System staff. The assessment and input has provided direction for the first phase of the credential study. Additional input will be sought for the second phase of the study.

  The investigative programs in the five former agencies have merged to support the entire HHS System. Work has been reengineered to target resources where they can do the most good: tightening screening criteria of complaints, such as giving priority to concerns about public health and safety over the issues dealing with paperwork concerns; using word processing to transcribe reports rather than investigators writing them themselves. These and other efficiencies have reduced a four year backlog of complaints in one year. The percentage of completed investigations of complaints has increased from 40% in 1992 to 78% in 1996.

Reengineering the Process for Credentialing

Actions/Recommendations (pg 45):

- **In January, 1997, introduce legislation requiring comprehensive study by R&L to result in a model credentialing process**
- **By January, 1998, introduce legislation recommending comprehensive changes to the process of credentialing facilities**

  Status: Accomplished. LB 183 was passed by the Legislature in April, 1997. This bill instructed the Department of Regulation and Licensure to conduct a study of the regulation system for health facilities in Nebraska. The result of this study will be a comprehensive design for a model system (streamlined, cost effective and adaptable to change) for the credentialing and regulation of health care practitioners, facilities, and providers in Nebraska. The first part of the model, dealing with facilities, has been presented in a report to the Governor and Legislature.

- **By January 1998, introduce legislation recommending comprehensive changes to the process of credentialing facilities.**

  Status: Current and ongoing. LB 1016 was introduced in the current legislative Session. If passed, it will establish criteria for the determination of what categories of facilities should be regulated and provide for a mechanism to examine the laws, regulations, processes and results of the facility regulation system. The proposal will also provide for acceptance by the other recognized independent accreditation bodies and in addition to the authority to inspect facilities, the Department may adopt rules and regulations that would allow for recognition of alternative methods for assessment of facilities for compliance requirements.

- **By January 1998, introduce legislation recommending generic changes to process of credentialing professions and occupations**

  Status: Upcoming. The credentialing reform study will continue through 1998 developing recommendations for the process of credentialing professions and occupations. Legislation is expected to be proposed in January 1999.

- **By January, 1999, introduce legislation aligning provisions specific to individual professions and occupations with generic requirements.**

  Status: Ongoing. The credentialing reform study will result in specific legislation addressing the health professions in January 1999.

Department of Finance and Support

Implementation Plan
By June 30, 1997: (pg. 48)

- **Orientation and training of employees to new agency and the new System completed**
  Status: Accomplished and ongoing.
  - In 1996, approximately 300 employees from all five former agencies participated in three random surveys to determine if transition supports were meeting employee needs. In response, approximately 900 employees attended training between January and May, 1997, on organizational change and dealing with uncertainty, provided through the Methodist Employee Assistance Program. Methodist EAP training provided over 33 sessions for employees on organizational change, team building, burnout, conflict management.
  - HHSS Administrators received updates on various important areas during 1997, with the expectation that they would then take the information back to share with their employees.
  - A Resource Guide was prepared and distributed to all employees in January, 1997. This Resource Guide included organizational charts and descriptions of the primary functions for the three new agencies; phone numbers of some key contacts within HHSS so employees knew where to refer questions from the public; information about the HHSS web page; answers to frequently asked questions; information about how to order new letterhead; etc.
  - A second Resource Guide was distributed during February, 1998. Included was a listing of all HHSS employees, phone numbers, locations; culture principles; System TDD number; glossary of terms; Service Area map; list of key contacts in the HHS System.
  - A work group is developing a training curriculum and an orientation video that describes the culture/work expectations. Release is planned for late spring, 1998.

- **Organizational design and staffing work within divisional units and planning for implementation completed**
  Status: Accomplished. All three agencies have developed an organizational structure and staffing. Finance & Support Divisions are: Financial Services; Communications & Legislative Services; Human Resources; Medicaid; Staff & Partnership Development; and Support Services.

- **Develop a structure and working relationship regarding Medicaid-related functions and responsibilities among the three agencies**
  Status: Ongoing. The three agencies have agreed on placement of Medicaid-related functions. This continues to be refined as HHSS implements Medicaid managed care in rural areas of the state.

