

Nebraska Division of Behavioral Health
Joint Committee Meeting
State Advisory Committee on Mental Health Services
State Advisory Committee on Substance Abuse Services
State Committee on Problem Gambling

May 3, 2012 / 9:00 am – 4:00 pm
Lincoln, NE – Country Inn & Suites

Meeting Minutes

I. Call to order and roll call *Jim Harvey*

Jim Harvey, Division of Behavioral Health Committee Facilitator, welcomed committee members, and others present, to the meeting. Chairpersons Bev Ferguson, State Advisory Committee on Mental Health Services, and Ann Ebsen, State Advisory Committee on Substance Abuse Services, called the meeting to order at 9:05 am, on Thursday, May 3, 2012. Roll call was conducted and a quorum was determined for the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. A quorum was not determined for the State Committee on Problem Gambling.

II. Housekeeping and summary of agenda *Jim Harvey*

Jim Harvey confirmed the order of the agenda and described the logistics of the workstation groups for the afternoon.

III. Approval of minutes *Bev Ferguson; Ann Ebsen*

Chairperson Bev Ferguson, State Advisory Committee on Mental Health Services, requested a motion to approve the minutes. Motion was made by Sharon Dalrymple and seconded by Robert Donlan to approve the February 2, 2012 minutes of the State Advisory Committee on Mental Health Services. The motion was carried by general consent.

Chairperson Ann Ebsen, State Advisory Committee on Substance Abuse Services, requested a motion to approve the minutes. Motion was made by Debra Shoemaker and seconded by Jay Jackson to approve the March 8, 2012 minutes of the State Advisory Committee on Substance Abuse Services. The motion was carried by general consent.

No minutes were presented for approval by the State Committee on Problem Gambling.

IV. Public comment

a) None

V. Introductions *Jim Harvey*

Each Committee member stated their name, their role on their respective Committee, and a statement about their reason for serving on their Committee.

VI. Returning Veterans Resource Network *Joel Schneider/Norm McCormack*

(Attachment A and Attachment B)

Joel Schneider is a member of the State Advisory Committee on Mental Health Services, and a Peer Specialist with the Veterans' Administration.

Norm McCormack is a Mental Health Consultant and Trainer in private business.

There is currently a lot of activity regarding veterans and the Veterans Administration with many returning veterans and increasing numbers of veteran retirees. 30%-50% of returning combat veterans

experience co-morbid disorders of substance abuse and Post-Traumatic Stress Disorder (PTSD). The Veterans Resource Network was formed to help prevent the chronicity of PTSD and other disorders from developing by identifying the needs, providing assistance with resources, mentoring, and instilling hope. The Veterans Resource Network is reaching out to Committee members and others in hopes of developing liaisons with other existing resources. They are especially open to ideas on outreach to veterans living in rural Nebraska. Joel and Norm also appealed to licensed practitioners to donate one hour per week to the “Give an Hour” program for veterans. A packet of resource information was handed out to Committee members.

VII. Consumer Workforce and Peer Recovery Supports *Carol Coussons de Reyes*

(Attachment C)

Carol Coussons de Reyes is the Administrator of the Office of Consumer Affairs (OCA).

The Mission, Vision, and Membership of the newly developed OCA People’s Council was presented. The purpose of this council is similar to the three advisory committees represented today. Information on the Certified Peer Support and Wellness Specialist (CPSWS) training as well as data on the utilization and employment of CPSWSs. Discussion was held on the recovery model and medical model related to treatment and wellness.

VIII. Sex Offender Issues – Goal 4 of DBH Strategic Plan *Scot Adams*

Scot Adams is the Director of the Division of Behavioral Health (DBH).

At a previous meeting, the State Advisory Committee on Substance Abuse Services requested the topic of Sex Offenders be presented.

The DBH Strategic Plan states “An effective system to safely manage sex offenders in outpatient settings will be ready for implementation.”

Nebraska law was changed due to the increasing number of sex offenders in the prison system, so that individuals who have completed time for their crime but are still deemed dangerous could be civilly committed and receive treatment before returning to the community. A group of agencies was formed to explore and further develop sex offender treatment. Discussions were held with the Regional Administrators to work with the Regional Behavioral Health Authorities as a resource to this group. Training opportunities have been extended to State staff as well as private providers to determine who has interest in serving this population. Cameron White from the Department of Correctional Services provided additional information stating that approximately 1,000 inmates are sex offenders and approximately 200 of those inmates are released on average per year. Mr. White also reported on the training models being used.

IX. Primary and Behavioral Health Care Integration *Debra Shoemaker*

(Attachment D)

Debra Shoemaker is a member of the State Advisory Committee on Substances Abuse Services, and the Director of the People’s Health Center (PHC) in Lincoln.

PHC is a Federally Qualified Health Center (FQHC) established to provide services to all who are medically underserved. The FQHC schedule of discounts (sliding fee) is based on the patient’s ability to pay. The person cannot be denied services due to the lack of ability to pay. FQHCs are funded in accordance with Section 330 of the Public Health Service (PHS) Act. Currently there are six (6) FQHCs in Nebraska. Health services provided include medical and dental, and PHC started behavioral health services five (5) years ago. Integrated care better meets the behavioral health and overall health care needs of the people served by the FQHC. Debra reviewed the functions of an integrated care provider. The PHC uses Motivational Interviewing. There are currently no grants available to open new clinics, but grants can be used to open satellite clinics.

X. DBH Committees – Feedback

Heather Wood

(Attachment E)

Heather Wood is the Quality Improvement and Data Performance Administrator in the Division of Behavioral Health.

A State Advisory Committee Survey was handed to members of each Committee to respond to in accordance with their experience in participating on their respective Committee. The survey is anonymous. Members not present will have a survey e-mailed to them. Feedback on the results of the survey will be provided at a future Committee meeting.

XI. Substance Abuse Counselor Education Contract

Nancy Folkert

(Attachment F)

Nancy Folkert is the Training for Addiction Professionals (TAP) Program Coordinator.

The Division of Behavioral Health (DBH) contracts with the Lincoln Medical Education Partnership (LMEP) Training for Addiction Professionals (TAP) Program to provide Substance Abuse Counselor Education across the state. TAP also provides education for Certified Compulsive Gambler Counselors. TAP plays a role in fulfilling the DBH Strategic Plan in all five (5) Strategies: Accessibility, Quality, Effectiveness, Cost Efficiency, and Accountable Relationships.

