

State Advisory Committee on Mental Health Services
February 2, 2012 – 9:00 a.m. to 4:00 p.m.
Country Inn & Suites – 5353 No. 27th St. Lincoln, NE
MINUTES

Mental Health Committee Members Present (17):

Adria Bace, Beth Baxter, Kathy Boroff, Pat Compton, Sharon Dalrymple, Robert Donlan, Beverly Ferguson, Kathleen Hanson, Jette Hogenmiller, Dave Lund, Colleen (Cody) Manthei, Kasey Moyer, Mark Schultz, Joel Schneider, Diana Waggoner, Cameron White, Sheri Dawson,

Mental Health Committee Members Absent (2): Jerry McCallum, Joyce Sasse

DHHS Staff Present: Scot Adams, Maya Chilese, Jim Harvey, Nancy Heller, Dan Powers, Blaine Shaffer, Marla Augustine, Kathy Wilson

Public Present: Alan Green, Julia Hebenstreit

I. Opening

- a. Chairperson, Beverly Ferguson, called the meeting to order at 9:00 a.m. Committee members introduced themselves. Roll was taken and a quorum determined.
- b. Motion was made by Adria Bace and seconded by Kathleen Hanson to approve the November 3, 2011 Minutes of the joint MH/SA meeting and approve the February 2, 2012 Agenda. Voice vote was in favor and the motions carried.

II. DBH Strategic Plan Implementation -- Scot Adams

- a. Co-Occurring Roadmap is available on the internet site for all to read.
- b. Financing has two aspects: Medicaid and Health care reform.
 1. Federal government is enforcing the Institution for Mental Disease (IMD) rule of a maximum of 16 beds in a residential facility that can be covered by Medicaid. At-risk managed care can cover the rest. Must get the regulations right.
 2. Essential benefits package must be carefully crafted by the courts and federal government to free funds for other activities.
- c. Sex offender (SO) management and treatment program is in development through meetings and study with other states.
 1. Kathleen Hanson: Why can SO live so close to schools? Cameron White: Contact State Patrol
 2. Dave Lund: What about charging MH patients for assault. Scot Adams: sometimes person is moved to criminal justice system because better equipped to handle.

III. Supportive Employment Grant -- Jim Harvey

(Attachment 1)

Employment Development Initiative - The Center for Mental Health Services (CMHS) through the National Association of State Mental Health Program Directors (NASMHPD) awarded an Employment Development Initiative (EDI) grant to the Nebraska Division of Behavioral Health (\$103,000). DBH will be using this grant planning and implementing activities to foster increased employment opportunities for people with mental health and/or substance use disorders. This grant will provide DBH with a mechanism to systematically address and improve Supported Employment (SE). DBH will partner with State Vocational Rehabilitation (VR) on this Supported Employment (SE) effort.

1. DBH will develop the capacity to monitor fidelity consistent with the SAMHSA SE Toolkit with assistance from the Dartmouth Supported Employment Center (Lebanon, NH).
2. As part of the Evidence Base Practice Workgroup, DBH will address SE issues including updating the service definition, and making recommendations on how to sustain fidelity monitoring, develop a cost model and address data issues.
 - a. Review and update existing service definition to comply with current SE best practices and federal VR program requirements. When completed, the revised definition will reflect a Nebraska model for addressing Supported Employment consistent with the EBP.
 - b. Fidelity Monitoring – Review tools and make recommendations for a sustainable process.

- c. Cost Model – Develop cost model for use by DBH.
- d. Data – Develop data base and/or linkages for existing databases between providers, DBH and State VR. This includes performance measures to be used by SE providers.

Schultz: Combine employment efforts in Vocational Rehab with DBH. Create NE model so more helpful for people.

IV. Evidence Based Practice Workgroup -- Jim Harvey

- a. Statewide Quality Improvement Team (EBP Workgroup) Charge - The Charge of the Evidence Based Practices Workgroup is to provide recommendations to DBH leadership by September 29, 2012 on a consistent and sustainable way of doing fidelity monitoring linked to outcomes on Evidence Based Practices (EBPs). Using EBPs is an investment in what works. The goal is to improve the use of EBPs in order to achieve more effective use of limited community resources. The initial focus will be on the SAMHSA Evidence Based Practices and services funded by the Division of Behavioral Health as reported on Uniform Reporting System Tables 16 & 17.
- b. The consumer involvement on this work group will come from the two DBH Advisory Committees. Consumer/Family members from the State Advisory Committee on Mental Health Services who volunteered were: Kathleen Hanson, Cody Manthei, Kasey Moyer, Sharon Dalrymple, and Jette Hogenmiller.
- c. First meeting will be March 1, 2-4. Second meeting will be April 5, 2-4pm.
- d. Charter is attached to minutes.

V. Public Comment (10:00) – moved to be held as scheduled at 10:00

Alan Green: Community Health Endowment formed after sale of LGH to Bryan Hospital brought in consultants to look at how to integrate physical and mental health services. Report, available at chelincoln.org, notes that (1) Lancaster County plans to close the Community Mental Health Center of Lancaster County and transferring services elsewhere and (2) need to integrate recovery services with traditional services (3) include consumers in advisory groups. He will draft a letter to say that consumers need to be totally involved.

VI. Hospital Diversion & Keya House -- Kasey Moyer and Alan Green (Attachment 2)

Summary of the Powerpoint presentation

- 1. MH Association of Nebraska is a peer-run organization employing 21 peers with 13 peer volunteers.
- 2. Keya House is a living facility to help individuals with serious mental illness avert crisis and do away with the necessity of higher levels of care; while obtaining necessary knowledge, skills and abilities to maintain wellness and work towards recovery from mental illness. Individuals are allowed to remain up to four days during their time of crisis diversion.

