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Stakeholder Survey Results

Nebraska Division of Behavioral Health Strategic Planning

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Nebraska Division of Behavioral Health Strategic Planning Initiative – 2010

Stakeholder Survey Results

The purpose of this non-scientific, web-based survey was to give interested persons an opportunity to weigh in on the areas of concern that had been previously identified as important through other behavioral health planning efforts. The results were compiled by the University of Nebraska Public Policy Center on behalf of the Nebraska Division of Behavioral Health and the Joint Strategic Planning Group. The results will be considered with other sources of information by the Division of Behavioral Health and the Joint Strategic Planning Group to frame a draft strategic plan presented for public input the fall of 2010. The survey was publicized in a news release on July 11, 2010. The results were compiled September 7, 2010. A total of 347 people started the survey with 265 respondents completing some or all of the survey. The results include full and partial survey responses. Demographic information describing survey respondents is included in Appendix A.

Explanation of tables

Respondents were told that all items were important but were asked to rank them in the order they would like the Division of Behavioral Health to work on them over the next three to five years. The means reported are the average ranking by respondent. The numbers across the top of each table are priority rankings with 1 as the top or most important priority and 8 as the lowest priority. The numbers in each ranking category are the number of respondents who ranked the item at that priority level; so if the number 18 appears in the column headed with the number 1, it means 18 people ranked it as the first (highest priority) item in the list they would like the Division to work on. The lower mean indicates higher importance, so the top answer was ranked as having highest importance overall to respondents. Tests of significance were not done because the goal was only to get a snapshot of relative ranking.

Analysis of comments

All comments made on the survey are attached in Appendix B. A summary of comment content is presented in the body of the report. The summary was approached using qualitative research techniques which resulted in emerging thematic areas that are reported with examples drawn from the comments.

Organization of this report

This report is organized by the four areas probed in the survey: Accessibility, Quality, Effectiveness and Cost Effectiveness. These areas were determined by the Joint Strategic Planning Group after a review of previous Nebraska planning efforts in behavioral health. More information about the process and documents reviewed prior to development of the survey is available on-line at: http://bhstrategicplanning.nebraska.edu/

Accessibility

Survey Question:
The following recommendations related to Accessibility of Behavioral Health Services have been offered by other planning efforts in Nebraska. All of them are important. Please rank them in the order you would like the Division of Behavioral Health to work on them over the next three to five years. So if you rank something number 1, you are saying that it is the first area you would like to see the Division work on to increase access to public behavioral health services.

Mean	Answer	1	2	3	4	5	6	7	8	Responses
3.22	• Increase behavioral health service capacity	68	55	44	28	22	23	17	8	265
3.37	• Expand community based treatment options	52	63	46	27	25	24	23	5	265
3.64	• Emphasize early Identification and referral	51	39	42	45	35	27	16	10	265
4.23	• Promote standards for timely access to services	23	39	39	44	52	24	30	14	265
4.63	• Support Long term Recovery	22	31	35	36	41	40	30	30	265
5.22	• Create a uniform definition of system roles, responsibilities, and handoffs	27	14	19	31	33	45	55	41	265
5.38	• Formalize system linkages between justice and behavioral health systems	6	11	31	41	39	48	53	36	265
6.30	• Expand use of telehealth	16	13	9	13	18	34	41	121	265

Survey Question:
What do we need to do to provide access and standards for access to behavioral health services?

Respondents provided extensive comments to this question. In general, the comments about what needed to be done to provide access and standards for access fell along four general themes: Suggestions for organizational change; Concerns about accessibility for specific populations or geographic areas; Suggestions related to service delivery systems; and ideas for promotion of behavioral health in Nebraska.

The suggestions for organizational change included changing the role of Nebraska's behavioral health regions, doing away with or streamlining the work performed by the current administrative services only managed care contractor; enhancing the ability of insurance companies to fund or adequately address behavioral health issues; changing commitment laws and procedures; making it easier to use tele-health resources to deliver care; and generally simplifying the way the behavioral health system works including how it interfaces with other systems.

Comments about accessibility for specific populations or geographic areas cited the need for special attention to service systems for youth in transition to adulthood, homeless, elderly, children particularly in rural areas, justice involved people, and generally the need for services in rural areas to be as accessible as they are in urban areas. Particular concern was voiced about a need to increase accessibility through tele-health and innovative delivery mechanisms in the Panhandle.

Accessibility and service system development comments included suggestions to integrate behavioral health services in primary care settings; involve families and consumers more directly in service planning; provide consistent behavioral health standards and definitions across systems; increase overall service capacity, number of service providers and locations of service providers; generally increase funding for services; encourage service delivery methods that have been proven effective and culturally appropriate.

Several comments were also made to promote accessibility of behavioral health services via strategic marketing to community members. Suggestions included ideas for marketing techniques (brochures, ads, etc) and message content (locations and process to access service).

Quality

Survey Question:
The following recommendations related to Quality of Behavioral Health Services have been offered by other planning efforts in Nebraska. All of them are important. Please rank them in the order you would like the Division of Behavioral Health to work on them over the next three to five years.

Mean	Answer	1	2	3	4	5	6	Responses
2.85	• Incorporate flexibility and choice of service for consumers and families	57	57	49	53	18	15	249
2.90	• Encourage and expand avenues for consumer / family involvement in the system	40	72	61	40	22	14	249
3.06	• Include consumers in system planning process	57	45	48	46	32	21	249
3.63	• Increase ease of access to information and records for consumers and their providers	47	29	32	45	53	43	249
4.20	• Emphasize culturally responsive and culturally/linguistically competent care in service delivery systems	24	24	32	36	64	69	249
4.37	• Policy, administrative practices and regulatory practices must be subjected to continuous data-based evaluation	24	22	27	29	60	87	249

Effectiveness

Survey Question:
The following recommendations related to Effectiveness of Behavioral Health Services have been offered by other planning efforts in Nebraska. All of them are important. Please rank them in the order you would like the Division of Behavioral Health to work on them over the next three to five years.

Mean	Answer	1	2	3	4	5	6	7	Responses
3.05	• Increase awareness of behavioral health among all system participants	71	49	28	31	18	21	18	236
3.72	• Promote best /evidence based practice adoption	46	35	38	24	34	31	28	236
3.83	• Move to accountability without overburdening consumers and providers of service	30	34	39	48	36	26	23	236
3.90	• Share assessment information across systems/providers	23	41	41	40	34	37	20	236
4.25	• Implement a uniform system for collection and analysis of data	24	29	39	25	44	39	35	235
4.50	• Policy, administrative practices and regulatory practices must support effective collaboration among the consumer and systems	23	21	31	40	33	37	51	236
4.76	• Balance an emphasis on wellness with State's public safety responsibilities	19	27	20	27	37	45	61	236

Survey Question:
What information do you want to see as part of a regular, transparent report of performance for the behavioral health system? (Forming a "dashboard" of information to gauge how the system is moving toward a vision and goals)

Comments from respondents included a number of suggested measures and reports for the behavioral health system. These suggestions generally reflected three themes: Outcomes that can be compared; Quality of life measures including numbers and perceptions; and reporting mechanisms that are timely and transparent.

Comments advocating comparative outcomes reflected a desire to compare provider, regional and state outcomes using consistently available measures such as aggregate assessment data, provider service data (including wait times, denial of service, transfers, claims information), service usage in each service array element, cost data associated with provider service data and consumer outcomes, and national outcome measures allowing Nebraska to be compared to other states.

Many respondents cited the need for transparent, regular reporting on quality of life measures including consumer/family satisfaction with services and providers, complaint data, aggregate views of consumer

goal attainment, and data associated with elements such as housing, education/work, and transportation.

Suggestions related to reporting mechanisms centered on a desire for complete information that is reliable, transparent and reported on a regular basis. Generally respondents asked for reporting mechanisms be easy to read and meaningful for consumers, families and providers.

Cost Effectiveness

Survey Question:
What are your ideas to increase cost-effectiveness for the public behavioral health system? (for example, you may suggest changes in regulations or in the way services are delivered that could result in system savings or efficiencies)

Respondents provided a number of suggestions related to increasing the cost effectiveness of the public behavioral health system that could be grouped in three categories: Funding, Administrative considerations and suggestions for the service delivery system.

Funding suggestions included consideration of payment systems used by Medicaid (e.g., moving to a centralized, paperless billing system), moving to consumer directed funding within the public behavioral health system, and incorporation of service funding that recognizes the unique needs of rural and frontier settings (e.g, tele-health, drive time, etc).

Comments related to administrative structures centered on decreasing duplication and redundancy via streamlining regulations and administrative practices. Examples included movement to shared assessment data across systems and electronic health records; minimizing required paperwork and rewarding consumer/family contact by providers; reducing duplication of required organizational audits; and effectively using community partners for transportation, housing and vocational service needs of consumers.

The most comments for this question were directed at making service delivery systems more cost effective. Many suggestions related to smarter delivery of services that lead to more sustainable outcomes for consumers/families such as ensuring early access to preventative physical care/medications; promoting personal responsibility and quality of life outcomes; and encouraging strength based practices. Other suggestions related to the service array, for example: recovery through enhanced aftercare and long term recovery strategies (including such care for sex offenders); considering a mechanism for short term disability if needed to attain stable long term outcomes; fully developing the service array and making them accessible; encouraging a system that rewards best/evidence based practices resulting in positive consumer outcomes; and promoting behavioral health prevention through appropriate systems.

