Behavioral Health Oversight Commission
Final Report

Background

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

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

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

Charter

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

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

Strategic Focus

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

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

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

1. Moving Behavioral Health Forward

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

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

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

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

A. Strategic Vision Statement

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

1. Promote wellness, recovery, resilience, and self determination for adults and children and such system will be consumer and family driven;

2. Focus on and create positive outcomes coupled with a performance evaluation process that supports continuous quality improvement for the division as well as the Regional Behavioral Health Authorities, providers and recipients of services;

3. Provide inclusive and transparent planning through genuine partnership and collaboration with a diverse group of stakeholders, including meaningful participation by consumers, to promote a rational, strategic decision-making environment and process;

4. Focus on prevention and early intervention;

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

6. Encourage public/private partnerships;

7. Pursue every opportunity to maximize available revenue sources, including but not limited to Federal grants and maximization and capture of Federal Medicaid match dollars, and these new revenue sources will be reinvested in the behavioral health system;

8. Implement a process that expands the above seven strategic vision statements into specific processes, activities and objectives to be accomplished and provide progress and accomplishment measurements to ensure the above strategic vision statements are effectively implemented.

B. Core Values and Guiding Principles

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

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

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

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

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

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

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

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

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

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

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

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

C. Recommendations

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

The Commission recommends the following:

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

    a. The **strategic plan** will:

        1) Encompass at least a 5-year timeframe to provide direction, focus, priorities, goals, and action steps to achieve system transformation and reduce the current reliance on a crisis-oriented mode of operation.

2) Recognize the Division of Behavioral Health as exercising primary leadership in behavioral health services and as the driver of policy and policy-based financial decisions within the Department of Health and Human Services.

3) Establish expectations regarding collaboration among the DHHS divisions that eliminates cost shifting, reduces fragmentation, increases funding/reimbursement flexibility, and supports access to appropriate and quality care regardless of payer source and eligibility.

4) Identify long-term funding strategies to ensure realistic, sustainable financial support and maximize available federal revenue sources, including the Federal Medicaid match.

5) Include performance measurements, indicators, competencies and report cards that reflect the mission, vision, values, and principles of recovery and recovery-based care and an outcome evaluation and research process that continuously identifies ways to improve services and supports (Plan-Do-Check-Act Cycle), including those that are consumer operated.

b. The **strategic planning process** will:

1) Include a broad group of informed, empowered stakeholders of the behavioral health system at all stages of the process, including decision making. This requires the development of a plan that includes those who use or have used services and in sufficient numbers to be representative of the perspective of consumers. Meaningful inclusion is not limited to those consumers employed in consumer-specific positions in government. That plan of consumer inclusion is reviewed, refined and implemented as a first priority in development of the planning process. It will ensure meaningful education, supports for authentic "seats at the table" in accord with LB994 (2006) consumer "inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation and research".

2) Include, in a collaborative and inclusive manner, the development of mission, vision, values, principles, and definitions that reflect individual, program/service, and system perspectives and incorporate both regional and state-wide points of view.

3) Consider the accomplishments and challenges experienced in other states that have previously initiated transformation efforts.

4) Incorporate available technology (webinars and other web-based resources) in the planning process in order to improve access and expand opportunities for participation, including fostering opportunities for increased computer access for consumers.

5) Utilize the Legislative Behavioral Health Oversight Commission's June 2008 Final report as a guiding document in the strategic planning process. Worthy of special consideration is the following excerpt from that report:

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

- Consumer involvement in all aspects of service planning and delivery.
- Development of a consumer focused culture that is driven by the needs of consumers.
- A plan for integrating the administration of behavioral health programs.
- A comprehensive statewide plan for behavioral health services
- Development and management of a data and information system.
- A quality improvement plan.
- Services that are research based, focus on recovery, and include peer support.
- A methodology for measuring consumer, process, and system outcomes.
- Development of plans for developing the behavioral health work force.
- An integrated rate setting methodology.
- Development and implementation of peer support services" (NDHHS, 2008).

2. Suspend the service definition revision process currently underway until the adoption of the strategic plan so that the vision, core values, principles, and definitions of recovery and recovery-based care are be incorporated into new and existing service and support definitions.

3. Suspend the Title 206 Rules and Regulations revision process currently underway until the adoption of the strategic plan so that the vision, core values, principles, and definitions of recovery and recovery-based care can be incorporated into new and existing rules and regulations.

4. Suspend the at-risk managed care planning efforts currently underway until the adoption of the strategic plan so that the vision, core values, principles, and definitions of recovery and recovery-based care can be used to guide discussion, examination, analysis, and decision making around the feasibility of a managed care program in the public behavioral health system.

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

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

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

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

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

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

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

2. Behavioral Health Workforce Shortage

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

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

Discussion

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

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

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

Legislative Action

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

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

1. Provide funding for two additional medical residents in a Nebraska based psychiatry program beginning in 2010 until a total of eight additional psychiatry residents are added in 2013. Each of these residents would participate in rural training for a minimum of one year. Beginning in 2012, a minimum of two of the eight residents would be active in the rural training each year;

2. Focus on training of behavioral health professionals utilizing the telehealth network that is already established throughout Nebraska. This is particularly helpful to rural areas in Nebraska;

3. Establish learning collaborative partnerships with other higher education institutions in the state, hospitals, law enforcement, community-based agencies, consumers and their families in order to develop evidence-based, recovery-focused, interdisciplinary curriculum and training for behavioral health professionals delivering behavioral health services in community-based agencies, hospitals and law enforcement;

4. Beginning in 2011, two interdisciplinary behavioral health training sites would be developed until a total of six sites have been developed. Each of theses sites would provide annual interdisciplinary training opportunities for a minimum of three behavioral health professionals.