VII. NE Behavioral Health & Criminal Justice Collaboration – Cameron White & Blaine Shaffer (Attachment 3)

- a. Summary of the Powerpoint presentation, entitled "Closing the Gaps: Nebraska Behavioral Health & Criminal Justice Collaboration"
 - 1. The FY2011 scope of BH issues in state prisons shows 32% having psychiatric issues (excluding solely SA), 77% having SA related disorders and 26.5 were prescribed psychiatric medication.
 - 2. There is a need for increased data sharing between systems and for linkage between systems of improve and increase access to MH and SA service.

-- Working Lunch --

VIII. Law Enforcement DVD – Sarah Cox - Portions were shown of a video recently made by DHHS and funded by the U.S. Department of Justice Bureau of Justice Assistance to instruct rural police officers how to handle members of the public displaying possible MH or SA problems. When final, the video will be made available on the web.

IX. Regional Report: Region 3 – Beth Baxter

(Attachment 4)

The Region 3 Annual Report was handed out and presented in a Powerpoint. Region 3 has been chosen by the National Council on Community BH as a Learning Community for one year, through April 2012. Trauma Informed Care is used because research shows that it is more effective and cost efficient.

X. Family Help Line & Family Peer Support – Maya Chilese

(Attachment 5)

Summary of the Powerpoint presentation entitled "Nebraska Family Helpline & Family Navigator/Family Peer Support Services".

1. The Family Help Line is a single point of access to children's BH services in Nebraska. The primary target is parents.
2. Screening for immediate safety. Develops strategy with parents.
3. Top 5 Child Issues: family rules, aggression in the home, arguing, school authority, grades, additional family stressors.
4. Family Navigator provides further support and assistance after referral.
5. Family Peer Support Services uses specialists to provide a variety of services and support.

XI. Consumer Survey – Heather Wood

(Attachment 6)

The Summary of Results from the 2011 Behavioral Health Consumer Survey was presented. The consumer survey data used in Tables 9, 11, and 11A for the Uniform Reporting System had been reviewed at the previous meeting. During the spring and summer of 2011, the DBH conducted the annual Behavioral Health Consumer Survey. The purpose of the survey was to solicit input from persons receiving mental health and/or substance abuse services from the publicly-funded, community-based behavioral health system in Nebraska on the quality and impact of services received. Generally speaking, consumers reported being satisfied with the services they received from community mental health and/or substance abuse programs funded by DBH. Once available, the 2011 Behavioral Health Consumer Survey report will be posted on the Division's web site.

XII. Continuous Quality Improvement Program – Heather Wood

a. Summary of Powerpoint presentation.

1. By continuously checking, systems can be determined to be effective or not.
2. Plan, Do, Check, Act approach to services.

XIII. Public Comment (3:00)

None

XIV. Committee Recommendations, Comments & Future Agenda Items

- a. Jette Hogenmiller: Going in a good direction. What are the next steps?
- b. Beth Baxter: Priority should be children's BH. How can DBH provide leadership in CBH and promote early intervention. More attention to Vets' services. For the agenda: Evidence based services—more information on transitioning.
- c. Pat Compton: Start earlier to help Vets and those being discharged from correction facilities. For the agenda: Children transitioning out of child care.
- d. Joel Schneider: Considering making a presentation on Vet needs. For the agenda: Presentation on PTSD and SA, peer support for Vets.
- e. Beverly Ferguson: Want update on At-Risk Managed Care. Encourage creative Peer to Peer activities. Experience has taught her to never give up hope.
- f. Kathleen Hanson: The Shaffer/White presentation was interesting and shocking. If the Legislature passes the budget cuts, how will DHHS handle consumer response? Instead of IMD, supported housing would be better with domestic instruction, not arts and crafts.

- g. Dave Lund: Liked Shaffer/White presentation. Principle issue is poverty. 47% of problems start in childhood. Need stronger attention to children's MH and mentoring.
- h. Kathy Boroff: Liked the Keya House presentation. Support already mentioned agenda suggestions.
- i. Diana Waggoner: Focus more on children: better prevention and early intervention.
- j. Kasey Moyer: More education. How to stop crisis early. For the agenda: Vets' needs and managed care.
- k. Adria Bace: Good information on block grants. CQI is important but need to know how to get outcome.

XV. Adjournment & Next Meeting

- a. Motion was made by Kathleen Hanson and seconded by David Lund to adjourn the meeting. Voice vote was in favor and the meeting was adjourned.
- b. The next meeting will be Joint MH-SA-GAP on Thursday, May 3, 2012 at Country Inn and Suites

Reviewed by Diana Waggoner February 17, 2012

Approved by James J. Hawsey
Federal Resource Manager
Division of Behavioral Health

Date FEB 17, 2012

Employment Development Initiative

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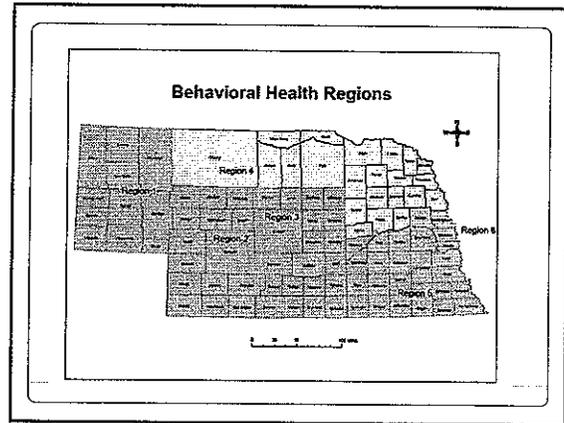
More to come ...





- A peer-run organization
- Incorporated in 2001
- Currently employ 21 Peers
- 13 peer-volunteers
- Affiliated with NMHA, USPRA, NABHO, NCMHR, IAPCA
- Nationally Accredited!