Streamlining Contract Procedures

Actions/Recommendations:

- **A four-step contracting process will be used**
- **A single HHS System contract template developed to streamline and use standardized language where possible**
- **The period of contracts lengthened from two to five years, as appropriate**

- **Outcomes to be achieved defined in terms of effects on the lives of Nebraskans**
- **Technical assistance provided to community/state partnerships to meet outcomes**

  Status: Accomplished and ongoing. The Department of Finance and Support has created a grants management/contracts team. This team is working with Legal Services and will make recommendations to the Policy Cabinet on streamlining contract procedures.

Planning for Results-Based Budgeting (pg. 50)

- **Take opportunity to be leader in developed of new budget process based on results.**
- **Get agreement of both administrative and legislative policymakers on concepts of results-based budgeting.**

  Status: In progress. The Department of Finance and Support is taking the lead in developing a new Budget Framework for the HHS System for the next biennium (2000-2001). This is a first step in aligning funding streams around outcomes for results-based budgeting. Work continues with the Governor's Budget Office, the Legislature's Appropriations Committee, and the Legislative Fiscal Office for the biennium budget that is due September 15, 1998.

Legal Services (pg. 51)

- **Undertake a review in 1997 to determine feasibility of consolidating the appeal and hearing function within one agency, presumably the Finance & Support agency.**

  Status: Ongoing. A work group is reviewing Administrative Hearing regulations for the five former agencies. A comparison study is underway to identify those regulations that are common to all of the former agencies. The goal of the work group is to create a uniform set of Administrative Hearing regulations. Legislation has been introduced regarding the Office of Juvenile Services Administrative Hearing provisions (LB 1041). The work group will check at the end of the Session to see if the bill has passed, and will begin the next steps in consolidation.

System Advocate: (pg. 52)

System Advocate responsibilities include:

Assessing individual questions/concerns/complaints and directing them to the appropriate system area or agency for response;

- **Helping the program understand the issues of the individual, if necessary;**
- **Assisting in finding the answer at the closest possible level to the work;**
- **Ensuring that the individual gets an appropriate response;**
- **Reporting system problems to the Policy Cabinet;**
- **Supporting development of the Health and Human Services System to meet the goals of the Partnership Act; and**
- **Making monthly reports to the Governor, Legislature, and Policy Cabinet**

  Status: Accomplished and ongoing. The System Advocate can be reached at 1-800-254-4202, and assists individuals who aren't sure where to go with questions and concerns regarding the Health and Human Services System. During 1997, a total of 1,604 contacts were made with the System Advocate. The majority (96%) were telephone calls. Most contacts came from general citizens (592), clients (410) and state employees (222). Other contacts included providers, associations/organizations, legislators, local officials, government offices in other states, and community group. There were 906 requests for

information, 474 expressing a complaint, 199 requesting help, 16 reporting abuse/neglect, 7 reporting fraud, and 2 making a suggestion.

Managing/Reengineering Medicaid: (pg. 54)

- **Senior Care Options Program**
- **"Managed Care" Long-Term Care Project**
- **Behavioral Health Partnership**
- **Statewide implementation of managed care**

Status: Accomplished and ongoing. Medicaid is a joint federal/state program that pays medical bills for certain low-income people who cannot afford medical care. These four are included in the nine priority initiatives in the Action Plan and make up much of the work for employees in the System. These initiatives are developing strategies that can contain Medicaid costs and/or produce cost savings, while maintaining quality services. Here is a brief update on the four initiatives:

- The Senior Care Options Program targets older Nebraskans who are considering admission to a nursing home and want Medicaid to pay for the needed care. The goal of Senior Care Options is to provide "the right care at the right time" by using home and community-based services when appropriate. This program is available statewide.
- HHSS began a study of long-term care services in June, 1996. The study focused on a plan for changes to the existing long-term care system for the elderly and persons with disabilities, and management of those services for individuals under the Medicaid program. HHSS issued a Long-Term Care Plan in May, 1997 that contained recommendations in this area. Legislation was introduced during the 1998 Session to fund assisted living alternatives to long-term care.
- Nebraska's behavioral health services redesign focuses on moving approximately 200 rehabilitation services beds from the three Regional Centers to the community, where they will be eligible for reimbursement from Medicaid. No individual will be moved to a community until there is a specific program developed for them. Nebraska has invested $10 million "up front" to allow development of needed community programs over the next two years.
- HHSS is expanding Medicaid managed care to rural Nebraskans through partnerships with Integrated Health Organizations (IHOs). The HHS Southeast and Western Service Areas have been selected as initial target areas for implementation of Medicaid managed care in rural Nebraska. HHSS will continue to identify local communities that are interested in partnering with the System to develop managed care networks across the state.