XII. DBH Strategic Plan: Access

Group

(Attachment G)

XIII. Public comment

- a) Alan Green, Executive Director of the Mental Health Association of Nebraska, commented on Peer Support. He explained that Peer Support is not a replacement for current services, it is a component of a continuum of services. The system should not be designed to fit an individual into services, but providing services that fit each individual. Alcoholic Anonymous is credited for starting the concept of Peer Support, but Peer Support can also be staffed by trained, skilled individuals. Mr. Green also discussed the Second Annual Statewide Behavioral Health Conference being held in Lincoln May 21-23, 2012. He stressed that this is not a consumer conference, but brings consumers, providers, and policy-makers together to learn from each other and work together. CEU's are approved for Mental Health, Substance Abuse, and Problem Gambling providers. The conference offers high level information at an affordable cost.

XIV. Committee recommendations and comments

Committee Members

- a) Appreciated learning how the FQHCs are integrating Behavioral Health with primary health care.
- b) Need further discussion related to Peer Support; a chasm/void exists between Mental Health and Substance Abuse fields in the terminology and understanding of the function of Peer Support; need to bring both groups together to educate each other and develop mutual understanding; both formal/paid/non-volunteer and informal/not paid/volunteer Peer Support services are needed; formal/paid/non-volunteer Peer Support examples include job duties at settings such as a respite care house or hospital emergency room where an individual is expected to be on the job during specified hours and complete assigned duties; informal/not paid/volunteer Peer Support examples include Alcoholic Anonymous sponsors who volunteer to be available for individuals who need support at unspecified times with no specific job assignments; the expectations are changing in Mental Health that individuals truly recover and live productive, satisfying lives; in Substance Abuse, Alcoholics Anonymous started 12-step programs that promise change and recovery.
- c) Address how Peer Support fits into the Parole-Probation-Corrections services; how can Advisory Committees help Parole and Probation understand the concept of Peer Support and how it may be used in these services.

XV. Items for next agenda

Committee Members

- a) More discussion on Peer Support roles, paid versus not paid
- b) State Advisory Committee on Substance Abuse Services only—Marijuana discussion related to Prevention—Renee Faber

XVI. Adjournment and next meeting

- Motion to adjourn made, seconded and approved at 4:01 pm.
- The next meeting of the Joint Committee of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services is scheduled for Thursday, November 8, 2012 from 9:00 am – 4:00 pm.
- The next meeting of the State Advisory Committee on Mental Health Services is scheduled for Tuesday, August 7, 2012 from 9:00 am – 4:00 pm.
- The next meeting of the State Advisory Committee on Substance Abuse Services is scheduled for Thursday, September 6, 2012 from 9:00 am – 3:00 pm.
- The next meeting of the State Committee on Problem Gambling is scheduled for Friday, August 3, 2012 from 9:00 am – 2:00 pm.

Overview

Returning Veterans Resource Network

Presented to:

Nebraska Governor's Mental Health Advisory Committee

Veterans in Nebraska

Total – 149,594 (2010)

Wartime Service – 111,300 (~75%)

Male – 133,900 Female – 11,300

WWII	12,400
Korea	17,300
Vietnam	50, 200
Gulf War to Now	37,000

The Burden

From ancient times forward, mankind has recognized that veterans of war come home bothered by what they have seen and done. History tells us that veterans of the battles of Troy “woke in the night, fearing the blades of their enemies.”

Rips in Emotional Fabric

- PTSD is seen in approximately 30% (conservative estimate) of people who have been exposed to “an event outside the range of usual human experience.” (APA, 1980)
 - Sexual assault
 - Serious physical assault
 - Ongoing childhood physical/sexual abuse
 - Mass casualty events
 - Combat theater duty

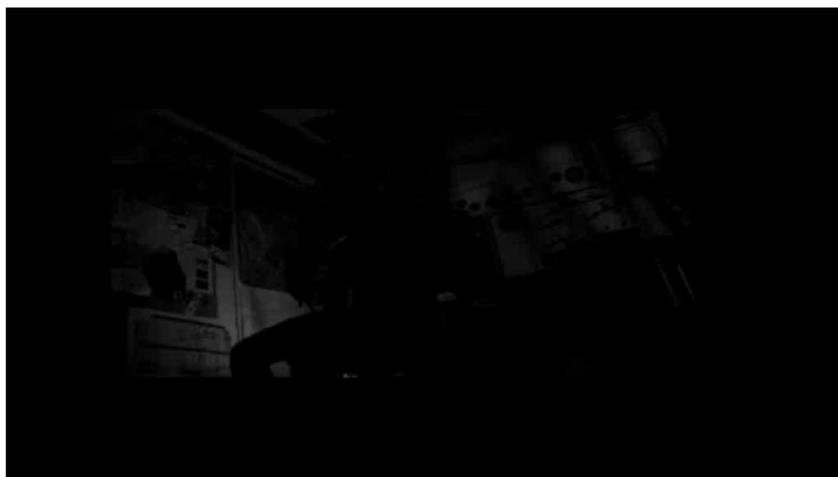
Tears in the Flesh

- Traumatic Brain Injury
 - Signature wound of OIF/OEF
 - Wide spectrum of disability
 - Often mis-diagnosed and mis-treated
- Battlefield Wounds
 - High survival rate
 - Large number of amputees
 - Broad range of limitations

Bringing it Home

- Persistence of military training
- Overlearned response set
- “Combat-like” reaction to external stimuli
- Recurrent thoughts and memories
- Emotional numbing
- Limited reintegration to family, school, community, and jobs

The Simplest Things....



Triggers



Why A Network?

- Avoidance of formal helpers
 - Federal system is cumbersome
 - Bureaucratic system demands wide disclosure
 - Resources are centralized – not widely available
 - System of care is overloaded
- Range of needs not met by one system
- Identification with “Brothers-in-Arms”

What a Network Provides

- Identification
- Acceptance
- Assistance
- Camaraderie
- Mentoring
- Walking Point ALL the way HOME
- Instilling Hope

Forming Up

- Local veterans and families
- Stable
- Desire to help
- Personable
- Committed
- Knowledgeable about community
- Aware of resources
- Organizational skills

Logistics

- A stable place – “Base Camp”
- Points of Contact
- Emotionally safe environment
- Meeting times and frequency
- Leadership
- Fund raising
- Outreach
- Staying connected

Expanding A Network

- Liaison with existing resources
 - Community
 - Local veterans' groups
 - State and county veterans' services
 - VA
 - Vet Center
 - Medical Care
 - Mental Health Care
 - Fire, police, and rescue
 - Critical Incident Stress Management (CISM)

Expanding A Network

- Liaison
 - Judiciary
 - County Attorneys
 - Clergy
 - Local business and industry
 - Schools
 - Community Service Organizations
 - Military units (National Guard and Reserve)



Who We Are

The military commitments of the United States, particularly those in Iraq and Afghanistan, have created a new generation of veterans. Like their predecessors, veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) come home affected by, and changed by, their experiences.