Mental Health Association of NE



Keya House



Hospital Diversion Program

Keya House Mission

- Is to assist individuals living with serious mental illness avert crisis and do away with the necessity for higher levels of care, while at the same time obtaining necessary knowledge, skills, and abilities to maintain wellness and work towards recovery from mental illness.

Registration Guidelines

- Serious Mental Illness, co-occurring disorders and/or high risk for relapse
- Medically stable
- Resident of Region V Systems Service Area
- 19 years of age or older
- Maintain personal hygiene/prepare meals/ and clean up after themselves
- Have permanent Housing
- Follow House Rules
- Not have physical illness within the past 24 hours
- Is a voluntary registration
- Not be a sex-offender

Exclusionary Guidelines

- Guest does not have SMI or co-occurring disorder nor is at risk for relapse of substance abuse
- Is not medically stable
- Is a sex offender
- Does not have permanent housing
- Is not able to maintain personal hygiene, cook for oneself, or clean up after self
- Is not willing to sign necessary documentation
- Is not voluntarily registering

Initial Phone Intake

- No one can come to the house without first calling and completing the initial phone intake and making a reservation!
- What can the House do for you?

Crisis Aversion

- Goes by many names: Hospital Diversion, Crisis Diversion, Crisis Respite, Peer Respite
- Can take many shapes: (meet the person where they are) total recovery, Hybrid recovery w/ clinical component, step-down from hospital (aka Living Room)
- For us it is all about preventing the need for intrusive, coercive, and sometimes punitive crisis services

Crisis Prevention v. Crisis Response

<p>Win - Win</p> <ul style="list-style-type: none"> Individual remains in control of their life Quality of life Work, housing, family & friends Benefit for the community Emergency services remain available for true emergencies Less costly, more effective Less disruption, kids/school 	<p>Lose - Lose</p> <ul style="list-style-type: none"> Traumatic for the person Loss of autonomy Loss of treatment choice Loss of quality of life Expensive for the community Police, ambulance, emergency room, crisis center Possible judicial expense
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Medical Model

- Narrowly focused on illness, symptoms, deficiencies, and incapacity
- Primary patient/client role and pursuit of treatment goals
- Consumer is expected to adhere to the advice of professional
- Staff prescribe what they feel is in the best interest of consumer
- Motivation for change is fear and punitive
- Consumer is expected to comply or adhere to the professional advice
- Medication compliance emphasized
- Responsibility for treatment and direct costs on provider
- Service system may expect persons duplication of efforts or have separate access for person with multiple issues
- Services are embedded within the MH System when possible

Recovery Model

- Multi-dimensional
- Holistic
- Re-establish valued roles and pursuit of recovery goals
- Consumer is empowered to assume personal responsibility for health and lifestyle
- Staff offer education, guidance and support
- Motivation for change is health and personal control
- Consumer is guided to assume responsibility for self-monitoring healthy behaviors and increase activity in dimensions where the consumer perceives and imbalance
- Medication based on informed choice
- Systems integration assists persons with co-occurring disorders
- Emphasis on the use of natural community resources!

House Rules

- Visitation 7a.m. to 11:00 p.m.
- No pets allowed
- Doors are locked at all times
- No Fees
- Guests cannot be physically ill
- House Consensus
- Guest responsible for own meals
- No Borrowing
- Smoke Free / Drug Free Workplace
- Appropriate Dress
- Staff/Guest House Cleaning
- 15 min phone use
- No Waiting List

Not Allowed!

- Harassment (words, music, TV)
- Smoking
- Drinking/illegal drugs
- Detox
- Share Medications
- Sleep in common areas or in another guests room
- Stealing
- Weapons or Violence



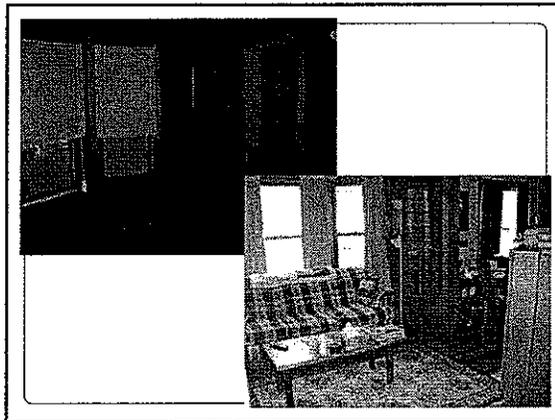
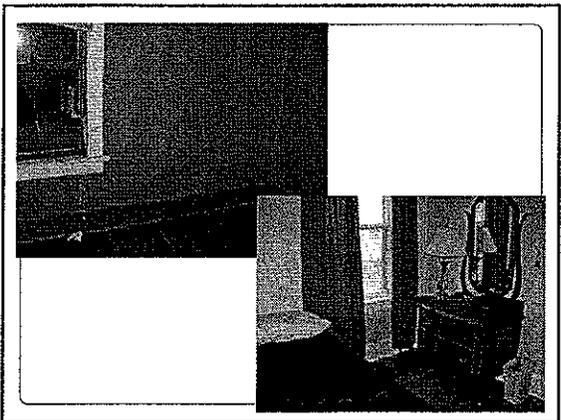
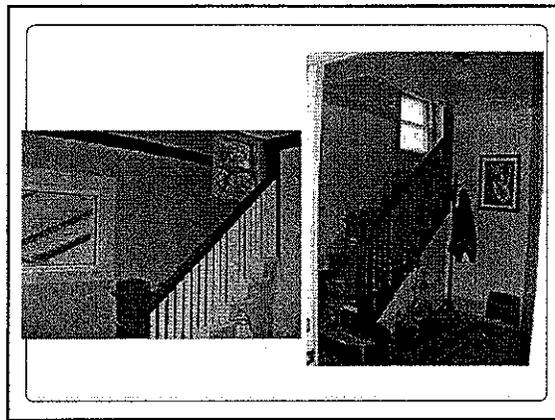
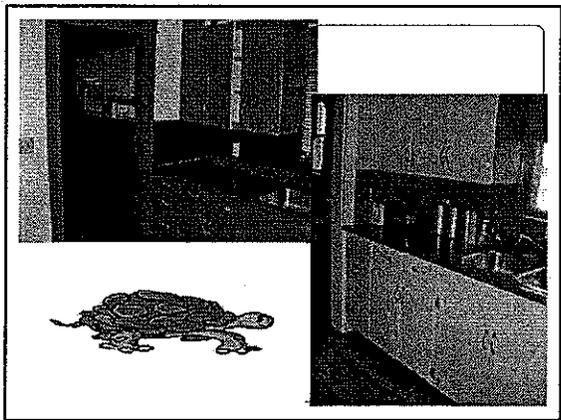
Key Numbers