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1997 HHS SYSTEM LEGISLATION

LB 30 (Beutler) - WATER WELL STANDARDS & CONTRACTORS LICENSING ACT - Civil Penalty Provision - provides a two year period for civil penalties to be brought against persons covered in the Water Well Standards and Contractors Licensing Act;

LB 138 (Wickersham) - EMERGENCY MEDICAL SERVICES - creates a single board to oversee emergency medical services; combines basic and advanced EMS statutes; provides for reporting/notification of infectious airborne diseases;

LB 183 (Wesely) UNIFORM CREDENTIALING - authorizes a study of the credentialing process of HHS programs, providers and facilities;

LB 194 (Dierks) - HIV - HOME TEST KIT EXEMPTION - exempts reporting requirements for home test kits;

LB 195 (Dierks) - HIV - EXPERT REVIEW PANEL FOR INFECTED HEALTH CARE WORKERS - requires HHS R&L to provide expert review panels for health care workers who have become infected with HIV;

LB 197 (Dierks) CONFIDENTIALITY - addresses sharing of confidential information between the new agencies;

LB 307 (Wesely) - TECH AMENDMENTS TO LB 1044 (NEBRASKA PARTNERSHIP PROJECT) Redesignate certain functions/duties, i.e., child care/foster care, Medicaid within the HHS system and incorporates bills passed in the 1996 Legislative session & other statutes missed when LB 1044 was passed;

LB 396* (Dierks) VETERANS' HOMES - creates the Division of Veterans' Homes within HHS and creates a council to resolve policy disputes between the Veterans' Homes and the Department of Veterans' Affairs;

LB 518* (Beutler) - NEBRASKA SAFE DRINKING WATER ACT - (amended into LB 517) provides for administrative penalties; capacity building; and establishes a state revolving loan fund which is administered by the Department of Environmental Quality;

LB 579 (McKenzie) - ENVIRONMENTAL LEAD BASED PAINT HAZARD ACT - provides for certification of lead paint abatement; (select file)

LB 587* (Wesely) - HHS PARTNERSHIP IMPLEMENTATION (in committee)

- Community State Partnership - Sets standards for community/state partnership arrangements;
- Integrated Health Services Plan Act - Creates a commission to work with the HHS System to develop a plan for integrated health care services including behavioral health;

Regional Community Public Health Services Act - Establishes uniform Health and Human Services regions for Nebraska based on Area Agencies on Aging regions;

- Developmental Disability Unit - moves to Health and Human Services
- Discretionary Position language

LB 610 (Wesely) - NEW BORN SCREENING - authorizes the department to collect a $3 fee for new born screening and make available $2,000 worth of supplemental foods for individuals needing the food supplement.

LB 622 (HHS Committee) - HEALTH AND HUMAN SERVICES CLEAN UP BILL -

- Physician language - provides that when a medical doctor is appointed in HHS Regulation and Licensure he/she will be a member of the Policy Cabinet and clarifies that this person will decide contested cases;

- Health facility regulation licensure - allows nursing homes to provide more than one type of bed with only one license; allows hospitals to purchase physician offices and not have to license them;

- Mental Health Practice Provisional License - provides a provisional license for mental health practitioners who must obtain 3,000 hours of supervision before becoming licensed;

- Clinical Laboratory Certification Act - moves implementation date to 1999;

- Repeals the former Dept. of Health's duties regarding inspection of toys & the Nurse Incentive Act

- Barber Board - moves responsibility of sanitation inspections to Barber Board;

- Mobile Home Parks - requires all mobile home parks to meet electrical and sanitation standards;