Survey Question:

The following recommendations related to COST Effectiveness of Behavioral Health Services have been offered by other planning efforts in Nebraska. All of them are important. Please rank them in the order you would like the Division of Behavioral Health to work on them over the next three to five years.

Mean	Answer									Responses
3.19	• Focus on prevention and early intervention	90	30	33	21	21	24	9	17	245
3.99	• Emphasize supports ie, transportation, stable housing & employment/education	32	42	39	33	36	26	19	18	245
4.12	• Promote clear pathways linking service in justice, Medicaid and behavioral health systems	23	36	47	39	34	32	16	18	245
4.46	• Maximize information sharing across systems	22	39	25	43	28	32	35	21	245
4.52	• Capture Medicaid match dollars	26	30	35	30	29	35	39	21	245
4.73	• Promote strategic use of evidence-based practices via policy, reimbursement, monitoring, and training	25	28	25	31	41	22	41	32	245
5.09	• Pursue Grants and outside funding	16	24	27	21	35	47	39	36	245
5.90	• Create cadre of providers available by telehealth	11	16	14	27	21	27	47	82	245

Appendix A

Demographics of Survey Respondents

Self-Identified Role of Respondents

Survey Question:

My perspective is informed by these roles or experiences

(Note that respondents could choose all that apply)

Answer	#
Consumer - Mental Health	25
Consumer - Substance Abuse/Addiction	10
Consumer - Gambling Addiction	3
Family Member of someone receiving behavioral health services	60
Provider - MH	88
Provider - SA	46
Provider - GA	2
State Agency Employee	27
Public Official	8
Advocate	63
Interested Community Member	74
Other -please describe	30
Youth	10

Other -please describe
Emergency Dept. Nurse
Business Manager MH & SA facilities.
association with those needing and or using services including those for youth
Mental Health Therapist
SC
Non-profit board member whose organization receives state funding
CASA volunteer (court appointed advocate for children
Psychiatrist
work a Community Action Agency
MH clinic administrator
Special Education teacher
Psychiatric Fraud Investigator, CCHR
Telehealth Coordinator & Cilent Access Director
Peer Support Specialist
Taxpayer

Creighton Medical Associates
County Agency Employee
RBHA
Regional BH advisory bd
behavioral health provider. There is nomore MH or SA. This is a perfect example of barriers.
physician
peer support (employed)
Clergy
Child Advocate
director of MH/SA service
contracted provider
local public health employee
Graduate student/intern
local health department
adult family home provider
clinical supervisor
Provider for Co-Occurring Disorders
PH agency
mental health counselor
Consumer-Mental Health
early childhood
Public School Teacher
training coordinator
Health Educator
School Administrator
Ordained Clergy
Provider -MH
clergy
family member
Public Health Employee
Health Educator
staff at a Clubhouse

Age of respondents (optional question)

#	Answer		Response	%
1	24 or younger		2	1%
2	25 to 35		39	17%
3	36 to 49		63	27%
4	50 to 64		118	50%
5	65 or older		14	6%
	Total		236	100%

Nebraska Communities represented by Respondents

Adams	Hartington	Pilger
Albion	Hastings	St Columbans
Alliance	Hays Springs	Scottsbluff
Atkinson	Johnson Lake	South Bend
Bancroft	Kearney	South Sioux City
Beatrice	Laurel	Sutherland
Bellevue	La Vista	Sutton
Chadron	Lincoln	Walton
Columbus	Louisville	Wayne
Cozad	Macy	Wisner
Creighton	Madison	Wymore
Crete	Martell	
Dannebrog	Mead	
Dakota City	Minden	
Elkhorn	Norfolk	
Elwood	North Platte	
Firth	Odell	
Fort Calhoun	Ogallala	
Gering	Omaha	
Giltner	O'Neill	
Grand Island	Palmyra	
Gretna	Papillion	

Appendix B

Text responses to comment field survey questions

Survey Question: What do we need to do to provide access and standards for access to behavioral health services?

Text Response
Increase the availability of behavioral health services in the Panhandle area. There is a huge need, and very limited resources.
1) Have a single BH authority for entire state instead of 6 different ones. 2) Combine MEdicaid and BH and counties into one system.
Advertise so that the people know what services are available and where. Speedy appointments so that mental illness symptoms do not worsen before they can get in to be seen. Have a way to prescribe medications at the time of the first appointment, if necessary. Intake and psychiatrist screening for medication at same time?
Provider greater array of service options for youth 19-25 years of age. Current service options are not developmentally appropriate and responsive to the young adult. It appears that the DBH has accepted the justice system as a default service provider to this population.
Improve support of the primary care providers' role in identifying behavioral health care needs and helping them get their patients into needed services in the community, as well as ongoing involvement with the primary care clinician in the treatment plan.
Involvement in the schools; assessment capacity without OJS intervention for youth; services without OJS involvement.
If you require documentation to follow the client, then you have to develop a way for providers to access the documentation that may be in place with another service provider. Clients do not remember whom or when they see MH providers and often switch offices. the requirement puts too much additional burden on the current provider without compensating them for their time to tract it all down and get hold of a physical copy.
Use the community services available. The smaller providers are not being utilized and reffered to by Magellan and the DHHS
Distribution of funds to population centers. Eliminate Regions to create state to local provider arrangement
There need to be more services available to children in rural areas. These services need to be readily available and should include psychiatric services.
Do not renew the contract with Magellan to police behavioral/mental health care. Many suffer because of their ongoing denial of services.
I wish I knew.
make the system easier to navigate and provide additional funding for prevention programs that target a specific population- and increase funding for community mental health and substance abuse outpatient treatment
Review the how many people have to OK it. If the doctor wants it or the parent why does Magellen get to override it?
You need to make sure to look outside of Omaha and Lincoln for services. There are people outside of those areas that need services. It is appalling that there are not enought treatment services in the Central and Western Service Areas. We need access to all levels of treatment in all areas of Nebraska.
We need to be able to cross categories with funds (DD and Behavioral Health) as many of our dual diagnosis population continues to have their behavioral health needs unmet, resulting in unsuccessful community based service experiences.
Better regulate the insurance industry and make them provide care without the threat of withdrawing approval

every few days or weeks based on current diagnosis or prognosis. No more disjointed care. Lessen anxiety for those being cared for and care-givers alike. If they know they will have continuous access to mental health care, then much of the stress will be relieved and they can concentrate on recovery rather than on getting access to care.

Let the money follow the patient.

Community awareness plus workers who are well oriented to available resources. Hot line operators as first line representatives of services to general public. Hot line for employed workers to use so they, too, can match services needed for clients

Community support is vital, local programs not only for those with mental health issues but also for families.Increase local programs for the elderly who suffer depression and anxiety

uniform access, agencies differ too much. Magellan is difficult to manuever to get needed services.

IMPLEMENT ELECTRONIC TRANSFER/ACCESS OF BEHAVIORAL HEALTH TREATMENT RECORDS TO FACILITATE A SMOOTH, SEAMLESS TRANSITION FROM MEDICAL TO CLINICAL PROFESSIONALS/SERVICES PROVIDERS.

You could identify key organizations who have proven their ability to develop and implement outpatient services that allow quick access for patients. - Make it easier for private practices, whether for-profit or non-profit, to utilize the state's telehealth backbone, as this has been a major roadblock to our expanding services to underserved areas. - There is a large disconnect between the justice system and behavioral health in terms of understanding / implementing / goals for the chosen level of care for youth. - Standards for access need to be easy to understand, not constantly changing and be easily accessible to providers. It currently takes constant vigilance to try and keep up with and decipher these. - Our state is considered regressive by others in terms of having appropriate access to various medications and other treatments.

Your staff needs to listen to families with children, in particular, with mental health issues. The "one size fits all" theory is not working. Caseworkers who have issues of their own don't need to be working with children and families.

Create a uniform definition of system roles, responsibilities, and handoffs

Put inserts in Newspapers, advertise on tv, put brochures in clinics. Mail brochures out to the public.

More youth programs for substance abuse and behavioral issues

The EPC process should not be the sole responsibility of law enforcement. A psychiatrist, LMHP, or MSW, who are working with a client have more knowledgable regarding that person's need of hospitalization than a police officer who doesn't know them. Some person's who are a danger to themselves or others are not going to tell an officer.

Allow more access for those of us in the Panhandle. It is difficult to get support and answers when everything is centered around Omaha and Lincoln.

Inpatient treatment facilities need to be expanded. There are many, many times that patients must wait for inpatient treatment after a Mental Health Board hearing. There have even been instances when patients were discharged without treatment because there were no beds available.

simplfy procedure

It will be a safeguard keeping people from falling through the cracks.

Thoroughly screen caseworkers and their supervisors to ensure they are competent in the provision of human services and committed to advocating for the success of clients accessing their services. These individuals must make communication much more thorough and integrated between their clients, providers in the community, law enforcement, and other services.