12/10/2009 to 12/31/2011

- Total Guests (unduplicated) 165
- Total Guests (dup) 354
- Total Days 1484
- Average # of visits/guest 7

1/1/2011 to 12/31/11

- Total Guests (unduplicated) 109
- Total Guests (dup) 218
- Total Days 812





LPD Referral Program

David Tafoya Heather Suggett
Chad Magdanz

- LPD gets the call for a wellness check
- Police Officer emails peer companions
- Peer Companions make contact with individual
- Peer Companions report back to police officer

LPD Referral Program 9/28/11 to 12/31/11

- Total Referrals 61
- Total Officers 41
- Attempts to Contact 69
- Total Successful Contacts 40 (56%)
- Total Referrals to Services 38

Peer Companions in the Mental Health ED

- 1 Full-Time Peer Companion
 - 3 Part-Time Peer Companions
- 11 am to 11 pm Monday through Sunday

**BryanLGH Mental Health
Emergency Department,
Adult Psychiatric and Affective Unit**

Thank You



HOPE
Higher Opportunities through
the Power of Employment

Mental Health Association of
Nebraska
(402) 441-4771

ATTACHMENT 3

CLOSING THE GAPS:**NEBRASKA BEHAVIORAL HEALTH
& CRIMINAL JUSTICE COLLABORATION**

State Advisory Committee
on
Mental Health Services

– February 2, 2012 –

Cameron S. White, PhD
Behavioral Health Administrator
NE Department of Correctional Services



Blaine Shaffer, MD
Chief Clinical Officer
Division of Behavioral Health
NE Department of Health & Human Services

**Introduction:**

Goal: Provide information about Behavioral Health issues in state corrections and state behavioral health and discuss crossover issues and inter-agency collaboration

How It All Began:**LB1199 from 2006**

1. Sex Offender Statute
2. New civil commitment standard - Dangerous Sex Offender
3. New responsibilities for State Corrections for evaluation and treatment
4. Began meeting weekly with DHHS Behavioral Health – state level, regional center staff, other stakeholders
5. Began to have an appreciation for and awareness of common issues

State Prison Overview:

- a. State Agency
- b. 10 institutions (aka: prisons); concentration in Lincoln, Omaha
- c. 4,450 adult inmates; primarily males, but about 300 females
- d. Offense Categories:
 1. Sex Offenses 18.1%
 2. Assault 13%
 3. Drugs 12.7%

**Scope of Behavioral Health
Issues in State Prisons:**

- a. FY 2011 (7-1-10 to 6-30-11) Data
 1. 32% inmates are found to have a psychiatric issue (exclusive of sole s.a. issue)
 2. 77% have a substance related disorder at intake
 3. 26.5% (n=1,191) of inmates prescribed psychiatric meds on 6-30-11
- b. Correctional population has a concentration of complex cases with multiple behavioral health issues

Treatment Programs:

- a. Follow a risk/need model; provide treatment to those with higher risk levels with greatest needs
- b. Risk/responsivity model
- c. Requirement to provide "community standard of care"
- d. Focus on assessment and best practice treatment

Treatment Programs (cont):

- e. Re-entry focus; value of social work
- f. Priority populations:
 1. Major mental illness: male and female residential mental health units
 2. Violent offenders: residential violence reduction program
 3. Substance abuse treatment: residential and non-residential programs
 4. Sex offenders: residential program
 5. Re-entry services: outpatient, non-residential programs at day reporting centers

Collaborations:

- a. Collaborative efforts result in a better state system of care
- b. Joint discharge planning for higher need discharging patients
 1. Began with CJ-BH grant then continued
 2. Goal is to connect patients with local resources
- c. County Safekeepers
 1. Began with CJ-BH grant
 2. Focus on better management of county jail arrestees who are high risk behavioral health cases

Collaborations (cont):

- d. Co-occurring Disorders
 1. Participation in BH task force
 2. Development of new job classification series for "Behavioral Health Practitioners"
- c. Sex Offender Issues
 1. Work groups
 2. Joint training

Other Initiatives:

- ❖ Law enforcement training video
- ❖ CIT and BETA training
- ❖ Jail Diversion
- ❖ Community Corrections partnering
- ❖ Statewide Trauma Informed Care work
- ❖ Jail Standards Board Jail screening questions

BACKGROUND

Prevalence of Mental Illness

1- year prevalence of diagnosable mental disorders (including substance related disorders) has been stable at 30% based on two major national interviews [Kessler 2005]

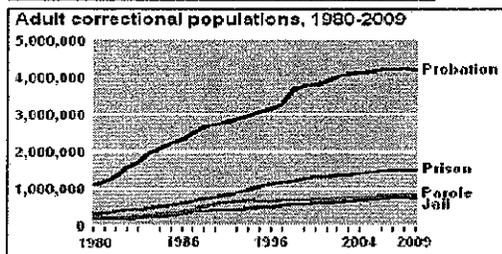
Treatment Trend

- The percentage of people with mental disorders getting treatment increased from the 1990s to 2000s but remained low (12% - 20%) [Kessler 2005]
- The three largest "psychiatric" institutions are jails:
 - Los Angeles County Jail
 - Rikers Island Jail, New York City
 - Cook County Jail, Illinois

Imprisonment Trend - Worldwide

- More than 10 million people are imprisoned worldwide with 2.3 million in the US [Walmsley 2009]
- The US has the highest number of prisoners per head of population at 756 per 100,000 worldwide [Walmsley 2009]
- Rates of imprisonment have risen in North and Central America, Asia, and Oceania [Walmsley 2009; Walmsley 2000]

Nationally, the number of adults in the correctional population has been increasing.