- Recreation Camps - gives the department authority to set fees for inspections

- Charitable Organization Licensure- repeals Department of Health's responsibility; other statutes cover licensure and inspection of such facilities;

- Mental Health Commitment of Juveniles under Article 43;

- Hearings in juvenile court for mentally ill closed to the public;

- Equitable basis for not-for-profit federations when soliciting charitable contributions;

- (Engineers and Architects Regulation Act amended into LB 622)

LB 658 (Beutler) - RADIATION CONTROL ACT - increases and caps the fee charged for environmental surveillance and emergency response;

LB 752* (Beutler) - CHILD SUPPORT - includes new hire reporting; license suspension; UIFSA; paternity acknowledgment; income withholding; genetic testing, and administrative process;

LB 760* (Dw. Pedersen) SECURE CONFINEMENT FACILITY (amended into LB 882) - moves operation of the youth secure confinement facility from OJS to the Department of Corrections; gives warrant arrest power to the Director of HHS.

LB 769* (Brashear) ASSESS COST OF REHABILITATION TO PARENTS - (general file)

LB 783 (Wesely) - MEDICATION AID ACT - defines a system to allow unlicensed assistive personnel to assist individuals with their medications; (in committee)

LB 864* (Wesely) - WELFARE REFORM - implements Employment First statewide; provides welfare coverage for certain non-U.S. citizens and provides technical amendments; (Nebraska Affordable Housing Act amended into bill).

Updated 6/13/97

***indicates bills introduced at the request of the Governor**

Unless otherwise indicated all bills were passed by the Legislature and signed by the Governor

Nebraska Health and Human Services System Priority Initiatives for 1997-1999

The Nebraska Health and Human Services (HHS) System Policy Cabinet outlined priority initiatives and set forth the strategic direction for the System in the Action Plan for calendar years 1997-98. The Action Plan includes priority initiatives that began with the five former agencies, transitioned to the Nebraska Partnership Project, and have become the "work of the day" for the Health and Human Services System. The Policy Cabinet recognizes the need to continue moving forward in these priority areas and to connect and integrate the work.

The nine initiatives that make up much of the work of the HHS System are:

- Implementation of Employment First welfare reform statewide;
- Integration of the child welfare and juvenile justice services into the Office of Protection and Safety;
- Simplifying rules and regulations;
- Redesigning the professional credentialing process;
- Making prevention an integral strategy throughout the system;
- Developing an integrated system of long-term care services;
- Expanding Medicaid managed care to rural Nebraska through partnerships with Integrated Health Organizations (IHOs);
- Developing a statewide system of services coordination; and
- Establishing a comprehensive and balanced behavioral health system.

HHS System Initiative:
Employment First: Nebraska's Welfare Reform ... working for all Nebraskans.

Did you know ...

- Most of Nebraska's public assistance recipients are children?
- Parents on welfare want to get jobs and provide better lives for their children?
- Nebraska's welfare caseloads have been reduced by 21% over the past four years?

Employment First began with two Pilot Projects on November 1, 1995. Based on the learnings from these pilot projects, Employment First was implemented statewide on July 1, 1997. The pilot projects were: Lancaster County, which included the city of Lincoln and surrounding area; and the Hastings Area, which included Adams, Clay, Nuckolls, and Webster Counties.

In conjunction with their case manager, clients determine if they are employable and what is needed so they can enter the labor market. In conjunction with their case manager, clients plan how they would address the needs that impair their ability to work. This is the basis of the self-sufficiency contract that clients sign.

The Self-Sufficiency Contract is an important component of Employment First.
The contract is completed within 90 days of the person's application for ADC financial assistance, or within 90 days of her/his semiannual eligibility review. The contract has a limit of 24 months. During this time the family can, if eligible, receive ADC financial assistance for up to 24 months. At the end of 24 months, the family will continue to receive assistance if:

- There is no job available to the family;
- The state has not fulfilled its obligations under the contract; or
- Termination would result in an extreme hardship for the family.

Families can request mediation if they believe the State is not meeting its obligation under the contract terms. If a client does not believe the mediation was successful, they can request an administrative hearing. Conversely, the case manager can terminate cash assistance to the family and the medical coverage for the adults if the family chooses not to cooperate. Benefits are restored once the client begins to cooperate.