While our nation's citizens welcome these new veterans with accolades and appreciation, for many the transition from soldier to civilian is difficult. Despite the many resources available to them, some veterans are handicapped by post-combat psychological reactions (e.g. Post Traumatic Stress Disorder [PTSD]), service-related Traumatic Brain Injury (TBI), and combat incurred wounds and injuries.

The consequences of these handicaps are many and severe. Veterans and their families are often confused about where to turn for help. For many, deciding even what to ask is a daunting task.

Recognizing the needs of these new veterans, a small and determined group of veterans of the Vietnam Era decided to help. Recruiting others, they formed the Returning Veterans Resource Network (Network) in 2007. From the start, the mission of the Network has been to

identify veterans and families in distress and offer guidance. Members of the Network help veterans and their families identify resources, assist them in making contact, and providing required documentation. The Network does not provide direct services. Assistance takes the form of guiding and mentoring – Veterans Helping Veterans.

What We Do

Members of the Network are involved in several veteran-related activities intended to assist veterans in the transition from warrior to civilian.

Outreach

Members of the Network attend welcome-home activities, recognition ceremonies, veterans' benefits briefings, and related activities. We offer consultation and training to persons who and organizations that offer services to veterans and their families. To increase awareness about veteran-specific issues and needs, and to improve our skills, we attend training activities offered by others.

To make direct contact with veterans and their families we participate in activities sponsored by Veterans Service Organizations (VSO). We distribute

flyers, posters, and brochures to VSO's and retail outlets. We work with the media (print and electronic) to reach out to veterans and ensure that help is available. We offer community workshops about veterans' issues, including Post traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI).

Peer Support

Several Network members partnered with the Omaha Veterans Affairs Medical Center (VAMC) to be trained as Peer Support Specialists. In this capacity, they work with the staff of several programs:

- The PTSD treatment team by co-facilitating Coping Skills groups;
- The HUD-VASH program assisting homeless veterans secure housing and basic homemaking supplies;
- The Veterans Justice Outreach program by working with the court system, local law-enforcement agencies, city and county correctional facilities to make contact with recently incarcerated veterans.

In support of these activities and to assist veterans in navigating the sometimes confusing maze of VA medical and benefits programs, a Network member volunteers his time in the VAMC's PTSD Clinic.

How You can Help

Contact Us:

(402) 734-1774

(402) 344-0266

Open Meetings

No Cost

Monday 7:00 PM

Forty and Eight

3113 South 70th St

Omaha, NE

Returning Veterans Resource Network

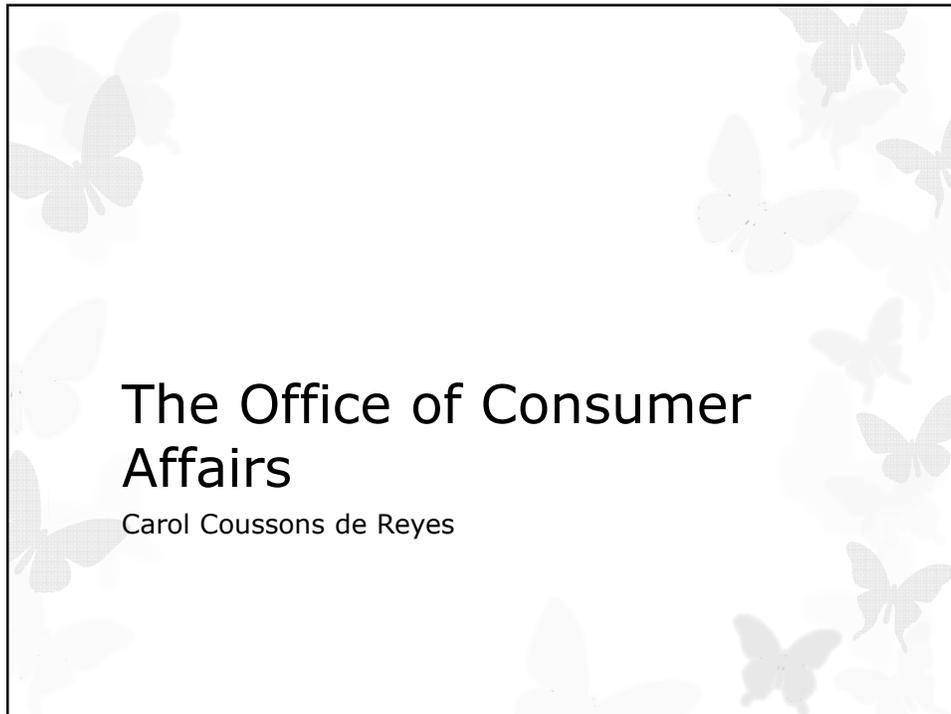


Omaha, NE

www.omahavetnet.org

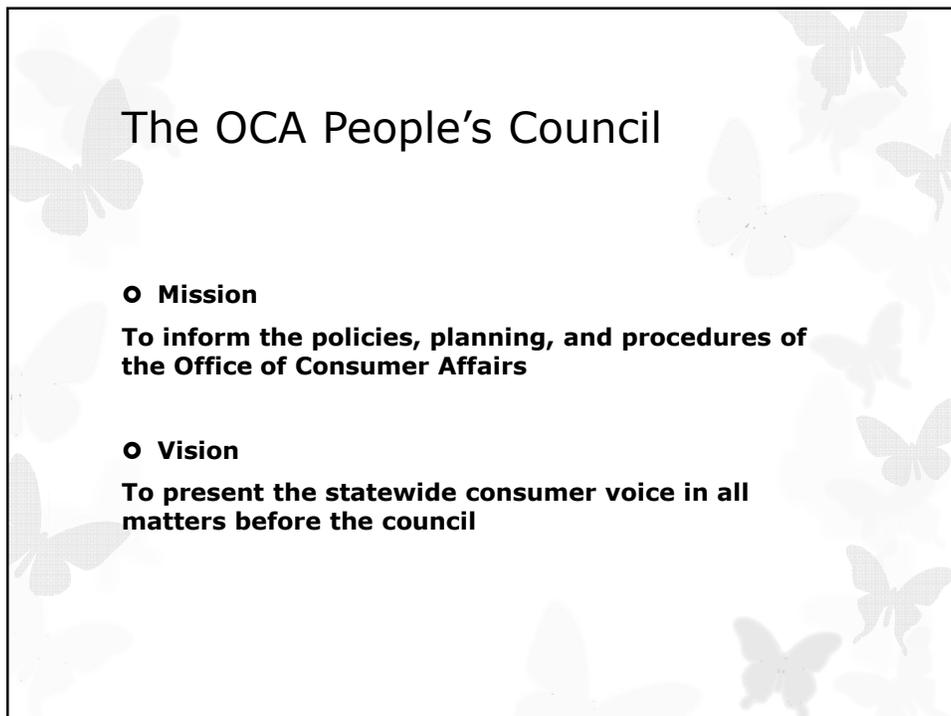
(402) 734-1774

(402) 344-0266



The Office of Consumer Affairs

Carol Coussons de Reyes



The OCA People's Council

○ Mission

To inform the policies, planning, and procedures of the Office of Consumer Affairs