Source: Bureau of Justice Statistics <http://bjs.ojp.usdoj.gov/content/glance/corr2.cfm>

Prevalence of mental health and substance use disorders

Type of problems	Federal prison	State prison	Local Jail
Both MH and Substance Use Disorder	13.0%	25.4%	25.5%
MH Disorder only	6.6%	9.2%	7.7%
Substance Use Disorder Only	41.6%	39.8%	40.2%
None	38.7%	26.6%	26.5%

Source: The National Center on Addiction and Substance Abuse at Columbia University (2010). Behind Bars II. <http://www.casacolumbia.org/articlefiles/575-report2010behindbars2.pdf>

Prevalence of mental health disorders in Western countries

	Male prisoners	Male general population	Female prisoners	Female general population
Psychosis	4%	1%	4%	1%
Depression	10%	2-4%	12%	5-7%
Any personality disorder	65%	5-10%	42%	5-10%
Antisocial personality disorder	47%	5-7%	21%	0.5-1%
Drug misuse/dependence	10-48%	4-6%	30-60%	2-3%
Intellectual disability	0.5-1.5%	1%	0.5-1.5%	1%
PTSD	4-21%	2%	10-21%	3%

(Fazel & Ballarín 2010)

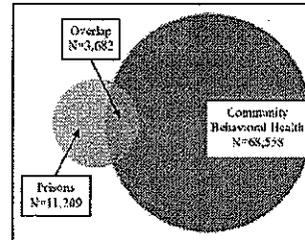
Part 1:

Establishing the baseline -
Estimating the size of the overlapping population

Analysis :
Identifying number of unduplicated individuals overlapping two systems

- a. Data period: 1/1/05 - 12/31/09
- b. Data sources:
 1. Crime Commission (jails)
 2. Correctional Services (prisons)
 3. DHHS (regional centers, community-based mental health and substance abuse)
- c. Study done by UNMC, College of Public Health

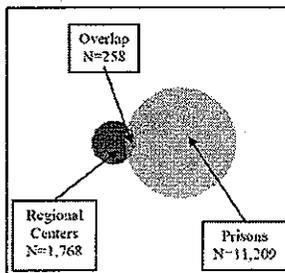
Prison – Community MH/SA Overlap



Overlap from the Prison Perspective
 Of the 11,209 inmates, 3,682 (33%) had at least one admission to Community MH/SA program during the 5-year period.

Overlap from the Community MH/SA Perspective
 Of the 68,558 Community MH/SA program consumers, 3,682 (5%) have been to prison at least once in the 5-year period.

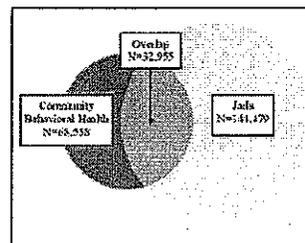
Prison – Regional Center Overlap



Overlap from the Prison Perspective
 Of the 11,209 prison inmates, 258 (2%) had at least one admission to Regional Centers during the 5-year period.

Overlap from the RC Perspective
 Of the 1,768 Regional Center (RC) consumers, 258 (15%) had at least one admission to prison during the 5-year period.

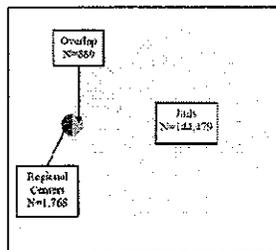
Jail – Community MH/SA Overlap



Overlap from the Jail Perspective
 Of the 144,479 jail inmates, 32,955 (23%) had at least one admission to Community MH/SA program during the 5-year period.

Overlap from the CBH Perspective
 Of the 68,558 Community MH/SA program consumers, 32,955 (48%) had at least one admission to jail during the 5-year period.

Jail – Regional Center Overlap



Overlap from the Jail Perspective
 Of the 144,479 jail inmates, 880 (0.6%) had at least one admission to Regional Centers during the 5-year period.

Overlap from the RC Perspective
 Of the 1,768 Regional Center consumers, 880 (50%) had at least one admission to jail during the 5-year period.

Part 2:

Identifying at-risk groups

Cohort and Data Period

a. Study Sample (Cohort):

1. Adult consumers (18 years and older)
2. Used services at least once from the NE Division of Behavioral Health - Community programs between 1/1/07 - 12/31/07
3. Include both mental health and substance abuse treatment consumers