Encourage families to pick the provider of their choice, do not allow untrained, unlicensed HHS workers to provide clinical referrals, which are usually to Behavioral Health Regions, or to LFS in Region II. Allow private providers to build their private practices and allow private providers to advocate for their patients without the fear of retaliation from the State of Nebraska HHS or Behavioral Health Regions. Provide funding for private organizations and practictioners to complement their sliding scales--do not encourage monolopies as this looks like a Restraint of

Fair Trade Practices and does not allow for the consumer to find the Quality of Care that is needed.
Be sure to include the family in all decisions made on behalf of the individual. Provide access to services so the family can keep their child at home, so parents don't need to relinquish custody. Provide a safe place for families to have to access respite care for their child.
Inadequate funding for community-based mental health aftercare is primary cause for backlog of patients awaiting transition from Regional Center SOSR Unit. Jobs, housing and other things needed for successful transition are difficult to obtain; however nothing is possible without funded mental health services such as therapy and aftercare!
Create a system that identifies and treats behavioral health issues in children before they become involved with juvenile justice. Run these programs through the public schools. Not just counseling services but behavior modification programs. Provide monitoring services for those with life-long mental health issues. Provide transition services between programs. Offer service co-payments based on income.
1) Behavioral health services must be funded at a level at which the public, both consumers in need of the services and their families, can trust that the services will be there on a consistent basis. This is NOT the situation now. 2) Screening pregnant women for substance abuse and offering services immediately would significantly reduce infant mortality, developmental and related disabilities impacting the infant, and allow the infant to go home to safe home or be placed in a loving adoptive home. Additionally, it would reduce the need for abortions among pregnant women with substance abuse issues. 3) Ending DHHS Behavioral Services appalling lack of senstivity or basic understanding of sexual minorities must happen as soon as possible. Presently the State of Nebraska allows dangerous behavioral health "professionals" to practice unproven, life-threatening "therapies" and "interventions" with the goal of changing homosexuals. Additionally, not assuring at least competent referral to appropriate behavioral services for sexual minorities places Nebraska in a position of threatening the lives of gay, lesbian, bisexual and transgendered people. 4) Expanding services at Nebraska's regional centers is a must. Presently judges cannot even get people with severe, violent mental health issues into appropriate care situations. 5) A greater understanding of dual diagnosis when addressing drugs, alcohol and substance abuse is needed. 6) Behavioral health services must be created and maintained. These services are too few and underfunded to make any meaningful impact on the lives of Nebraska's troubled youth. 6) This list could go on, but basically Nebraska needs to commit itself to providing community-based care and start allowing access to care for all people, regardless of personal religious judgement.
Work to remove the mandatory commitment proceedings. If your services are so good, why do you committ anyone to mental health services? If a person has committed a crime, they should remain in the criminal justice system, not a mental health system.
open up the income guidelines so the uninsured can access services, especially medication
Involve those living with mental health issues a real and active role in policy development and implementation.
Give help with financial aide to parents who cannot afford medical help
Consistancy and follow through by the administration at the Gov's office and the DHHS administration. We have been through multiple data gathering "expiditions" yet the plan continues to be secondary to popular political views that do not support maintaining best practices and funding them adequately.
recognize that someone who has not been hospitalized for mental health issues may be in the same serious need as someone who has. hospitalization should not be a pre-requisite for assistance.
The Community severly lacks knowledge of behavioral health care. I'm not sure if that lack of knowledge is intentional or not. Meaning..when it comes to behavioral health, people tend to ignore it hoping that it will go away. Society has really stereotyped mental health as being "dangerous". Is it? Could be. If a person doesn't have the whereabouts to obtain treatment and they go untreated, it could be fatal. More advertising and more shows and seminars on the mental health population need to be addressed. (maybe through NETV)
I am all for expanding community based services but there also has to be services in place for long term psychiatric care (something other than inpatient hospitalization). The wait for a bed at LRC is too long, not enough locked secure residential beds for those who need that level of care.

More services to low or no income families, provide culturally appropriate services, and increase the support available for long term recovery.
We need more patient and family education as to what can be accessed and where to find it in a timely manner.
We need transportation options for people to ensure they can get to the care they need.Perhaps letting all fields provide reimbursable rides if needed. We need more short term crisis centers as well as evening programs, (or a peer run place where people could go to be together and socialize,) to provide socialization opportunities and sense of belonging. As always, we need more mental health professionals and peer support specialists.
To provide access - reimburse providers appropriately Seek input from the providers
Look at the current standards in place. Some of the service definitions get in the road of providing quality, sensible services. When service providers have more "state" people coming in to audit, inspect, survey, report to, and provide data to than the provider has actual staff on duty - there is something wrong with the system. (Note: not one of the above has actually been to a site or talked to a consumer.) Everyone wants to count the widgets, look at the numbers, collect the data.....but no one wants to actually talk to a consumer (besides staff).
There is insufficient capacity in the SA and MH systems, especially for SA. We need to increase capacity in most levels of care and close gaps in the system.
More hospital beds. More psychiatrists.
Improve reimbursement so that agencies can create quicker access availability
Not implement the 16 bed rule for residential substance abuse treatment centers. This would severely decrease capacity and access.
What id the Division doing to increae numbers of competent providers? HRSA data indicates we are significantly under national standards for numbers of providers for our population and there are only about 20 psychiatrists and 50 PhD Psychologists working in outstate Nebraska outside of Omah and Lincoln. There needs to be much better coordination with the Medicaid/Medicare division which seems to feel that its job is to limit access to MH services. For example, only about 40 sites are "medicaid-approved" for telehealth service provision. We have an extensive electronic system across the State that can't be accessed for over half of the population. We also need to stop putting 90% of our State behavioral health resources into the 5% of the population that has very serious MH issues. Where are the prevention services in communities which would include outpatient services to children and adoescents to help keep them OUT of hospitals, corrections, and long-term care???
Remove M'Caid enrollment requirement for all facility sites if an organization has more then one facility---if one facility has the capacity to serve M'caid eligible clients, allow the other facility to not be an enrolled m/caid provider. This removes the need for substance abuse centers to require all sites be limited to 16 beds or less and allows current providers to not shut down beds that would otherwise be operational. This improves access to STR/Detox. Standards should not identify facility staffing for programs that have/maintain national accreditation, as national accreditation standards deal with that. Also, Nebraska's proposed standards are too limiting. Certainly only licensed/prov licensed staff can perform certain functions, but the state does not need to micromanage the staffing levels of programs beyond requiring the licensure of the licensed staff for the care that only they can deliver. Likewise, access to care would be better if staff to client ratio's were removed. I do not believe that any nationally accredited provider would jeopardize quality of care delivered. One example is with group therapy and the standard of 1:12 ratio. Removing this ratio would provide immediate improved access to care in OP, IOP, etc. With CSP services,I also do not believe there should be a staff to client ratio defined for nationally accredited programs. The auditing process is cumbersome when a provider serves one client for only one, two or three weeks of the month and with each discharge brings on another client. So their client list can look like they are out of ratio when, in fact, they are not. Quite simply, I think DBH should only define service levels of care (for nationally accredited organizations) by the number of hours of service required of that level of care and the licensure of staff required. (MD< APRN< LMPH< PLMHPPLADC, etc)
Increased psych res rehab services, more respite beds, more partial hospitaliztion services, more psychiatrists, a better way of stepping down from one level of care to another (smaller steps for consumers)
Increase funding based on documented wait list times. Review standards being used for access and to what extent

these are met by service type.

look at what is really working, evidence based practices in our community and around the country, and provide INCREASED FUNDING that will allow these things to happen. one Community Mental Health Center in Lancaster County is obviously not enough, and the Region V funded Blue Valley Mental Health Centers are fair apart and not well enough staffed, making access difficult. fund mental health services, that is build facilities and staff them well, that include rehab and recovery practices at LEAST to the extent that money is put into correctional facilities. i find it very difficult to determine why a $94+ million jail is necessary when the one CMHC in Lancaster County has to cut its budget nearly $400,000 this year ~ that's such a huge difference that it makes no kind of sense. we need to work from a longer range view of what we want our community to be, including bringing heart and compassion into our decision making. dream a world, a community that provides for its people rather than puts them or throws them aside. balance our use of economic and human resources so there are no remaining huge inequities.

Increase access guarantee funding to rural areas so we have as many treatment options as urban populations.

We need more substance abuse treatment programs that are offered on a sliding-fee scale (to include substance abuse evaluations).

Ensure that there is adequate funding for behavioral health services to be provided for all Nebraska residents. Ensure there is flexibility with regard to the frequency that services are provided in order to foster recovery-based, client-driven behavioral health services.

Increase funding and dedication to these services from legal/state/federal authorities.

provide more timely services both for substance abuse and mental healt especially among the homeless a 2-3 wait for services for subtance abuse and even longer for mental health leads many to not follow up

Resources are very limited and the waiting periods for people to get into an appropriate program are ridiculous. We need more community based options and standards in place to ensure those most in need are getting priority treatment.

Nebraska has made significant progress in becoming recovery-focused providing community-based alternatives to long-term hospitalization. The system has worked well to achieve this goal. However, current initiatives such as the proposed change to community support rate methodology, the disastrous "fix" for our youth in crisis, the growing number of transition age youth with no resources, the growing indications that access to the available resources is getting less timely (post-commitment days are rising as are average length of stay), indicate that we have a lot of work to do for the system to remain static. This is not our goal. We should, as a state with a conscience, be seeking ways to continue behavioral health reform.