○ Vision

To present the statewide consumer voice in all matters before the council

Membership

NAME	Region	Home City
Patricia Vasquez	Region 1	Gering
Judie Moorehouse	Region 1	Scottsbluff
Nancy Rippen	Region 2	McCook
Corey Brockway	Region 2	McCook
Paige Hruza	Region 3	Grand Island
Tammy Fiala	Region 3	Kearney
Candy Kennedy	Region 3	Minden
Lori Hack	Region 5	Lincoln
Phyllis McCaul	Region 5	Lincoln
Susan Hancock	Region 5	Lincoln
Amanda Owen-Doerr	Region 5	Lincoln
Jennifer Ihle	Region 6	Omaha
Mary Thunker	Region 6	Omaha
Ken Timmerman	Region 6	Omaha

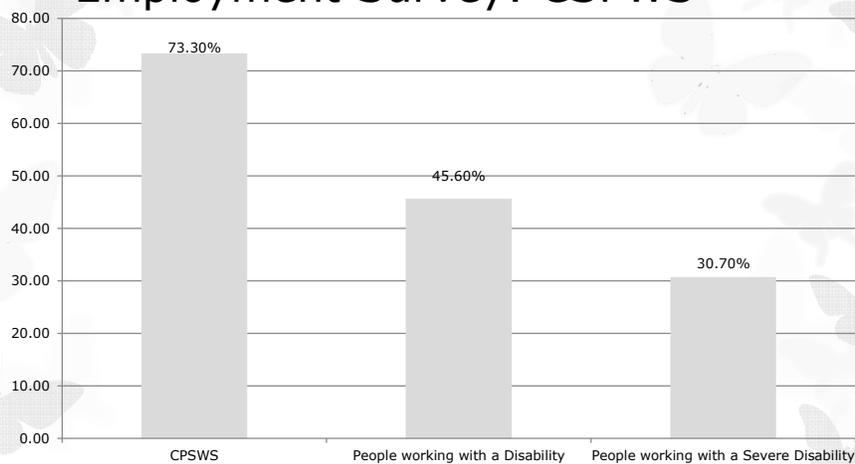
Peer Support and Wellness Specialist Training

- Mission:
- To identify, equip, train, certify, and further educate peers with the skills required to provide relationship building and trauma informed peer support for people utilizing behavioral health services.

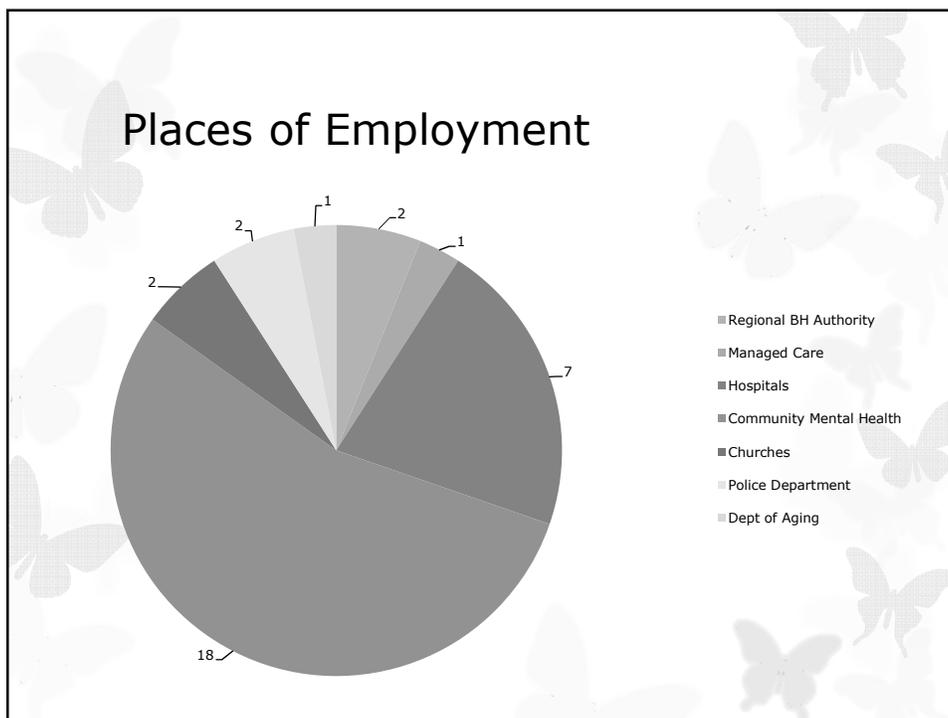
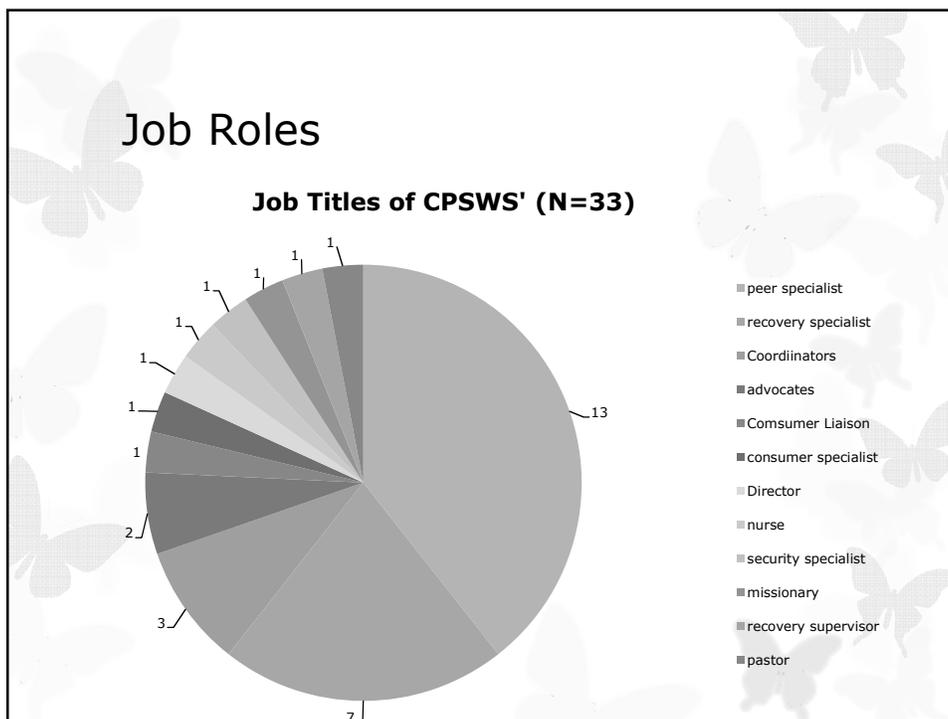
Peer Support and Wellness Specialists

- 76 Certified
- Annual Training and Testing
- 9 Facilitators in the OCA Facilitator's Circle
- Certification from the OCA

Employment Survey: CSPWS



- The average wage is \$14.95 per hour.