b. Data Period: 1/1/05 - 12/31/09

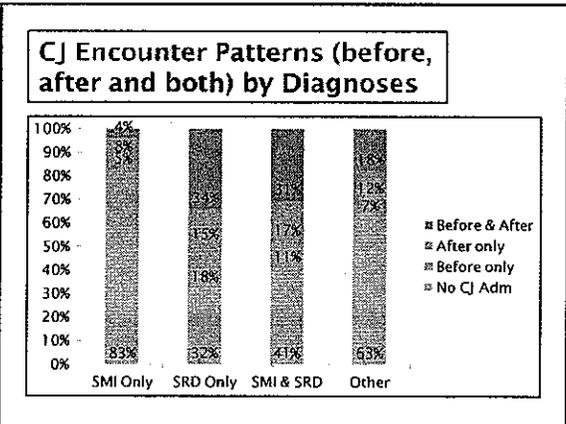
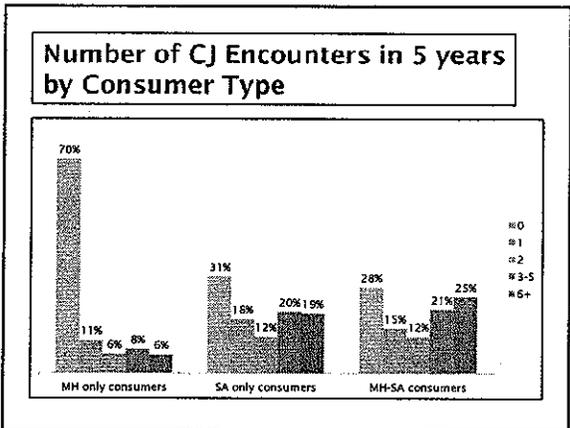
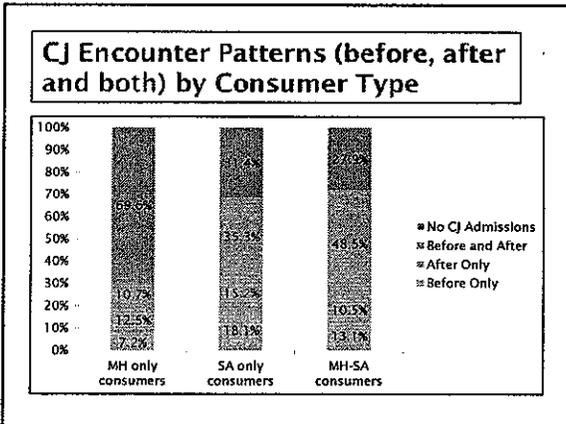
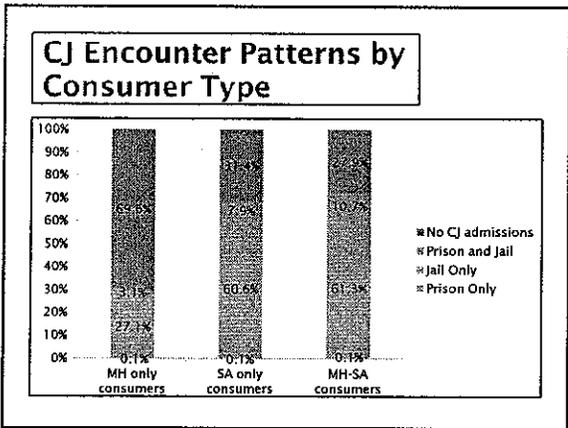
Cohort and Analysis

MH & SA Cohort
25,068

Criminal Justice encounter?

2005 2006 2007 2008 2009

Data Available for the 5 years on falls, Pivots, Community MH or SA



Who are at higher risk of CJ encounter?

1. Younger age
2. Racial/ethnic minority
3. Male
4. Substance abuser
5. Co-Occurring diagnosed
6. Lower education attainer
7. No private insurance
8. Unemployed
9. Homeless

Major Factors Predicting Criminal Behavior (The Big Four) :

1. History of antisocial behavior
 2. Antisocial personality patterns
 3. Antisocial cognitions
 4. Antisocial associates
- Mental illness not by itself a predicting factor —

Some Proposed National Trends:

- Mental illness not primary cause of criminal behavior
- Deinstitutionalization not primary cause of increased MI/SA in criminal justice system
- Most people in corrections did not come from a psychiatric hospital nor have been sent to one
- Two different populations with different histories, courses, outcomes
- State psychiatric hospitals increasingly used for forensic/court ordered and dangerous sex offenders
- Increasing recovery oriented systems of care would decrease admissions to both behavioral health and criminal justice systems

Summary and Recommendations

1. 22 % of jail and 33% of prison inmates have used community-based mental or substance abuse service at least once in 5-year period.

- Address treatment needs while individuals are in prison or jail
- Linkage with mental health and/or substance abuse at discharge from prison or jail

2. Individuals with substance abuse and with co-occurring diagnoses are more likely to have criminal justice encounters compared to individuals with only mental health problems.

- Need for more targeted approach in reducing criminal justice encounter among these groups
- Identification and implementation of effective interventions used in other communities

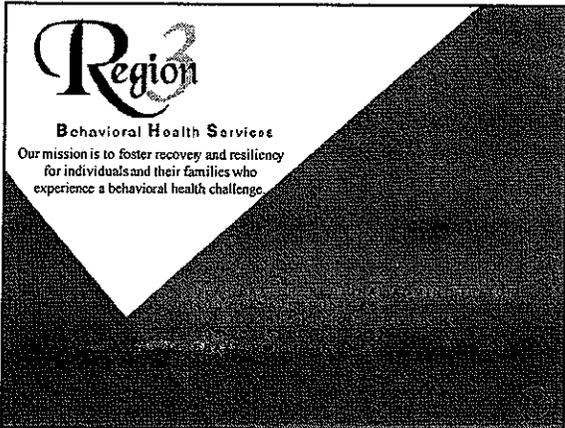
3. Policy and Programming Implications

- Need for increased data sharing between systems for more integrated and comprehensive evaluation
- Need for linkage between systems to improve and increase access to mental health and substance abuse service

THANK YOU

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Region 3 Behavioral Health Services

- Region 3 Behavioral Health Services is one of six Regional Behavioral Health Authorities (RBHAs) first created in 1974 through the Nebraska Comprehensive Community Mental Health Services Act with revised responsibilities and authority in 2004 under the Nebraska Behavioral Health Services Act which reaffirmed the roles and responsibilities of the RBHAs to reflect the evolution of the publicly funded behavioral health system in Nebraska.
- Region 3 is governed by a Regional Governing Board consisting of elected officials (Commissioners or Supervisors) from counties served.
- To accomplish the intent of the Act the following system partners are responsible for the delivery of services:
 - 5 Regional Behavioral Health Authorities
 - Department of Health and Human Services, Division of Behavioral Health
 - The Lincoln Regional Center
- Regional System provides for:
 - Local participation and autonomy in the development and delivery of needed services
 - Counties and the State come together to share resources to meet local needs