Expand the telebehavioral health capacity and fund the residential programs at a rate that allows providers can meet the staffing and treatment standards required by the service definitons.

I believe that the standards, or a set of uniform rules, for access should be done as a cooperative effort between interested parties to iron out the differences, sometimes as simple as different sets of definitions for services or client qualifiers, that keep clients from readily accessing services.

The staffing in most group homes that are linked with service providers is inadequate at best, due to the low wages available and the training is little or nothing. This only serves to keep behavioral issues re-occurring and does little to allow for the improvement of conditions.

1. Right size capacity for areas identified with inadequate capacity. 2. Guarantee capacity... if you want an organization to be available for 'immediate access' for assessments or services, then guaranteed capacity will ensure that slots/beds are available. 3. Increase levels of care available, e.g. Adult Day Treatment

Review data related to access time, waitlists, and capacity to determine what is the current practice, compare to national standards, implement standards applicable to Nebraska. Funding mechanisms need to support access in rural and under-served communities, i.e., capacity guarantee, flexible funding for gas vouchers, etc. Promote telehealth

Increase the number of "Qualified Professionals". Develop standards for post secondary programs.

Access could improve if there were a braided funding system and providers and consumers were not constantly

caught between what their payer source will pay for and what the consumer needs. Access would improve if there were adequate funding to cover the cost of services. Access would also improve if funding was adequate to allow for better salaries for persons wanting to work in behavioral healthcare. Right now the available workforce for behavioral healthcare service delivery is terribley scarce. With these three access criterea met then uniform outcome standards for entry into the public system and for movement out of the system.

Need more long term options. Too many people in and out of psych hospitals as their treatment is not long enough and follow up options are not enough

Work on a way to get patients out of the ER and into treatment quickly.

Providers wil not remain in small towns to provide services if it continues to cost more to provide these services with continued reduced payments for services.

You need not do anything.

Clearly communicate policy changes in writing to all Nebraska providers. Establish ideal waiting times (not longer than X days) for access to each service.

More education to the public. More outreach programs to the rural areas. More education to medical workers, in order to detect problems and refer patients to the proper health system.

We need to stop letting our jails become the new provider of mental health services. Behavioral Health needs to support individuals in crisis as well as supporting stabilization. Often, a client is stable, they lose their supports because they are "stable" and they quickly cycle back to crisis. Each crisis episode reduces the level of stability. Supporting stability, long term, will reduce the expenses of emergency rooms, jail beds, court involvement, victimization of citizens and victimization of those in services.

Bed space for acute cases are ever short of the demand for them. Can be approaced two ways, more available acute beds, and/or, transitional beds for those that remain urgent but no longer acute. Also need to examine early discharges. Often a brief 3 day stay only leads to a relapse into the need for acute care services once again. These "repeating cases" should be a flag indicating a need for longer inpatient stabilization services for the at risk individual.

Educating the public on what services are available before a client is hospitalized. Public awareness of what is available will help a family and client suffering from a mental illness to earlier prevention and help, hopefully decreasing hospitalizations or tragic endings. Standards should be flexible in the beginning of treatment and become more strigent as more treatment warrants. Sometimes just an interevention to help facillitate the resources a family needs is all that is required. Many families I work with are unaware of what is available and are poorly equipped for handling the symptoms of mental illness.

Get everyone on the same page. Look at the barriers to service as defined by consumers and providers.

Find a way to have a consumer access behavioral health programs quicker. With waiting list we loose people.

Utilize best practices to provide access and standards to access to behavioral health services.

Less reliance on rules/standards, more accountability for outcomes. Much more flexibility, much less bureaucracy.

More funds to provide more services in rural areas

Remember that care must be accessible in terms of costs, various treatment options, culturally tested treatment options that are evidence based or promising practices, and linguistically appropriate. Establish the standard that all services will be available in the preferred language of the client or patient or consumer. Establish that to the extent possible, interventiions and treatment options will look not only at cultural understandings/beliefs about behavioral/mental health, but that often, for persons with limited English proficiency, or who are new to the US, have no corollary with which to compare BH in their home countries. Also, establish standard for checking for dual diagnoses, especially where the criminal justice system is concerned.

KISS, Make it simple simple! I changed the last word to be more appropriate. The system is loaded down with too many workers. Families have at least 3 workers up to 8 workers. This creates confusion, blurred boundaries and frustration for the family. Cut the case load. Have one case manager and a family partner that can relate to the family. Cut the service coordinators, family support workers, trackers, etc. Too many people with limited time

that are not able to form a relationships to the family. With protection and safety it is important for the case workers to remember in our judicial system you are innocent until proven guilty. I have witnessed state workers passing judgement at the beginning of a case deciding that no matter what the children will not return to parents.

Capacity! Providers should be paid for the services they provide. Analyize the number of services that 1 patient received from 1 agency. There might be some waste here.

increase capacity through more funding

The service definitions have always been an issue and always "in revision" to get Medicaid to pay for the help individuals and families need. Getting Magellan to approve payment is another hurdle for providers, individuals and families. So many barriers seem to hold up treatment and what is in the client/consumer's best interest. Earlier intervention and treatment on the front end reduces expenses in the long term with juvenile justice involvement, addictions, homlessness, and incarceration.

More providers.

To provide access to behavioral health services we need to review the current policies on licensing of psychologists and substance abuse counselors. In rural areas we lose good SA counselors because the State of Nebraska places major road blocks on individuals interested in obtaining a Substance Abuse Counselor license. I have many examples where college classes are not honored instead the State insists that their TAP classes be taken. When this happens many just walk away from the State of Nebraska or opt for another career because the classes are costly, not convenient to attend, etc. Please note that many of the individuals I am talking about have vast experience in other States and then they come to Nebraska to be told they are unable to get a license. Many have majored in Drug and Alcohol studies, etc. With regard to psychologists, Magellan will not recognize or pay for a school psychologist to conduct tests. Many of these individuals have years of experience in the school setting and are capable of providing these tests. In fact, at one time the State of Nebraska grandfathered these individuals in to the system I would like to see that happen again. We are wasting the skills and expertise of many valuable clinicians by depriving them of providing this service. Please remember in a rural area you have limited number of clinicians available. If you truly want access to services then you need to encourage growth in occupations such as these and be open minded to new ideas. Thanks!

Find a more responsive contractor than Magellan, or even better do away with privitization of this aspect of services altogether. They do an exceptionally poor job on behalf of Nebrasa consumers and taxpayers.

Increase behavioral health bed capacity for Dual Diagnosis residential units, to allow each facility to serve more clients. In the priorities for admission include persons with past mental health board commitments, as well as the present mental health board committments. Timely access to services depends on the availability of beds and services. Funding for transition homes for Dual Diagnosis clients to include structure, Dual diagnosis support groups, longer transition into apartment living, assisting in community involvement in activities and extended education on living with diagnosis.

Increase the number of minority providers into the Behavioral Health model. Require that CLAS Standards training be taken by all Behavioral Health Providers and connect the training to the appropriate number of CEU's. Require Cultural Competencey training be taken by all Behavioral Health Providers and connect the training to the appropriate number of CEU's. Introduce and/or increase the number of trained interpreters to the Behavioral Health Model

Small towns in rural areas have little or no access to mental health care. Traveling therapist might be the answer to the transportation issues that arise from dealing with location and transportation. Get the help to the people instead of taking the people to the help. I am also a huge advocate of peer support. Perhaps a group of individuals/peers to reach out to some of those that are unable to drive to a city location to get help would be a new angle to approach.

Increase education requirements for individuals who provide mental health services. Provide adequate funding for services. Identify gaps in services. Identify and target high-risk populations (e.g., individuals in the criminal justice system, individuals with substance use, previous mental health hospitalizations, individuals with brain injuries, homeless individuals, youth transitioning to adulthood).

You need to meet federal guidelines regarding the CLAS standards which include the provision of services that are both culturally and linguistically appropriate. You must also not only provide them but must document and demonstrate how you are providing and evaluating them to ascertain that the federally required CLAS standards are being met.