When the client enters the labor market and has received cash assistance for at least three months, he/she is offered continued Medicaid coverage and child care subsidy payments. The Medicaid coverage is available to the family for at least six months -- with an extension of up to 24 months if the family's income is within 185% of the federal poverty level. Families with an income between 100% and 185% of the federal poverty level may be required to pay a monthly premium of up to 3% of the family income.

Child care assistance is available to families with an income level within 185% of the federal poverty level, although some families may be required to pay a portion of child care costs based on a sliding fee scale.

HHS System Initiative:
Integration of child welfare and juvenile justice services into the Protection and Safety Division

Why have these areas been integrated?

- Historically, there has been substantial inequity in the resources available to the child welfare and juvenile service systems.
- There have been significant increases in the juvenile offender population and there is a lack of service options.
- There was difficulty in accessing categorically-defined funding streams for services.
- Both areas serve populations with many common characteristics.

Integration of juvenile and child welfare services into the Protection and Safety Division in the HHS System during 1997 responds to these concerns by increasing service capacity and maximizing resources, improving overall service delivery, improving efficiency in management and operations, and overcoming categorical funding barriers. Integration makes better use of our limited staffing resources, eliminates duplication, and brings greater equity in the services and treatment provided to juvenile offenders. With the merger, caseloads can be redistributed to serve children, youth and their families in a more comprehensive and efficient way.

Increasing service capacity, maximizing resources, overcoming categorical funding barriers:

- Services to delinquent youth are being expanded through partnerships with communities and providers.
- The PS Division is developing criteria and program standards for a higher level of group home care that can serve youth who require a high degree of structure. This new level of care, along with current placement options, will provide the capacity to manage our juvenile population in-state at more favorable rates.
- As these resources become available, the population at the Youth Rehabilitation and Treatment Centers will likely be reduced and the length of stay for more serious offenders can be lengthened to the point where more meaningful intervention can be provided.
- Current HHS contracts for services are being adjusted to allow juvenile offenders and their families access to services historically found on the child welfare side, including legal support, development, case aides, family support services, home-based family therapy, intensive family preservation services, independent living services, and counseling services.
- Electronic monitoring services, tracker services, and day reporting programs are being implemented in all areas of the state.
- Integration of juvenile and child welfare services also means access to Medicaid managed care mental health services to the juvenile offender population. Juveniles aren't eligible for Medicaid services while in the YRTCs, but now become eligible upon release.
- Application processes for Medicaid enrollment have been streamlined and parole officers are being trained in how to access these services, which run from residential treatment to in-home services.

Increasing efficiency in management and operations:

Juvenile justice and child welfare staff have been co-located in Lincoln, Kearney, Norfolk, Columbus, and in the central administration. Plans are underway to co-locate staff in North Platte and Scottsbluff.

HHS System Initiative: Streamlining and simplifying rules and regulations

The Division of Regulatory Analysis and Integration was created within the Department of Regulation and Licensure to standardize the regulation promulgation process and streamline the rules and regulations of the Health and Human Services System.

Accomplishments:

- The division has developed and implemented a central coordination and tracking system for all rules and regulations of the new System.
- A uniform process for promulgating rules and regulations has been adopted. Proposed and existing regulations will be reviewed with respect to system-wide policies, objectives and outcomes to assure a common-sense approach to regulations, with the elimination of overly stringent, outdated and redundant regulations.
- Plans are underway to enhance accessibility by placing rules and regulations on the Internet through the HHS System's web page.

HHS System Initiative: Redesigning the professional credentialing process

The regulatory programs established in statute and regulation that govern the HHS System have been created piecemeal over many decades. The desired outcome for redesign is to develop a model credentialing process that contains a clear statement of policy regarding the role of Nebraska state government in credentialing practitioners, facilities, and providers.