What People Say about the Training

- **77% feel more in control over their life since the training,**
- **83% feel a greater sense of hope or discovery about their life's journey,**
- **67% changed their beliefs about mental illness,**
- **54% changed their beliefs about substance abuse,**
- **77% changed their beliefs about trauma, and**
- **100% that training provided tools that they can use to assist peers.**

● Carol Coussons de Reyes
Office of Consumer Affairs, Division of Behavioral Health
DHHS Nebraska
Carol.coussonsdereyes@nebraska.gov
402-471-7853





Mission Statement

To provide affordable, comprehensive, accessible, culturally appropriate, cost effective primary health care. We serve people in the Lincoln area, especially those individuals and families with limited resources or other barriers to health care to improve their overall health status.

What is a “Federally Qualified Health Center?”

- Receives Public Health Service (PHS) Act Section 330 funds
- Serves medically underserved areas (MUA) or a medically underserved population (MUP)
- An integral part of the nation’s health delivery system – providing cost-effective, community oriented, comprehensive primary health care services
- Only health care system controlled in partnership with patients – governed by a board with a patient majority

Continued . . .

- Physically located in a federally designated MUA
- Non-profit, or public tax exempt status
- Provide services to all, regardless of ability to pay
- FQHC schedule of discounts (sliding fee) based on the patient's ability to pay

Advantages for an FQHC

- Public Health Service drug pricing program (340B)
- Federal and local grant funding opportunities
- Medical malpractice liability protection through the Federal Torts Claim Act (FTCA)
- Enhanced reimbursement for Medicaid patients
 - \$137 vs. \$75
 - Off-sets costs of providing care for uninsured patients, including health education and interpretation

People's Health Center Today . . .

- 2012
 - Staff of over 70
 - 15,100 square feet of space
 - 23 medical exam rooms
 - 8 dental rooms
 - X-ray suite
 - Health Education Room
 - Lab for blood draws and simple tests
 - Support Services Offices

PHC Staffing

- Current Staffing & Capacity
 - 7 Medical Providers = 3 physicians, 3 nurse practitioners, 1 Physician Assistant
 - Contract with 3 pediatricians and 3 nurse midwives
 - 6 volunteer part-time specialists
 - 3 part-time dentists, 1 dental hygienist and 3 dental assistants
 - Current Capacity = 24,849 medical patient visits/yr
8,418 dental patient visits/yr
510 mental health visits/yr
34,717 total visits in 2011
2011 – almost 10,000 patients

Behavioral Health Integration Project (BHI Project)

- Funders: Region V Systems and Community Health Endowment
- BH Partners:
 - Community Mental Health Center
 - Houses of Hope
 - Cornhusker Place
 - CenterPointe
 - St. Monica's
 - Touchstone
 - BryanLGH West

Overview

- As many as 70% of primary care visits in the U.S. are related to behavioral health needs
- Many common medical problems seen in primary care involve poor health habits that may initiate, exacerbate or perpetuate symptoms and poor functioning.
- Health Care providers often lack the time and/or training to help patients manage these problems in evidence-based ways beyond medication prescriptions.

Hunter (2009)

Effects on Depression

- Enhancing primary care depression management on an ongoing basis resulted in substantial long-term treatment effectiveness. It increased the number of days free of depression impairment for two years when compared with usual care (647.6 days vs. 588.2. days).
- Katherine Rost, "Cost-Effectiveness of Enhancing Primary Care Depression Management on an Ongoing Basis," *Annals of Family Medicine*, 2005, 3:7-14.

Effects on Panic Disorder

- Primary care clients receiving collaborative care for panic disorder were more likely to receive adequate medication and more likely to adhere to the medication regimen than care-as-usual clients at three and six months.
- Peter Roy-Bryne et. Al., "A Randomized Effectiveness Trial of Collaborative Care for Patients with Panic Disorder in Primary Care," *Archives of General Psychiatry*, 2001, 58 (9).

Effects on Drug Abuse

- In a study of 598 chemical dependency patients, researchers found that those with higher primary care engagement were more likely to be in remission after five years. The study highlights the potentially important role of medical care and the integration of substance abuse treatment with primary care.
- Mertens, J.R. et. Al., "The role of medical conditions and primary care services in 5-year substance use outcomes among chemical dependency treatment patients," *Drug Alcohol Dependence*, 2008;98 (1-2): 45-53.

Purpose of PHC/BHI Project

- To establish and provide integrated primary and behavioral health services at People's Health Center. Many consumers currently being served by behavioral health care providers in the Region V Systems' network are unable to access primary care. This program will establish PHC as their medical home for primary care. In addition, patients at PHC for primary care will be able to access behavioral health care at the clinic or be referred to other community providers.

BHI Implementation Phases

- Phase I:
 - “Fast Track” medical appointments for the seven BH partners – 2-4 per week per provider
 - Quarterly Report: January through March, 2012
 - # of appointments kept – 211, with 62 new patients
(194 were Medical appointments, 17 were for an educational appointment for a chronic disease at no cost)
 - Percentage of no-shows – 23%
 - Payer Source – No insurance – 153 patients (79%)
 - Medicaid – 14 patients (7%)
 - Private Insurance – 6 patients (3%)
 - EWM – 7 patients (4%)
 - Medicare – 14 patients (7%)

(BHI Project – continued)

- Phase II
 - Hire a BH Therapist (MSW and/or LMHP)
 - Contract with CenterPointe
 - Short-term resolution model
 - 70/30
 - Depression, anxiety related issues
 - Pain management contracts
 - No show contracts
 - Billing Issues
 - Same-day billing for medical and behavioral health visits
 - 96150-96154 codes – behavioral health, psychological service for a medical condition
 - Do not receive an enhanced reimbursement rate for BH visits/encounters
 - Sliding fee scale for the uninsured

What is Integrated Care?