Survey Question: What information do you want to see as part of a regular, transparent report of performance for the behavioral health system? (Forming a "dashboard" of information to gauge how the system is moving toward a vision and goals)

Text Response
1) Single, uniform assessment measures used by primary care docs. 2) Cost of care uniform definition in 2 ways: revenue divided by units of services; cost of care divided by units of service. 3) client satisfaction survey data conducted by the state, not provider.
News articles.
Again, develop the service array to reflect the needs of young adults.
Number of individuals who have the supports necessary to receive services and successfully manage their care in their own community, number of indivduals who report they received the services they needed, number of physicians reporting their patients had access to necessary behavioral health supports and services, amount of stress reported by caregivers of individuals who receive behavioral health care services, financial burden reported by caregivers of individuals who receive behavioral health care services
Services provided; length of time information on consumers, perhaps based on age - services received in high school, 2 year, 4 years later, to current situation. Perhaps we could tell what worked the best overall. Experiences affecting the consumer - involvement w/law; homelessness; working; in school; etc. to see what and where to look to help others.
Track time it takes to get client into services, turnaround time for getting providers payment for services, average of claims denied due to a minor technicality, number of co-occurring clients and if they are getting treatment for all presenting issues, track family involvement and family perception of treatment/services effectiveness over a specific period of time. Measure both client and provider satisfaction with process from start to finish.
Data should be helpful not overwhelming and time consumung to input and read. A "dasboard " should have client stats shuch age sex DOB primar diagnosis recent presenting probleems and recemt hospitlazations if any.curent providers and current medications a snap shot
Evidnece based practice and then performance outcomes. BH wastes a great deal of resources on process without accountability.
patient or family satisfaction complaints about services or practitioers time until first appointment Length of waiting list outcome measures connection to after care services Distance required to travel to service available practitioners
It would be informative to see how many people are denied services when providers believe they truly need them.
the cost is a factor but beyond the cost is the importance of not just looking at the numbers to make the determination of whether something is successful or not. Sometimes we get our minds on "Best evidence" care when it is not always the best evidence practice that works. We need to address the cultural competence of providers in all areas-
How many people are calling for help, how many people are referred to what type of service and how is the follow up on it?
Public awareness/education; law enforcement eduation; accessibility of services to rural area comsumers; accessibility of services to dual diagnosis population
How do you measure success? # who got well enough to leave the system? # of complaints received / # of complaints resolved
measureable goals stated for the policy being implemented goals evaluated at stated and appropriate times. Look at what is working in effectiveness and enhance it and dropping or reducing less effective ways. State the positive in measureable goals. I guess another way to measure would be to state dollars spent and what the money purchased to help the client.

The different types/components of support services for persons with varying mental health needs.
INFORMATION ON SPECIFIC OUTCOME MEASURES AND GUIDLINES FOR IMPLEMENTATION OF PROVEN, NATIONALLY RECOGNIZED OUTCOME MEASURES. THIS WILL ENABLE SERVICE PROVIDERS TO IMCORPORATE PRACTICES THAT RESULT IN ACCEPTABLE OUTCOMES FOR THE CONSUMER AND THE BEHAVIORAL HEALTH SYSTEM.
Open, honest dialog between all involved. Sharing of all reports between familiy, caseworkers, health service personnel, etc.
Efficiency and effectiveness of treatment
I would like to see some kind of chart.
Sharing assessment information with the courts and school systems.
your question is word salad and I can't tell what you want
Hiow money is spent especiallyt what percent is being devoted to community services.
Simple, clearly-stated policies/practices that do not have to be interpreted, or are devised so that they can only be interpreted by those who enforce the policies/practices. Accountability by oversight for those who determine the requirements for clients, as well as providers.
unsure at this time, but we need a system of accountability that begins with the HHS workers themselves, then moves down to the specific dynamics of a reporting and trackinng system, if the system has no accountability, how can we expect our families to be accountable--lead by example, not cover-up modality to protect the system, consumers and providers are quite tired and fully aware of unprofessionals, some with current state licensed that are allowed to hide and posture simply because they work for HHS of Nebraska==this is simply unacceptable, and HHS Regulations and Licensure needes an immediate and complete overhall for this to be accomplished.
State of Nebraska actually putting its money where its mouth is--funding direct services, with emphasis upon funding community-based services.
1) Track number, type and severity of need among consumers, as well as length of wait to access care. 2) Track number of people who never do get any care even though they have requested it. 3) Track number of insurance refusals to pay for service, as well as the scope of benefits and how this is impacting access to care. 4) Track number of people made homeless or housing insecure because they cannot access care or care is inconsistent. 5) Track how many people are unable to take their medications consistently because of cost, barriers caused by the state's "managed care" system and private insurance companies. 6) Track the number of incarcerated people (state & county level) who have diagnosed mental health issues, the number of times they enter the justice system, and the number who cannot afford their medications upon release. Track the recidivism rates of persons with mental health issues. 7) Track the number of families requesting care for a minor with mental health issues, the number of times they are unable to access care and the impact upon the family unit (particularly in the terms of income earning ability).
How many people (with demographic breakdown) are taking psychiatric drugs. How many jpeople have had brain operations in the State to treat a psychiatric diagnosis. How many people have been administered ECT. How many people have died after having been administered ECT. How many people have been involved with the criminal justice system after taking psychiatric drugs. How many mental health workers have abused/harmed their patients while in the care of State facilities and in private practice. How many mental health workers have committed fraud while engaged in the psychiagtric/psychological industry.
Quality of life measures in addition to "beds and meds" data.
Outcome data - what makes an intervention successful - in various locations. How are we being consistant in data collection; monitoring best practices adoption, implementation and supervision... what collaboration efforts are being made: plans and outcomes; confidentiality of the shared assessments.
Awareness of behavioral health is a key factor in helping consumers to take advantage of resources available to them. Finding them the best or evidence based practices will help to ensure consumer success in their endeavors.
A real assessment of patient and consumer satisfaction conducted by a consumer advocacy group.

I would like to see more consumer input on evaluations of professional services and also professional input on what is needed to provide quality care. A collective survey that produces a picture of what is working and what is needed. That information would be shared with all stakeholders.
Number of consumers being served; how quickly accessing system; who are the providers; funding; who oversees what
Simple, easy for consumers to understand, constantly focused on the vision, use same data, not put more burden on staff to collect worthless data.
This scares me as the State has NEVER come up with an information system that works. Providers have entered huge amounts of data over the years but can not retrieve that info when we need it. This causes us to keep dual records. When we DO get reports back, there are major errors. We report information to Magellan, have attempted multiple times to rectify incorrect reports, without success. Incorrect information continues to linger. This does nothing to instill confidence in providers -- and I would be leery of reporting out on this info that has been collected. I am not trying to demonize the state or its contractor, but there is agreement amongst providers that this is a huge issue.
Uniform outcome study indicators which must be gathered and reported by all agencies.
We have too many licensed providers who are poorly trained and supervised and who see patients for inordinately long numbers of sessions and periods of time that need to be "reined in." Too often there are not adequate guidelines or research proven and effective procedures used by these providers and the end result is unnecessary sessions that cost the State and Medicaid money. There needs to be more emphasis on getting qualified indepaendent professionals (pschologists, psychiatrists and real LIMHPs) into practices throuighout the State - not just in the Omaha and Lincoln areas.
recidivism rates, length of days waiting treatment, including days waiting to transition from one level of care to another (step down/up),
Time from request for service to admission % of successful discharge by service type Length of stay by service type Outcomes of service--sympton reduction/improvement in functioning by service type EBPs being used by service type
fewer hospital, crisis center and correctional center admissions because outpatient support systems are in place and accessible. evidence that consumers and families are reporting progress towards recovery, as it is interpreted in the mental health system currently, in greater numbers. greater numbers of appropriate referrals for mental health among all system providers, indicating increased awareness about and less stigmatization of mental illness. evidence of better integration between mental health and developmental disability systems, and between adolescent and adult systems ~ in the best world, no 19 year old who has "aged out of the system" of child and adolescent services of any kind, DD, MH or correctional, would experience any gap in appropriate services.
Reports on effectiveness of services in Nebraska. Are the services being provided actually improving the lives of those they serve? If so, in what ways?
online outcome reports of providers and community data numbers. Research guiding practices easily accessible and identified.
# of Persons served # successfully completed
Key elements off the NOMS;
Utilizing evidence-based and/or promising practices Implementation of integrated dual diagnosis treatment Implementation of Wellness Management and Recovery practices Consumer satisfaction/perception of care Implementation of trauma informed care Consumers involved in meaningful life activities Competitive employment, vocational, education activities Decrease in offenses/arrests Increase in stabilization of family and living situations Readmissions within a specified timeframs (i.e., 30 days)
served, # put on waiting lists # reasons for not timely service or no service i.e. no insurance, preventative versus most severe