LB 183, passed by the Legislature in April, 1997, instructed the Department of Regulation and Licensure to conduct a study of the regulation system for health facilities in Nebraska. The result of this study will be a comprehensive design for a model system (streamlined, cost effective and adaptable to change) for the credentialing and regulation of health care practitioners, facilities, and providers. The first part of the model, dealing with facilities, has been presented in a report to the Governor and Legislature. The credentialing reform study will continue through 1998, developing recommendations for the process of credentialing professions and occupations. Legislation is expected to be proposed in January, 1999.

HHS System Initiative:
Making prevention an integral strategy throughout the HHS System

Prevention is important to the health and well-being of Nebraskans. Preventing health and social problems gives us an opportunity to not only live longer, but to live better, with enhanced quality of life.

HHS defines prevention as a planned strategy designed to keep a problem from occurring or from getting worse. There is recognition that both prevention and intervention strategies are needed in order to achieve the outcomes of health, safety, and self-sufficiency. Redesign of the Health and Human Services System provides the ideal opportunity for implementation of a new prevention-oriented approach to the delivery of health and human services. The Policy Cabinet has endorsed creation of a "prevention culture" throughout the new Health and Human Services System, and is working on the policies and procedures necessary to ensure success.

Traditionally, prevention is recognized as occurring at three levels: primary, secondary and tertiary. The Prevention Work Team has recommended a new approach to prevention, one that will enhance prevention's benefits by focusing on primary prevention opportunities **at all stages** of the continuum of care. Primary prevention will continue and expand in its traditional role of enhancing protective factors and reducing risk factors through population-based programs. Now, once a person is identified "at risk" and enters the care system as a result of early detection services, we can capitalize on a series of new opportunities for primary prevention. There are unique opportunities to practice primary prevention in every screening, diagnostic, treatment, or service-related contact.

In its simplest form, prevention can be viewed as involving three areas of opportunity: (1) the population or individual with the problem to be prevented; (2) the factors that cause the problem; and (3) the environment in which the causative factors and the person, family, or community come together. In this model, prevention can focus on one, two, or all three of these elements.

HHS has developed a prevention template or model that can focus on one, two or all three of these elements, and can be used to develop prevention strategies. The template for population-based prevention/promotion outcomes of health, safety and self-sufficiency includes:

- Identifying and analyzing relevant data (Epidemiology)
- Identifying appropriate target populations and interventions
- Establishing goals and objectives
- Implementing the strategies
- Evaluating the program and the outcomes
- Using feedback to refine the program

HHS System Initiative: Developing an integrated system of long-term care services

The Long-term Care Plan, released in May 1997, found there are few alternatives for Nebraskans in need of long-term care services, and that nursing facilities are the primary option for the elderly and persons with disabilities. Alternatives such as in-home care, adult day care and assisted living are emerging through various State, community and private programs, but continue to be limited in their availability. This Plan is the result of wide participation from individuals representing the HHS System, advocacy groups, provider associations, local Area Agencies on Aging, legislative aides, home- and community-based providers, health care professionals, and clients.

The study made a number of significant recommendations, which focused on:

- Making alternative services more available to the Medicaid population.
- Enhancing how services are provided, placing more emphasis on informal family and community involvement and support, thereby expanding available alternatives.
- Coordinating all long-term care services so that people seeking those services have access to many options.
- Developing a system to assist those in need with making their best choice, including a thoughtful evaluation and assessment of each client's medical, mental and social needs.
- Developing a system to measure and monitor the effectiveness of long-term care in Nebraska as alternatives expand and evolve.
- Changing the existing nursing facility reimbursement system to simplify the administrative burdens of both the State and the nursing home providers, enabling both to better manage their costs.
- Changing current laws and policies related to Medicaid estate planning to enhance the State's ability to prevent transfers of assets affecting Medicaid eligibility.
- Creating an environment that would encourage the purchase of long-term care insurance policies in the private sector to reduce reliance on Medicaid and other government services.

HHS System Initiative:
Expanding Medicaid managed care to rural Nebraska through partnerships with Integrated Health Organizations (IHOs)

The Health and Human Services System is committed to building a sustainable health care system in rural Nebraska. Rural areas can benefit from cooperating and working together to combine resources in building Integrated Health Organizations (IHOs). which is the strategy for expanding Medicaid managed care to rural Nebraska. The HHS System believes these IHOs are the best strategy for expanding Medicaid managed care in rural Nebraska and will provide the opportunity for improvement of health care delivery statewide.