“Integrated Care is a concept that is used to better meet the behavioral health and overall health care needs of those in primary care.” (Hunter, 2009)

Functions of the Integrated Care Provider

- Consult with primary care providers
- Sees patients for an initial 15-30 minutes to assess and develop treatment plan
- Behavioral health provider provides feedback to the primary care provider
- Based on primary care provider's preference and patient needs, a plan is implemented and monitored
- Work as consult with primary care provider
- May see patient for additional 15-30 minute sessions
- May see in traditional 50 minute session
- May refer out to other behavioral health services

Motivational Interviewing

- Request permission from patient to provide services
- Identify problem
- Gather information
- Identify goals
- Prioritize
- Define intervention

Model Outcome Measures

- Increase Provider Productivity
- Increase Capacity of Providers ability to provide Behavioral Health services
- Decrease Emergency Room visits by patients
- Decrease Substance Use by patients
- Improve Key Health Indicators
 - Weight
 - Blood Pressure
 - Diabetic Blood Sugar

Common Diagnosis

- 25% Depression
- 14% Chronic Pain
- 11% Anxiety
- 6% Substance Abuse Issues, including Alcohol
- 6% Major Mental Illness – Bipolar, Schizophrenia
- The majority of patients seen by Behavioral Services reports both mental health and physical issues
- 15% referred in-house
- 22% referred to community

Physical Health

- Hypertension
- Diabetes
- Chronic Illnesses
- Back and Neck Injury/Chronic Pain
- Fibromyalgia
- Obesity
- Eating Disorders
- HIV/STD

Behavioral Health

- Depression
- Anxiety/Panic Disorders
- Stress Related Disorders
- Disorders Related to Medical Conditions
- PTSD
- Relationship Issues
- Child Behavioral Issues
- Somatic Disorders
- Fatigue and Migraine Headache
- Non-compliance with Medication
- Other
 - Bipolar Disorder
 - Psychosis

Substance Abuse

- Prescription Drugs
- Alcoholism
- Marijuana Abuse
- Methamphetamine
- Cocaine/Crack

Contact Information:

People's Health Center

1021 N 27th Street

Lincoln, NE 68503

www.phclincn.org

Monday through Thursday

8:00 a.m. to 7:00 p.m.

Friday

8:00 a.m. to 5:00 p.m.

Deb Shoemaker

Executive Director

402-476-1640, ext. 1007

debs@phclincn.org

State Advisory Committee Survey

This survey is designed to better understand the way in which our advisory committees function. As a committee member, your participation in this survey is highly valued. We thank you in advance for your time!

Please indicate "Yes" or "No" to the following statements. Mark only one response per statement.

1. What was the **ORIGINAL** reason(s) you sought appointment to this advisory committee?

YES **NO**

- I have expertise regarding behavioral health services.
- I was specifically asked to consider becoming a committee member.
- It gives me a feeling of accomplishment.
- It supports my personal interests.
- To improve the quality of life for consumers.
- To be a voice for consumers and promote their interests.
- To improve consumer access to services.
- To improve behavioral health services.
- To provide assistance and recommendations to the Division of Behavioral Health.
- To evaluate organized peer support services.
- To promote peer support services.
- It supports my professional development.
- Other: *If yes, please specify.*

2. Which advisory committee are you currently a member of?

- | | | |
|-----------------------|------------------------|-------------------------|
| <u>Mental Health</u> | <u>Substance Abuse</u> | <u>Problem Gambling</u> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

3. How long have you been a member of this committee?

- | | | | |
|-------------------------|-----------------------|-----------------------|------------------------|
| <u>Less than a year</u> | <u>1-2 years</u> | <u>3-4 years</u> | <u>5 years or more</u> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

4. What, if any, are your suggestions for improving committee effectiveness?

Please continue to back page   

Please indicate your level of agreement by marking one response for each of the following statements.

	Completely Agree	Mostly Agree	Slightly Agree	Slightly Disagree	Mostly Disagree	Completely Disagree
I understand the purpose of this committee.	<input type="radio"/>					
I understand the statutes and bylaws governing this committee.	<input type="radio"/>					
I understand my responsibilities as a member of this committee.	<input type="radio"/>					
There is sufficient diversity amongst the members in terms of voices being represented.	<input type="radio"/>					
Roles of each committee members are clearly defined.	<input type="radio"/>					
I am knowledgeable about behavioral health service programs.	<input type="radio"/>					
I follow trends and important developments related to my committee.	<input type="radio"/>					
I attend the committee meetings regularly.	<input type="radio"/>					
I prepare for committee meetings in advance.	<input type="radio"/>					
Materials are distributed sufficiently in advance of committee meetings.	<input type="radio"/>					
Meeting agendas are clear.	<input type="radio"/>					
The meetings are conducted according to the agenda.	<input type="radio"/>					
Meetings start and end on time.	<input type="radio"/>					
The meetings allow ample time for discussion.	<input type="radio"/>					
I feel free to voice my opinion even if I may be the minority vote.	<input type="radio"/>					
The public comment periods provide valuable information.	<input type="radio"/>					
The committee uses data to inform any recommendations provided.	<input type="radio"/>					
Recommendations are made with equal input from committee members.	<input type="radio"/>					
Recommendations are made with mutual understanding.	<input type="radio"/>					
Recommendations are made respectfully.	<input type="radio"/>					
The minutes reflect a summary of attendance, matters discussed, voting outcomes, and recommendations.	<input type="radio"/>					
The committee has a process for handling any urgent matters between meetings.	<input type="radio"/>					
The committee accomplishes its intended purpose.	<input type="radio"/>					
I value being able to serve on this committee.	<input type="radio"/>					
I would be willing to do more for my committee if asked.	<input type="radio"/>					

Thank you for your participation! We appreciate your help!



WHAT PART DOES TAP PLAY IN FULFILLING THE NEBRASKA STRATEGIC PLAN?

Strategy 1: Insist on Accessibility

- Provide Core Education for individuals seeking to become Licensed Alcohol Drug Counselors(LADC) and Certified Compulsive Gambler Counselors(CCGC)
- Provide Continuing Education for LADC, CCGC, and LMHP personnel.
- Provide ASI and CASI training for eligibility for criminal justice registered provider list.
- Provide Core Fundamental Basic Training for clinicians to become GAP contractors.
- Classes are made available throughout the state either directly or through video conferencing.

Strategy 2: Demand Quality

- TAP contracts with highly qualified professionals in the field of counseling to instruct courses.
- TAP provides trainings throughout the state through travel and video-conferencing in partnership with NVCN
- TAP ensures all courses are pre-approved by the State of Nebraska Licensure and the TAP Program will meet the criteria put forth by the Division as stated in proposed Title 206, Ch. 7 or Title 172, Ch. 15.
- TAP reports participant demographic information and evaluation results to the appropriate state agency.

Strategy 3: Require Effectiveness

- TAP provides participants with access to the latest knowledge on evidence-based, empirically supported and promising practices.
- TAP provides continuing education based on the leadership initiatives which focus on such items as clinical supervision, co-occurring disorders, gender and cultural competencies.