Develope a common system/standards accross the state that every provider/provider entity would be help accountable too. This information needs to be available monthly to the intities and those meeting the standards need to be rewarded. What is the incentive today for a provider to be efficient and effective in the service they provide?
Length of stay in psych hospitals and rate of readmitance.
share the assessment information on NeHII state wide patient record system which is already used by multiple systems across the state
Caution would be to spend more money on gathering information rather than money spnt to help consumers.
Number of people treated (with delineation as to race, culture, age, sex) and "return" rates.
Admissions/discharges from LRC by region. Waiting list for LRC admissions. Inpatient recidivism for patients in all facilities (i.e. if Patient X is admitted 3 times at facility A, 4 times at facility B, and 2 times at facility C in the course of a year that is a case for special handling)
Consumer and community safety should prevail, again, individuals in mental health crisis are often brought to jail more than they are brought to behavioral health providers. I also believe that agencies should be responsible for producing results that can be tracked and the data analyzed to determine how to best serve people in the community. We should focus on providing services that meet the needs of the consumer rather than dictated services with little or no benefit to the consumers stability.
Wait time for inpatient bed for acute care individual.(Set obtainable goals) Wait time to exam by psychiatric servies physician. After discharge support in place prior to the actual discharge. Goals for care established for inpatient AND community based servies. Psychiatic stability reached prior to dischage planning.
I would like to see a report that shows how many families are requesting services but are denied due to "formalities" with the system. Example: Magellan.
Missing data, for example, race, ethnicity, language preference, and to what extent we have not heretofore had a "system" for checking for dual diagnoses, nor issues that address why within some cultures, seeking help, especially within the scope of BH, is shunned, taboo, or left to religious or other practitioners. Ownership of the inability, at this point, to report on performance with respect to gathering data that is race, culture, ethnicity, and language specific, is a limitation faced by the STATE of NEBRASKA. Fears of racial profiling, stereotyping, and differing standards of care- are real fears, with historical basis, and therefore warranted, also impair the ability to collect this data in this manner. Yet, this speaks to performance, and patients likelihood to comply with recommended treatment plans, including meds, and the correct usage of meds...
an easy-to-read, accessible, updated dashboard that is current on a regular basis(monthly/quarterly) would be great
I recognize the importance of accountability however, I also recognize that with all the paperwork and burdens that are placed on the provider it is very difficult for the provider. The State of Nebraska requires CARF or JACHO that already requires performance measures, etc. What about all agencies obtaining this?????
Anything would be better than the current.
Develop uniform assessment over the state using ASAM criteria. Transfers from one organization to expedite appropriateness and eligibility determinations.
With Nebraska becoming a more diverse set of communities, a Cultural Competency piece is also needed here. Not only for racial and ethnic minorities, but for immigrant-refugee-asylee communities, rural communities, the elderly, and those with disabilites.
Recovery has to be the ultimate goal. Judging the health system according to the participants ability to live to the best of their ability is the goal- measuring that is something that i don't have an answer to.
Previous hospitalizations Previous incarcerations Previuos diagnosis Rates of homelessness
Numbers of patients (including demographic data) moving through the system with specific measurable outcomes indicated and progress towards acheiving overall program goal of facilitating independent living.

The number of unduplicated consumers and the level of treatment they are receiving. Statistic information on these consumers including geographic, economic, legal involvement, etc.
Consumer feedback on services. Total number of persons served by age across region. Trends in reason for referral. Family involvement.
Like to see provider outcomes, wait times for each service by Region,
Something that does not include any additional time for the worker that is already under extreem demand and overloaded on paperwork and client needs that is already demanded. Magellan already askes every possible question to get into services. Can it be linked to pre authorization and reauthorization as to eliminate duplication?
I do not have enough understanding of what is available to answer the question. Total numbers of people served, days waiting, length of sobreity, employment, housing, etc. do not necessarily report that a system is high performing. Numbers can be generated easily enough for clients served, that doesn't prove program quality or effectiveness.
BH Services are available and provided so they are accessible to consumers/families. Bh Services are provided in a timely manner - indicating adequate supply of services is available and accessible. BH Consumers are using the more intense services less as they are able to access and use community based services supporting their recovery.
Nebraska needs to stop using the medical model for behavioral health. We need to use a evidence and strength based model. Promating recovery, providing living skills so consumers can live on their own and not in residental care. There more often no comminucation between providers a consumer. A consumer see's more than one provider different medical things and communication is lacking. This needs to stop and communication must start! Consumers die up to 25 years sooner than the "normal" population and this needs to be worked on.
Quarterly progress reporting on key indicators of success relating to the quality and effectiveness of the behavioral health system,e.g. consumer involvement, effective collaboration, promotion of best/evidence based practices.
The difficulty of sharing assessment information across the system/providers results in the same task being completed multiple times - something that is NOT consumer friendly and serves minimal purpose. The state/medicaid regulations do not reflect an awareness of the present challenges for providers and in some cases are excessive, result in higher costs of services, and frankly have little to do with quality care for consumers. An example, completing monthly service plan reviews - while ongoing review of treatment goals is appropriate and best practice, I'm certainly not aware of any research that suggests monthly reviews are needed much less effective.
My main concern is medication and having people coming out of the hospital on medication that their provider does not have or the consumer can not afford. Sure there stable while in the hospital and come out to a needed medication adjustment due to cost or availability. I do believe we as a state need have better communications between facilities in order to stop the merry-go-round.
I would like to see what the prevention efforts underway. Of course you must treat those in immediate crisis, but in my opinion you have to GET to crisis before any help kicks in and then it often is not the appropriate service, it is what is available. If more emphasis was put on prevention efforts including parent education and family support, money would be saved in the long term and families would experience less crisis and be better educated to deal with their own family members issues. Less focus on payment issues and more on systems thinking outside the box is needed! It seems that the state is always fighting about who the payor is or should be-focus more on healthy individuals for a healthy state.
Estabilish statewide indicators (that correlate with SAMHSA's national efforts)based on goals of the strategic plan and train on the use of logic models that will be used to improve management of services and accountability/transparency at the agency/organizational level.
Access to free non redacted medical records. If the providers can share information consumers should also have access to their complete medical records. If services are refused they should be able to have an answer as to why they are not eligible for services.
Access to services, recovery indicators, quality of life, satisfaction

Annual report identifying diagnosis, type of treatment provided, and some measure of estimated improvement or success of treatment.
What services are available...where are they available...how do you access them
Needs to include client involvement and family involvement. Needs to identify support systems (formal and informal)
number of persons served and timeliness of service. Number of state personnel employed in behavioral health number of behavioral health service providers
Want to see that clients are seen more than once and that progress is being made along with information on ages of clients and ethinicity
I'd like to see some feedback to the community and an awareness that help is available if needed. So many of our folks are afraid of asking help. They see the state as "against them" and they need to develop some trust in our health care professionals.
P&P that will indentify and focus on goals and objectives of services. Easy to understand statistics in each area to locate services that are not working or need improvement.
rEGIONAL INFORMATION FUNNELED UP TO THE DIVISION SHOWING A STATE WIDE INFORMATION.
number of interventions with follow up data over the course of 5 or 10 years
The choice above : Implement a uniform system for collection and analysis of date. It sounds so simple and easy, but it is hard to make it "uniform" as services are so different from inpatient, outpatient, and others. I don't think it is a good idea to make it uniform cause "definition of servies" are different. The goals and mission statements of each organizations are so different.
What does the data reflect is common practice in the behavioral health system. Is the referral system supporting early access to services rather than waiting for emergency crisis intervention and more intensive levels of care? To what degree are people with behavioral health problems being readmitted to intensive levels of care within 30, 60, 90 days of discharge from intensive levels of care? (In other words what are the quality control issues that we are tracking to make sure that people are being served well and effectively....rather than admitted, symptoms reduced and released back only to relapse.)
equal opportunities for consumers throughout the state
I would like to see if working within community based services can continue to provide as a philosophy and means of working with many aspects of the various agency providers a clear effort to build on wellness not looking at how much this cost or that cost or how much money we need to save. The state gov't needs to fund recovery for mentally ill individuals and not use this money for other general fund practices.
Information on statewide service numbers and outcomes rather than the isolation of region specific data
History of placements Family history Discharge summary from previous therapists Established goals for the system, family and individual

Survey Question: What are your ideas to increase cost-effectiveness for the public behavioral health system? (For example, you may suggest changes in regulations or in the way services are delivered that could result in system savings or efficiencies)

Text Response
Sliding scale fee.
Provide fewer direct services through the State/Regions and provide more enabling/capacity building/training services; adequate funding for individuals to direct their own services through private providers; competitive reimbursement that will allow access to services in private practices/not-for-profit behavioral health care organizations.
This is not an area that I see telehealth making a world of change. Mental health providers develop a trust level with clients. I just don't see that happening long distance over a camera and microphone.
Centralized client electronic file accessible by all providers and updated to reflect their part of an integrated care scheme. Update the antiquated Medicaid EDI system, still using delivery by modem pool. Take a look at the Emdeon Vision tracking system for claims management. Combine all Medicaid claims submissionm Managed care and CFS into one centralized EDI system like almost all of the other States in the country do. Why does a provider have to sort out which department at Medicaid to forward a claim to, or if it requires a paper claim, etc.
While BH can partner with other agencies they should not get into the business of transportation, housing or employment. There are other resources and partners who do that more effectively. I would also emphasize that that is also true for all prevention dollars. BH specializes in after action. Prevention is better served by public health and other community initiatives.
stop contracting with out of state agencies for operation of system as it is a dollar drain and eliminates opportunity to develop capacity and infrasytructure in State. Require performance data and evidence based practice. Whgat is cheapest in short run may not be cheapest in long run.
There are currently too many people involved to get the person to services, review how many people does it take to get service to people. Better train people to realize what people are wanting, sometimes people feel noone understands them and they are just getting pushed around the system.
Help family's early on in crisis by providing services before behaviors become severe. Early intervention will provide the educaiton that is needed for thr family to beceom well.
Nebraska has invested in telehealth technology - make more use of it, especially in rural areas; develop network of non-state resources that provide services, making state funding the "last option."
I believe in my first choice as preventing "money down the drain". Money surely could be saved using telehealth. Of course, not everyone has Skype or computers. But could the client get someplace with that capability? They could have regular appointment time with provider via this method. Take a page out of rural medicine and how they use telehealth. I hate to give my #7 and #8 lower rankings. All the recommendations are vital.
A continuum of services is needed, which includes acute care settings. The state has shirked it's responsibility in providing care for persons with severe and persistent mental illness.
ALLOW BEHAVIORAL HEALTH PROVIDERS TO INCLUDE ANCILLARY SERVICES WHEN IDENTIFIED AS RELEVANT TO POSITIVE MENTAL HEALTH OUTCOMES, INSTEAD OF REQUIRING CONSUMERS TO DISRUPT THEIR PROGRESS, CHANGE SERVICE ENVIRONMENTS AND RUN THE RISK OF RELAPSE.
Our organization is attempting to find ways to provide telehealth services to rural patients. If this would be made easier to implement we have several sites that would be ready to go live. This would cut down on transportation costs, wait times, etc. some of which saved money could be used to better enhance telehealth services to be provided by both for-profit and non-profit organizations. Again make grants available to any organization that is able / willing to enhance access to services.