NETWORK MANAGEMENT - REGIONAL ADMINISTRATION

- Network Management assists in developing, implementing and evaluating regional behavioral health service needs, barriers to effective service delivery, and the identification of strategies to address individual, programmatic and system needs.
- Region 3 manages a network of 15 community-based behavioral health providers of which 14 are contract providers and the Region provides therapeutic case management for youth with serious emotional disturbances and youth and adults who have experienced a psychiatric crisis situation.
- Region 3 also contracts with 5 community coalitions for prevention activities
- Provides oversight and monitoring on its provider network
- Region 3 ensures that the behavioral health system operates in an effective and coordinated manner.

FISCAL MANAGEMENT

- Region 3 utilizes contract monitoring, the tracking of outcome and performance standards, and fiscal and programmatic reviews of network providers to ensure the effective and efficient utilization of public resources.
- In FY11 Region 3 contracted with the Department of Health and Human Services, Division of Behavioral Health and the 22 counties in Region 3 provided matching funds based upon a formula set forth in the Nebraska Behavioral Health Services Act.
- During FY11 Region 3 expended a total of \$12,642,402
 - 91% expended for services
 - 7% expended for system coordination/enhancements
 - 2% for regional administration/network management

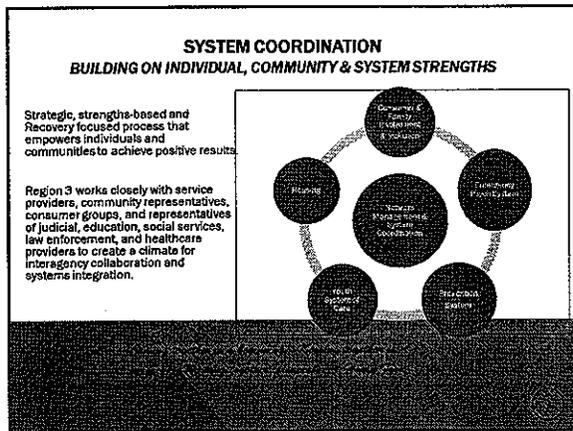
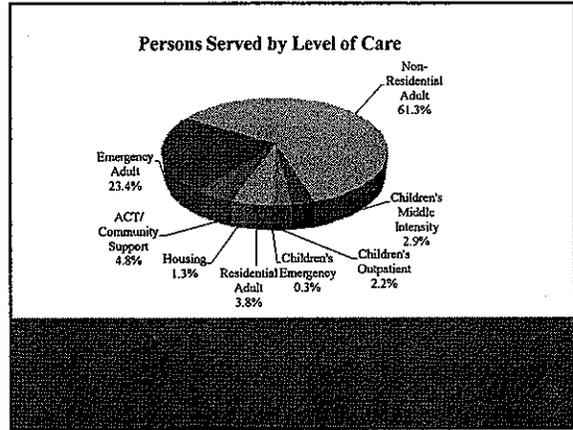
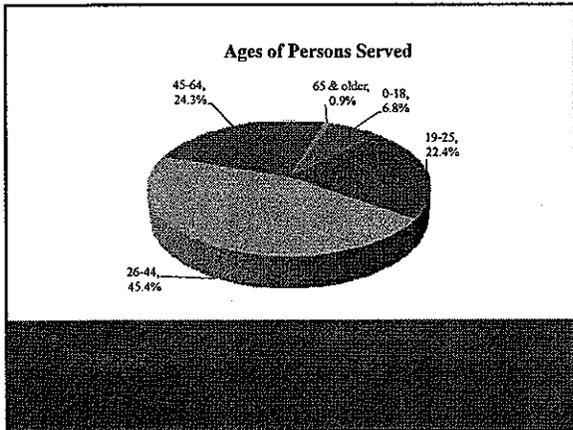
Category	Amount	Percentage
Region 3 Services	\$1,798,176	14.21%
System Enhancements	\$163,247	1.53%
Network Administration	\$283,405	2.24%
Coordination	\$699,522	5.27%
Region 3 Services (Total)	\$11,842,158	91.93%

FISCAL YEAR 2011 EXPENDITURES BY CATEGORY

Category	Amount	Percentage
Prevention	\$112,452	1.47%
Administration	\$263,405	2.24%
System Coordination	\$699,522	5.27%
System Enhancements	\$163,247	1.53%
Emergency Services - Adult	\$2,524,864	20.10%
Emergency Services - Children	\$124,478	0.99%
Residential	\$3,088,435	24.43%
Non-Residential Adult Services	\$3,445,814	27.25%
Community Support	\$411,135	3.25%
Housing Assistance	\$230,626	1.82%
Children's Middle Intensity	\$1,368,152	10.81%
Children's Outpatient	\$292,177	2.30%

SNAPSHOT OF INDIVIDUALS SERVED

- During FY11 a total of 8,054 individuals were served
 - 73.3% served had no health insurance
 - 47.8% were unemployed at the time of admission to services
 - 97.3% were considered residents of Region 3 counties
 - 50.4% were female
 - 49.6% were male
 - 36% served had some type of legal involvement at admission
 - 61% were admitted for a primary mental health disorder
 - 29% had a primary diagnosis of substance abuse/dependence disorder
 - 5% experienced a dual diagnosis