Strategy 4: Promote Cost Efficiency

- TAP will continue to partner with, DHHS, Regional Behavioral Healthcare Systems, Nebraska Correctional Services, ATTC and others to provide trainings in the most cost efficient ways possible.
- TAP will continue to provide trainings throughout the state through travel or video-conferencing to ensure availability to professionals throughout the state in the most cost effective manner.
- TAP seeks to gain CEU approval for as many certifications and licensures as possible.

Strategy 5: Create Accountable Relationships

- TAP will continue to have an open relationship with behavioral health professionals to ensure we are offering what they need to be effective in their work.
- TAP will continue to reach out through our website, www.lmep.com, list-serve, exhibiting at conferences, as well as other ways as they present themselves.



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VIII. DBH Strategic Plan: Access – Group break out session 1:15 – 3:00

The DBH Strategic Plan says:

Strategy 1: Insist on Accessibility

Increase access to appropriate and effective integrated behavioral health services, particularly for vulnerable populations.

Leadership Initiatives	Outcomes
1. Lead the development & implementation of standards for service access related to factors such as geography, linguistics, culture, transportation, availability of behavioral & primary healthcare services, & cost.	1. Publication & implementation of standards for access for each area (MH, SA, PG) & each service

WORKSTATION Results

<p>#1 Karen Harker</p>	<p>Define access at the service level by logistics (time, geography, etc.).</p> <ul style="list-style-type: none"> – Appointment times - hours the service is open – What is a reasonable drive time / travel time to a given service?
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Team #1 – LOGISTICS

*Limited resources for gasoline, etc. to get to services; no transportation; no funding; how to acquire resources?

*Use of technology, i.e. tele-health to access services (resources)

*Outpatient services for new patients (acuity issue/status is a factor)

*Crisis situations are immediate; urgent/emergent – access within 24 hours; routine/ongoing - depends on service; 7-14 days

*Technology plays a role: 1) tele-medicine; 2) tele-health

--embraced to overcome some barriers (transportation distance versus across town)

--removes distance/time barrier

--can help with time factor

*Staff shortages impact technology/time/distance barriers

*Education on services both for consumers and community

*Available times for agencies to handle walk-in appointments for reimbursable services

*Establish the need of the consumer

--Crisis = immediate need/life threatening

--Acute = in pain, but not life threatening

--Non-crisis

*Priority populations (according to federal regulations)

*Ability to travel could be a barrier - time/distance

*Needs analysis/triage to determine acceptable time to access services

*Tele-medicine - does it help overcome some of the barriers?

--social/networking

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- confidentiality issues
- not available to those with no internet/computer
- *Use of peers or other community resources (i.e., schools, pastors, senior centers)

- *Availability of immediate services—appropriate services
- is the individual ready for services (i.e., Substance Abuse Treatment)—in twenty-four hours or two weeks?
- priority populations have established timeframes for guidance
- *Barriers
- transportation system not available
- cost
- tele-medicine/peer support

- *Emergency (consumer defined)
- quicker than “normal” time
- between on-site and crisis – loss of control of situation or function as autonomic person
- four to six weeks is too long in a perfect world
- the safety risk (to kids) immediate
- available to immediate/appropriate services/appointments (i.e., crisis response, warm lines, Keya House; providers go to consumers)
- volunteers, peers, on-call personnel
- there is a need to work on the shortage of qualified professionals – use incentives for qualified professions

#2 Sue Adams	Defining access at the service level – Access to what services? If a person says I agree I have access, what is that access to (a certain professional/credential, a service, a group of services, etc.)?
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Team #2 – SERVICE LEVEL

- *Individualized – what they need, when they need it – person centered
- *Prevention, Intervention, Pre-Crisis, Crisis, Hospital, Treatment, Forensic
- *How do consumers know what is needed?
- *Peer Support – Mental Health
- WRAP
- level of education/training
- know what is needed
- the community has services
- inter-related
- referrals
- *Education on what is available is needed?

- *Continuum of services – involves accessing what is needed
- *Provider and community education /community connections book
- *Care managers know what is available – break down silos
- *Need common, consistent language
- *Affordability – and availability - level of care to all who need it
- *Medical home
- *Diagnosis - access for all (Sex Offenders, Autism, etc.)

- *Tele-health in Behavioral Health services
- *Services that are helpful

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- *Culturally appropriate services
- *Acute (voluntary)
- *Evaluation/referral
- *Alternatives - frustration with no options for post-hospital (guardianship - how can they support the individual?)
- *Level of Care between secure and lower levels
- *Full course of treatment offered/available
- *How do we support without critical mass?

- *Coordination of care – behavioral health/primary integration
- *Wrap-around services – are they appropriate?
- *Mentors
- *You don't know what you don't know
- *Identified services are accessed quickly (better care /cost efficient)
- *Service
 - consumer education
 - promotion of personal responsibility
 - wellness
 - available at all times
 - points of service
- *Culture development - related to wellness
- *Population needs have changed
- *Services
 - time
 - amount
 - duration
 - flexible
 - not program based
- *Support for caregivers / relatives
- *Treatment for those who want to be there
 - not avoiding unpleasant consequences (i.e., jail)

- *Geographically “equal” number of providers
- *Sex Offender Treatment Services
- *Services based on community perception of their own need
- *Consumer based information system - to decide what is needed
- *Infrastructure to decide - adjust service array
- *Build relationships with people not in crisis - community level
- *Co-location of behavioral health/primary care - better informed
- *Records accessibility
- *Doctor/Psychiatrist- tele-medicine

- *What you need - when you need it
- *Peer services - all level of services
- *Prevention services - early intervention (especially kids)
- *Service animals
- *Provider education - taught to empower consumers (work, friends etc.) is possible
- *Services that provide quality of life outcomes
- *Use of technology – Alcoholics Anonymous, Mental Health applications

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#3 Maya Chilese	How to increase access to Recovery Oriented Systems of Care, Services and Supports such as: <ul style="list-style-type: none"> – Housing: a stable and safe place to live; – Employment / Jobs What is needed in the future to improve access? What are the barriers?
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Team #3 – RECOVERY ORIENTED SYSTEMS OF CARE (ROSC)

- *What helps to prevent relapse, promote recovery
- *Positive supportive education - especially for family
- *Child care - family - respite
- *Opportunities for other family members (i.e., other children)
- *Relapse prevention planning
- needs better care coordination
- team approach
- client ownership of one plan
- *Peer – “family”/ team support

- *WRAP planning - self-resiliency planning and education earlier (Middle School and High School)
- *Flex funding for other supportive activities (i.e., recreation, family/community building)
- *Medication management (not doctor support but “peer” check-ins)
- medication education
- parent-child has consumer ownership
- peer support at doctor appointment
- *In-home supports for children and families
- *”Clearing House” of resources/ideas (for consumers and families)
- *Crisis response/aversion (community/consumer based--not treatment)
- *Recovery competencies (moving to ROSC standards, less clinical focus)