Use treatment methods that work for the patient. Sometimes cost saving practices really end up costing more, because they don't work.
Focus review on outliers rather than up front red tape
I would say that if a child needs assistance for their behavioral health. The state should provide some assistance with that. So many children are not getting the help they need due to their parents not being able to afford it.
Linking of services with the courts and behavioral health systems. Provide funding for parents that have children that need services and are not able to get help because they aren't able to afford it.
New admissions to the behavioral health system need affordable access to medications immediately upon diagnosis to prevent hospital admissions and unneccessary costs.
Make sure that safeguards are in place to check each step in the cost trail to make sure dollars are being spend effectively.
We now have a law that requires mental health recipients to be citizens of the U.S., but very little training on what can/should be done when an illegal alien is EPC'd. The cost of long-term treatment is considerable and providing government-funded services only to those who are legally entitled to receive them would save the counties and state a considerable amount of money. And it's the law!
Develop clear and consistent determinations regarding provision of services for immigrants who are in an illegal status. Substantially increase availability of Telehealth access for use by providers.
do not duplicate services, such as Community Support who write treatment goals but are not clinicians, and who act on such goals as they were or are clinicians, and who do not usually work collaberatively, and without transparency and without accountability, do not allow those who are not clinicians to GAF, do not allow this program to continue with successful dismisals on paper to ensure funding only to find out that the consumer never successfully completed any program through our Behavioral Health Region--hold Regions accountable, demand excellence and fund nothing less that high standards of excellence--you are further complicating the problem by allowing and condoning such funding
Do all that is possible to help families before major crisis happens. Provide preventive supports for families.
Increase number of Aftercare service opportunities for Sex Offenders.
Focus on long-term wellness rather than short-term fixes. Look at long-term cost effectiveness rather than short term budgets. A mentally stable population should require less state services over the long-term.
You need a full complement of behavioral services available first, before you can maxmize cost savings. Currently Nebraska's behavioral health system essentially does not function. We're reaping the cost of that lack of care and access to it through our incarceration rates both on the county and state level. The jail and prison systems are picking up where the behavioral health system is non-existent. It is much more cost-effective to treat behavioral health issues in the least restrictive environment possible when compared to the cost of incarceration. More funds need to be expended on behavioral health and less on incarceration. As a state, we would save money and lives if an understanding of these two issues would occur.
Require a complete physical exam of all psychiatric patients from a competant non-psychiatric medical practioner to uncover underlying physical ailments BEFORE a psychiarist can claim a psychiatric diagnosis from the DSM.
Encourage the development of identified emerging and evidence-based practices by having the courage to reallocate funds from traditional inefficient/ineffective services that are funded simply because they have always been funded.
i would like to see a program to help cover medical costs for individuals and families that make too little for private insurance, but don't meet medicaid requirements, either. the people lost in the cracks.
I think that the development of a behavioral health telehealth system would be very beneficial, similar to the hospital system that is in place now. Having this system in place would allow you to reach several of your strategic planning goals, it gets services to individuals that do not have transportation to reach providers, it cuts down on the amount of administrative travel costs, more consumers can be reached to expand consumer involvement, and it gets providers more access to trainings they need to provide the best services. The best thing is you do not

need to "reinvent the wheel", Region I has telehealth currently and is utilizing it successfully for all of the above. Cost savings, efficiency, consumer access and involvement all rolled into one!

Supports must be emphasized first, if a consumer's basic needs are not available to them, they are not able to focus on any other area of their life.

Include more peer support specialists. Provide certification for trainings.

Create a medicaid premium cost, for persons who receive social security disability and open it up as an option to purchase for those who are uninsured and would meet requirements set. I think a workforce should be developed to oversee disability claims and to review cases of people who receive social security disability yearly, in most cases. Disability is often viewed as "permanent" when in reality, it shouldn't be. People should be assessed regularly and held accountable to work if possible. Allow people "short term" disability to ensure if relapse happens they don't lose their homes and have to start completely over after an episode.It is very costly monetarily as well as devastating for a person to have a relapse and then find out that due to inability to pay for rent they are losing the security of their home and independence. Put more stipulations on medicaid received by disability recipients. Standards, like insurances have; 2 ambulance trips per year, then you pay for any additional, 1 MRI, 1 CAT scan, 2 emergencey room visits etc... I think the system would look alot different if we held ourselves and other's accountable for the gross misuse of our medicaid dollars. Target areas that will TRULY support recovery and wellness. Strength based practices such as; let's teach people how to work, how to budget, how to manage symptoms, how and where to socialize. I have a mental illness and refuse to be considered "disabled". I work 40 hours and believe alot of people who are on disability don't work because of that label. People with diabetes, cancer, heart disease, they work. I agree not everyone with a mental illness can work. There have been times in my life that I haven't been able to work, but then I fought hard to get back to where I could work. It's a support system approach that encourages optimal opportunities to live life fully, like everyone else.We need to lighten up the approach as well, it doesn't always have to be so serious, like therapy. I like to role model learning while having fun. Mental health rehabs are far too serious, there are the right times to lighten up. My last subject of concern is medication and I don't know if this topic fits here or not. Practioners are literally drugging people while they are still drugged on a previous medication. Let's quit the playing with people. If a medication don't work, make it mandatory that the medication has to be out of the system before another is tried. How many combinations does it take before providers figure out that compounding meds. on top of each other over and over again most likely will not work, in fact often scare people away from medications that may very well help them. In the last two months, two people I have had the priveledge to know who had a mental illness literally walked into the emergency room, was sent home, went back and died. This is my deepest concern. Why are we not treated with the human dignity that people without mental illnes are treated? Emergency/medical practices need to LISTEN to us!

Decrease the number of "bean counters," increase the number of teachers (Old DPI staff were good teachers for out-state programs, new staff, Look at expense of CARF ($6,000) look at expense of outside financial audit ($7,000) look at way system is planning to use LMHP's (are now clinical supervisors) who MUST review each case plan at least monthly - this person will be buried in paperwork and will not have much time to see consumers.

I would argue that the issue is not inefficiency of providers. Our problem is a lack of state support for SA and MH services. Providers work incredibly well together and it is not a lack of linkages, or a lack of information sharing, or failure to work with other systems. WE HAVE A LACK OF SERVICES. Nearly all levels of care across the state have waiting lists. There are not services available and persons languish on waiting lists. We focus so much on priority populations that the uninsured individuals who are not IV users, or pregnant, wait MONTHS for services. This is horrible. Too many insurers have pushed people into the publicly funded system. Our clients are being demonized and need services that they can access at the present time. NE needs to step up to the plate and help these individuals. They can become employed, taxpaying citizens if we help them with treatment, rather than ignoring the problem and letting them end up in the criminal justice and corrections systems which ultimately ends up costing us (taxpayers) more in the long run.

The BH Division, Medicaid, & Magellan are still in silos despite many efforts to impact change and cooperation. Too difficult for providers to navigate and provide what is in the client's best interest.

Develop more intermediate services such as respite beds, day hopsitalization Develop a system to meet the needs

of the consumer, rather than have consumer fit into one category or level of care Allow consumers more choices for wrap around services (rather than one provider who offers the service in a 50 mile radius) Allow individualized plans and more flexibility to consumers without "punishing" providers financially

all the integrated agencies could have the same format for pre-treatment assessments, for instance, so that it is available and share-able as a person moves from, say, a substance abuse facility to a mental health facility. as one "ages out of the system" [see comment above], hir history would be easily accessible to the adult providers. supports such as transportation, housing, would be readily available to all the consumers of such an integrated system. again, if a 19 year old may no longer stay at a facility, a different facility would be immediately available as needed, reducing chances of homelessness, criminal system involvement, gap in services that might lead to relapse. clearly better linkages between correctional and mental health systems are necessary, so that MH services are in place when people leave the correctional facility, with no gap in services/meds that might lead to greater rates of recidivism. maybe the "providers available by telehealth" could be the soure of linkages between these systems, i.e. short term case managers to help move people from one system into another.

Adopt policy on Deemed Status. Nationally accreditated providers would only go through State/Region fiscal audits. Agencies would be required to submit copies of their detailed accreditation reports and notification of accreditation/re-accreditation.

Reduce duplication of organizational monitoring by utilizing "deemed status" for nationally accredited organizations. Proposed service definitions require clinical oversight that is costly and does not add value to the service

Regulations do nothing but strangle a system. Regulate, regulate - a very good way to stifle energy, creativity, effectiveness and accountability. Lets create a structure that fosters and promotes energy, creativity, effectiveness and accountability and then create accountibility measures and use these measures as regulators.

Create a system where "evidence based" practices are used; but stress early prevention as the key to saving money.