The HHS System anticipates the emergence of locally-controlled health care provider networks in rural areas. These networks will be the central "building blocks" of local integrated health and human services networks. Rural communities will see improved practices, efficiency, increased quality of care and the number of patients who use local providers and revenue that remains in the local area.

HHSS will provide education and consultation in the ongoing development of IHOs. The Southeast and Western Service Areas have been selected as initial target areas for implementation of Medicaid managed care in rural Nebraska. HHSS will continue to identify local communities that are interested in partnering with the System in developing managed care networks across the state.

HHS System Initiative:
Developing a statewide system of services coordination

A Services Coordination Work Group made recommendations to the Services Leadership Team on a definition of services coordination and a model process for developing a statewide system of services coordination. Another work group took that information and developed an Implementation Plan for a statewide system of services coordination. Those recommendations have been reviewed, with several components undergoing further system-wide review and comment.

Services Coordination has made the greatest strides in the areas of developmental disabilities and Medicaid Waiver services:

- We are in the process of identifying approximately 4,500 persons with developmental disabilities who were being served by two case managers - one from former DPI and one from former DSS.
- Program rules and regulations are being reviewed for consolidation and revision.
- Criteria has been developed for primary Service Coordination assignments.
- A single assessment document has been developed and is being field tested.
- The implications of technology exchange are being reviewed.

HHS Initiative:
Establishing a comprehensive and balanced adult behavioral health system

Why are we redesigning behavioral health services?

- For years, consumers and families have said that mental health and substance abuse services do not meet peoples' needs, and the mid-level services that would allow people to live in the community were not available.
- Many people need mid-level type services, not hospital-based care. Current services do not match the needs of the most needy patients. Individuals are forced to receive services in a more restrictive setting than necessary.
- Regional Centers frequently become *places to live* rather than a place to receive services.
- Distribution of resources between institutions and community programs is out of balance. For example, Nebraska currently spends approximately $50 million a year on inpatient mental health services (31st in the nation) and only $15 million on community mental health services (49th in the nation). Approximately $10 million in spent on community substance abuse services.
- There is inadequate accountability for public mental health dollars. There is no uniform method for tracking how many individuals are being served and exactly what services they are receiving.

We're redesigning behavioral health services in order to:

- Provide better services to Nebraskans through transition to a new role for the Regional Centers. Regional Centers are still a key component of the continuum of care, and in their new role will provide acute and secure residential services.
- Make the best use of our limited resources. We're maximizing limited resources through managed care financing so that dollars follow consumer need. CMG Health has been hired to provide the function of utilization management for Nebraska's behavioral health system, based on criteria developed by HHS. CMG does not benefit if a person is denied access to the Regional Centers.
- **Enhance community/state partnerships through development of local networks.** Behavioral Health Redesign is a priority initiative for the Health and Human Services System. Behavioral Health services are developing as a specialty network for the six Service Areas across the state.

We're focusing on the needs of individuals:

- The primary services involved in behavioral health redesign are the rehabilitation services provided in the three Regional Centers.
- Services available for persons with mental illness are being moved, not cut. Rehabilitation services will be moved from the hospital setting to the community in phases over the next two years, making it possible to receive reimbursement from Medicaid funds.
- Having mid-level community rehabilitation services available will give people more choices and access to services earlier in their illnesses, helping prevent hospitalization and lowering demand for emergency services.
- No patient will be moved from the Regional Center until there is an appropriate community service in place.
- As individuals move to the community, the resources for those services will follow them to the community and away from the Regional Centers. Over the next two years, there will be a real reduction in the Regional Centers of approximately 200 rehabilitation beds, and a reduction of the resources associated with those beds.
- We value state employees, who have been part of the planning and implementation of new community services.

Investing public mental health dollars in behavioral health redesign

HHS has made a commitment to invest $10 million "up front" in new dollars for community services, *before* moving any consumers from Regional Centers. This eliminates the need to depend on reductions in the Regional Centers to pay for development of community services. This investment maintains current capacity and funding in Regional Centers for FY 1998, and allows development of more appropriate alternative community services.