- *Self -Directed Care
- *More environmental strategies
- more access to community
- *Support to consumers in assisted living facilities

- *Community and social connection
- *Opportunity to build own identity and develop a purpose
- building strengths
- transition of identification of “I’m an addict” to “I am a person”
- *Supportive opportunities that expand
- *Consumer education and empowerment

- *Coffee House--places that support healthy socializing
- *Childcare; play groups
- *Community gardening
- *Skill building that supports “reintegration”
- outreach coordinator
- *”Virtual” wellness center
- connection to activities/recreation
- not another separate program but purposefully utilizing community resources (purchase capacity at community service agencies for client to access free of charge, and provider write a “prescription” for the individual to use/attend)

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–also include job training

*Housing support – not only for homeless but to safe healthy ROSC

#4 Nancy Heller	How can access be improved by the use of Peer Support?
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Team #4 – PEER SUPPORT

*All Types of Peer Support are needed

--paid/not paid

--community

--intentional

--Mental Health/Substance Abuse/Problem Gambling

*Where are the places Peer Support is needed?

*Educate on illness as well as resources available and experiences

*Recognized value across many venues/needs

*What “other” sources available to identify needs for Peer Support?

*Does every hospital have access to an Emergency Room peer?

*Can a 211 operator refer to a Peer Support?

*Build awareness that Peer Support is available

*Are there enough opportunities to train Peer Support?

*Do providers have enough information to refer to Peer Support?

*Inform providers how successful Peer Support is to empower them to do job

*Build awareness with—

--211 operators—shelters--transitional-housing--law enforcement—Mental Health/Substance Abuse organizations and listservs--schools-staff—churches--support groups—Continuums of Care-- Medical Providers—Federally Qualified Health Centers--legal system

*Peer Support training—

--posted on Office of Consumers Affairs website

--Regions host and advertise training

--listservs

--anywhere else need to “advertise”

*Affordability to employment of Peer Support

*Law Enforcement knows that Peer Support is available when an individual is in crisis and/or needing behavioral health services-if individual doesn't require higher level of care

*Widespread dissemination of Division of Behavioral Health-Law enforcement DVD

*Peer Support in Veterans organizations--especially in rural Nebraska

*Make behavioral health providers/clinicians aware of how to access Peer Support

*Peer Navigators--Transition Age Youth—when an individual is recovering to a place where they no longer qualify for therapy--who do clinicians contact?

*Collaboration between existing behavioral health groups to dialogue to understand integration of medical model and Peer Support (Evidence-Based Models)

*Double-edged sword—employ Peer Support and put someone else out of work?

*Better access to resources from personal experience

*Peer Support gives hope that others cannot

*Cultural barriers--identify and train culturally appropriate peers—especially in rural areas

*Awareness of how we “label” Mental Health/Substance Abuse/Behavioral Health needs

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- awareness of where peers meet--where the individual feels comfortable
- *Adult needs versus Family/Children needs—the differences need to be addressed
- terminology for adults is Peer Support
- terminology for Family/Children is Family Navigators
- *Peer Support doesn't necessarily need to be a formal program—can also be community integration/"natural" Peer Support
- *How do we support an individual during a transition phase?

- *Look for ways to integrate into existing programs--or are stand-alone programs a better way to utilize Peer Support?
- *Stand-alone programs could improve access to Peer Support
- additional linkages separate from existing programs
- *How do we know where the Peer Support are and how do we access them?
- Is there a list?
- Do we give it out?
- *Does paid or not paid Peer Support create barriers?--or more opportunities?
- *How do we match Peer Support with individuals?
- based on personal needs
- what is most effective?
- depends on how well the job description is written to describe the need
- *Need better ways to advertise the Peer Support training and to tell providers about the training

#5 Heather Wood	How is access specifically measured? Suggestions on specific measurable access standards for MH, SA, PG
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Team #5—MEASURE ACCESS

- *Population: Demographic factors and chronic- life situations show up
- *In-service versus general population
- *Access: wait times--priority pops versus other populations
- into service
- access to additional services
- *Screening tools
- appropriate timing (open mind)
- integration with other service types
- pivotal intervention points
- increase in screening for Problem Gambling
 - need to be open to primary care research
 - dealing with behavioral health
 - PARTNERSHIP

- *Waiting list – access problems
- *Helpline numbers
- 211 / Hotline)
- peer support—are hospitals aware of how/who to contact?
- number of referrals?
- *Where?
- 1) shelters (vulnerable)

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- keeping track of who's going to services
- track interest, involvement, and access
- how long is an individual in the back of a car?
- availability / placement issues
- 2) with consumers
 - what is success? (follow through)
- 3) Emergency Rooms
 - what data is collected?
 - attempts to find services
 - success in finding services
 - capacity issues/availability

- *Transportation—timing from when a call comes in to access to treatment
- *Urban versus Rural
 - person's location known
 - continued contact up to placement
- *Crisis – is there instant access?
- *Units
 - what has been tried?
 - does a situation lead to hospitalization?
 - what are the issues leading to care?
- *Providers
 - waiting list/capacity
 - 911?

- *Waiting list
 - Emergency Room wait time / number of admissions
 - priority populations
- *Mental Health--quality of services, discharge process, and recovery all effect the waiting list
- *Step down from higher Level of Care
- *Independent/ involved consumers
- *Discharge process
 - defining expectations
 - education
 - individualized planning – best fit

- *Outcome measures - at various points in time
 - not the same for everyone - what is "success" to me?
 - individualized and person/family-directed
- *Discharged from service
 - when the individual feels ready
 - funding issues
 - is the individual happy when they leave?
 - is the individual safe when they leave (children and parents)?
 - is the environment safe to return to?
- *Discharge plan
 - is it implemented/followed?
 - is it created with the consumer and owned by the individual?
 - is it agreed upon with the consumer?
 - does the consumer have choices (family-centered)?

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- are there goals versus expectations?
- *Recovery – standards
- *Admission – what is recovery/success?
- *Discharge – recovery –progress in success
- how do we get there in Mental Health?
- *Continued recovery
- *Individual versus system
- involves competency of staff providing the services
- does it include Evidence-Based Practices?
- does it include recovery competencies?
- *Recovery access

- *Service Definitions
- criteria versus need - according to who?
- appropriate
- effective – audits of treatment standards – according to national best practices
- integrated – Mental Health / Substance Abuse / Problem Gambling / People’s Council
- vulnerable – define and then compare to patient population percentages
- *Availability of services types
- by area
- Behavioral Health Regions
- *Waiting list
- time between first contact to appointment
- distance to service
- frequency of need versus available access