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

Recommendation

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

3. Enhanced Communication and Partnering

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

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

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

Discussion

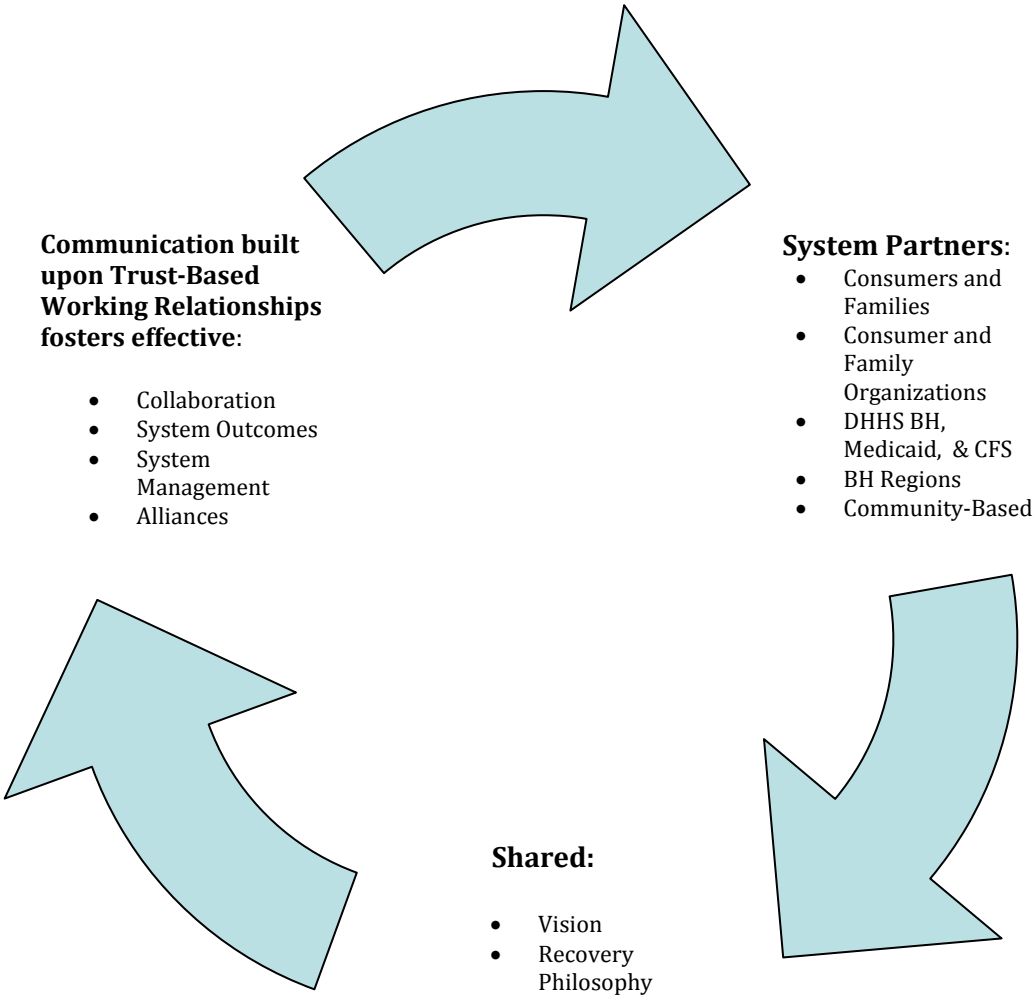
The third point of the Strategic Vision Statement addresses the provision of: *"inclusive and transparent planning through genuine partnership and collaboration with a diverse group of stakeholders (including consumers) to promote a rational, strategic decision-making environment and process."* We recognize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

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

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

Recommendation

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


Communication built upon Trust-Based Working Relationships fosters effective:
• Collaboration
• System Outcomes
• System Management
• Alliances
System Partners:
• Consumers and Families
• Consumer and Family Organizations
• DHHS BH, Medicaid, & CFS
• BH Regions
• Community-Based
Shared:
• Vision
• Recovery Philosophy
• Resources
• Commitment to Excellence

References

Nebraska Department of Health and Human Services (2008). *Legislative Bill 928.* http://dhhs.ne.gov/Behavioral_Health/BHcommission/1-July-24-08/Appendix-3-LB928.pdf

Nebraska Department of Health and Human Services (2008). *Behavioral Health Oversight Commission July 24, 2008 III. Welcome – Governor Dave Heineman.* Retrieved from http://dhhs.ne.gov/Behavioral_Health/BHCommission/1-July-24-08/Appendix-2-Gov.pdf

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United States Department of Health and Human Services (2005). *The 10 Fundamental Components of Recovery*. Retrieved from http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

Additional Resources

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

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

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

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

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

Rhonda Hawks, Chair
Consumer Advocate

J. Rock Johnson
Consumer

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

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

Pete Tulipana
Provider of Community-Based Behavioral Health Services

Beth Baxter
Regional Behavioral Health Authority Administrator

Patti Jurjevich
Regional Behavioral Health Authority Administrator

Kathy Seacrest
Regional Behavioral Health Authority Administrator

TyLynne Bauer
Representative of the Norfolk Regional Center

Bill Gibson
Representative of the Lincoln Regional Center

Jim Egley
Representative of the city of Norfolk

Joe Patterson
Representative of the city of Hastings