Grant funding is great as long as the services are able to become sustainable, otherwise, we are setting people up to fail when the grant runs out. We should capitalize on medicaid match in this state but not at the expense of the person served. I have seen that access to medications and stable housing are KEY to stability and success for persons with mental health issues. And the community needs to support each other and work together for the betterment of services and stabilization of its more vulnerable populations. "It takes a village".

Obviously Community based services are the most economical, however, inpatient services that have truly stabilized a client will allow for the greater success of a client at the community based level of care.Transportation short falls often prevent an individual from meeting obligations with their home, Doctor, Hospial, or employer for example.

Unpopular as this may be, there is little accountability among the clients that receive services and much accountability on the service providers. There needs to be an increase in accountability in people receiving services and aid to ensure that the clients being helped are those that are going to benefit from the services not exploit the services to continue with like behaviors. I continue to see first hand clients use different systems for financial gain with little to no power on the service provider to intervene, as the client says: "I have my rights". Many dollars would be saved if there was a system set up to hold the clients as accountable for the service they receive as the ones that are providing the services. Great frustration among Behavioral Health Providers, hands tied and asked to knit a blanket.

Catching the families early and providing services in the community keeps the costs of treating individuals down. Yet, we do not tend to get the cases until the community treatment is no longer effective due to severity.

If someone is "stable", allow us to continue with services that got them to that level and maintain instead of pulling services out.

While telehealth is important to providers, and can benefit those who will receive services,many minorities as well as many whites, fear this tool as it might be misused. (George Orwells' 1984, EAGLE EYE, and other Big Brother' messages) This particular bullet should address this fear, and also have an accompanying strategy for increasing

awareness of benefits to telehealth, as well as the limits which can be restricted by a patient simply signing such a form to restrict what info is available in personal records, for all providers, and what can be restricted from use by the patient.
At the persent time too many people are involved in a case. All the money is going to salaries of these workers and little money is going to help the family with their basic needs, transportation and medical.
allow agencies who have national accredidation to received deemed status instead of yearly site reviews. Magellan should track if an agency has requested a services for a consumer and if that services is not authorized if the consumer ends up using higher levels of care. It is my understanding that they do not consider this a denial of services therefore it is not tracked. As a provider, if I can not authorize a level of care, I see this as a denial of services for that consumer.
changes to the use of public service commission providers for transportation, very costly when a gas voucher may be better option for the child and family. Are the "Lead Agencies" really going to save money? Or should the state look at "saving face" and look at who is really loosing in the end, it is children and families.
As I mentioned previously in this survey you need to look at regulations in licensing of SA counselors and psychologists. This would help with costs. Also address that rural areas do not have the luxury of a large clientele base all close to their agency in the rural areas you are driving hours sometime to see clients. The State of Nebraska needs to recognize this and assist those agencies.
Fre the Medicaid Director - she is an impediment to innovation in thi area.
this is one i mentioned earlier.. the options for those in outlying areas are limited. perhaps reaching those by visiting health professionals is a better option then the standard transporting them to the few clinics that are available. In home assistance might be a goal for the future. As well as bringing Peers into the lives of others that may only see the clinical side of any help they have gotten instead of out reaching to others that have been through the same issues as others are facing.
Promote treatment of individuals through community treatment centers with qualified staff members. Provide incentives to encourage providers to practice in rural areas. Provide incentives for hospitals, community mental health centers, etc. to provide mental health services to individuals.
Reduce adminstraive costs and increase direct staff numbers and salaries. Provide and promote more prevention and education (classes, workshops, seminars, conferences, study groups etc) in the area of good mental health practices through many cost effective avenues at different levels of the eduatinal system, hospitals, youth and adult day cares, church groups, outreach groups etc..."Bring Behavioral Health out of the closet"
Utilize outpatient treatment and link services. For example, if someone completes treatment but has no housing or job they are much less likely to stay sober. Need to provide a continuum of services to prevent relapse.
Services funded for capacity rather than fee for service, with regulations that mitigate against fraud.
Need to quit letting Medicaid increase cost of services by requirements (staffing ratios, costly supervision,etc) with no evidence the increased cost and mandates do anything to improve care--quality, outcome, or safety.
Our current system does not focus on prevention and early intervention and there is no grey between severe, when can get assistance and someone in early recovery or prevention, who gets no help and falls between the cracks. Frequenlty I see higher level of care than is needed because there is no moderate level of care available.
Allowing master level graduate students to deliver services that can be billed back to capacity within the regions would not only support the development of trained providers; it would reduce personnel costs for community mental health centers allowing for reimbursement rates to closer match the cost of service.
The sustainability of funding would help in cost effectiveness. Funding can be impacted negatively due to the priorities of funding resources be they state funds approved by legislature and governor or other sources.
Create more opportunities for self-directed care.
Stop requiring records to be redone by multiple providers; maximize information sharing via fax, secured email systems, etc.

Again, prevention-if you pay up front you will pay less down the road. I believe that the evidence shows this, yet it is hard to get help for small children who may be having behavior problems even pre-school. Working together more across the different areas that touch children and families.
The behavioral health system is already greatly underfunded for direct care services. Start putting the needs of persons served ahead of political ideology.
Be clear that evidence is just that and not local opinion or local surveys
Allow individuals to work and keep health benefits. It costs Medicaid but you are paying into the system in a lot of different capacities. More options available in the community with a focus on more non traditional services.
There are a number of policy, guidelines, etc. that could be adjusted to promote more efficient service delivery. Individuals move from provider to provider and often retell their story dozens of times. And often authorization is denied/not possible for the "little" things that can help someone stay well/healthy/in recovery - this is why I ranked supports as #1.
Provide services to ALL irregardless of payor sources.
Find some way to slow the revolving door which some clients get caught in.
Must have enough funding to continue long term services to children instead of only allowing a few sessions or no more after just starting services
I'm not convinced that telehealth is as effective as "live" interaction with service providers. I'm afraid that telehealth makes us feel better about services being provided, but in reality masks lack of services.
Allow agencies to talk and share information. Will reduce double dipping and more than one agency providing same/similar service.
transition away from regulations requiring large state government infrastructure
If telehealth is effective, I think this is the best way to meet needs at least in Western Nebraska. I believe in prevention, however I do not know if there is evidence based proof that this is effective!
make sure that there is not a duplication of services-make sure that there is sharing of information
My experience has been that when community agencies collaborate and work collegially, we can make our dollars go further. Including clergy, substance abuse programs, teachers and law enforcement would be a good help. At the moment, in my community, these groups are all acting completely independently.
Increased telehealth usage for the panhandle
Make the club house model easier to access and easier to authorize individuals to receive services. Club house model is the most cost effective programs available to persons with mental illness. They emphisis work, education and independent housing and the provide support in all areas.
Behavioral health care is overregulated. Service definitions are too stringent, therefore the rate does not support the definition ie. defining caseloads in Community Support. We don't match regulation to what consumer wants. Most clients do not want to spend the first 2 hours of their contact with you answering questions for a "comphrehensive psychosocial assessment". The national council has done research on client engagement and retention. (Reduced paperwork and initial session limited to an hour, focused on client's presenting concern) Too much focus on process (clinical supervisor reviewing treatment plan every 30 days) as opposed to asking for an annual outcome report (which is required by accrediting agencies) There are other ways to get consumer involvement on service plan such as concurrent documentation. Behavioral health care serves a broad range of consumers; yet the consumers that are involved represent about 10% (SPMI)of actual behavioral health care consumers served and although their needs may be great, their perspective may be skewed and do not represent the majority of clients
Again, needs assessment that will identify the services that consumers feel are most important in their everyday lives.
Behavioral Health must collaborate with the early care and education/intervention systems within NDE and DHHS to be successful in ensure young children (B-8) are having their social-emotional/behavioral/mental health needs

met, along with their families - especially those in the child welfare system. There is much work being done in our state around building capacity and implementing evidence-based practices/interventions for these efforts for very young children. Behavioral Health must become a collaborative partner in these endeavors in order to be successful in their goals - and to be cost-effective.
iMPROVE THE EASE OF ACCESSING SERVICES WITH MAGELLAN IN AUTHORIZING SERVICES INCREASE THE INFORMATION ABLE TO BE ENTERED ON THE COMPUTER REDUCING THE TIME NEEDED ON THE PHONE.
more patient/client directed approaches to treatments
It won't be enough to create a cadre of providers available by telehealth unless the reimbursement policies support reimbursement of telehealth. It has to be aligned in order to work.
counselors, therapists, psychiatrists become accountable for up-to-date training...some have been in facilities for to long and don't care anymore.
I feel mental health providers could provide better care and prevention or early detection vs. treatment of problems if reimbursement is optimized. In other words, be more aggressive preventing through case management instead of crisis management.
Tela-medicine can help alot.
Uniform reporting/billing systems and service definitions for state services such as Behavioral Health, Medicaid, Magellan, Children & Family Services
Spend less money coddling and financially enabling parents who are not getting their act together. I am shocked by the number of chances grown adults are given to learn responsibility and most never do. Children need to be placed where they will be safe, secure and successfully, and that is often not with unhealthy relatives. Maybe if unhealthy, irresponsible parents weren't coddled, they would decide to get their act together.
prevention and cost sharing

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