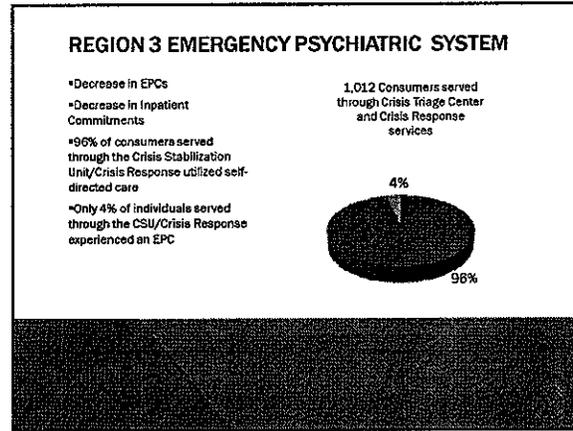


PREVENTION SYSTEM COORDINATION

"There is no power for change greater than a community discovering what it cares about." Margaret J. Wheatley

- The Region 3 Prevention System is a multifaceted partnership encompassing community, coalitions, agencies, providers and other key stakeholders collaborating to impact substance abuse and its related consequences.
- Provides technical assistance, training and consultation to community coalitions and other system partners to build coalition infrastructure, diversity and sustainability.
- Using the Strategic Prevention Framework Region 3 assists community coalitions to successfully implement evidenced-based prevention strategies.

- ### EMERGENCY PSYCH SYSTEM ARRAY OF SERVICES
- RECOVERY IS NOT A STEP-BY-STEP PROCESS BUT ONE BASED ON CONTINUAL GROWTH, OCCASIONAL SETBACK, AND LEARNING FROM EXPERIENCE.
- NATIONAL CONSENSUS STATEMENT ON MENTAL HEALTH RECOVERY
- Acute Inpatient
 - Subacute Inpatient
 - Crisis Stabilization (voluntary)
 - Crisis Response
 - Crisis Triage Center
 - Emergency Community Support (ages 12 and up)
 - Emergency Protective Custody (EPC)
 - Emergency Psych System Coordination
 - Medically Supported Detox
 - Social Detox
 - Telemedicine
 - Medication Management
 - Outpatient
-



REGIONAL YOUTH SYSTEM OF CARE COORDINATION

IMPLEMENTATION OF SYSTEM OF CARE VALUES AND PRINCIPLES TO IMPROVE THE DESIGN AND DELIVERY OF SERVICES AND SUPPORTS FOR CHILDREN AND THEIR FAMILIES ACROSS REGION 3.

System of Care Principles to improve the design and delivery of services and supports at these levels

- System
- Program
- Practice



- Region 3 funds an array of services for children and adolescents who experience a serious emotional disturbance and need services from multiple systems.

- These youth are at high-risk of being placed out of the home for services as a result of behavioral challenges, becoming a state ward specifically in order to access behavioral health services, becoming involved in the juvenile justice system, and/or dropping out of school.

CONSUMER AND FAMILY SYSTEM COORDINATION

- ❖ Works toward full and meaningful consumer and family involvement and inclusion in all aspects of the Behavioral Health System.

- ❖ These efforts are facilitated by the Regional Consumer Specialist who works in close collaboration with consumers of behavioral health services as well as professional staff and state administrators within the Regional Behavioral Health System advocating for consumer views and to achieve meaningful integration of consumers as a priority in the Nebraska Behavioral Health System.

- ❖ The Regional Consumer Specialist serves as an advocate and liaison to consumers of behavioral health services, including consumers of services which are designed to lead toward wellness and recovery from mental illness, substance abuse, or problem gambling



TRAUMA-INFORMED CARE: A REGION-WIDE FOCUS

- ❖ Seek to understand each consumer's trauma history.

- Trauma-informed services:
- Incorporate knowledge about trauma in all aspects of service delivery
- Are hospitable and engaging to trauma survivors
- Minimize re-victimization
- Facility recovery

- ❖ Regional Trauma-Informed Care Teams - Organizational and System

- ❖ Region 3 was selected as an "Adoption of Trauma-Informed Practices Learning Community Sponsored by the National Council for Community Behavioral Healthcare"

- Kay Glidden and Tammy Fiale were selected to present at the National Council's annual national conference in Chicago in April 2012 to share their efforts at successfully engaging and including consumers in all aspects of Region 3's Trauma-Informed Care Initiative.

WHY TRAUMA-INFORMED CARE

Why are we spending time and resources on becoming a trauma-informed organization/service system?

- ❖ Research tells us it will improve the efficacy of treatment and support.

- ❖ It's cost effective to get to the root of an individual's behavioral health needs - and often times trauma is at the core.

- ❖ The prevalence of trauma of those we are responsible to serve cannot be ignored. Individuals with histories of violence, abuse, and neglect from childhood onward make up the majority of consumers served by the public behavioral health system.

- ❖ It's the right thing to do.



BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

Created by Nebraska Legislature in 2009 (part of LB 603)

- BHECN's mission is to further the recruitment, retention and competency of the behavioral healthcare workforce.

- Region 3 selected as a regional BHECN site

- Develop and distribute Behavioral Health Workforce Survey and sample system partners

- Sponsor evidenced-based trainings for the behavioral healthcare workforce

- Recruit youth to study/work in the behavioral healthcare field in Nebraska

- Increase the utilization of telehealth across the region

- Initiated discussions with healthcare leaders regarding strategies for behavioral health and physical healthcare integration.



EVIDENCE-BASED PRACTICES

Investment in training, consultation, evaluation and fidelity Monitoring.

- Multisystemic Therapy (MST)
- Wraparound
- Assertive Community Treatment (ACT)
- Supported Employment
- Parent Child Interaction Therapy (PCIT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Transition to Independence Process (TIP)

Region 3 Behavioral Health Services Network and Service Array ...Hope, Recovery, Resiliency

□ \$11,506,228 expended on services for 8,054 individuals

○ 7,418 Adults Served (92%)

○ 636 Youth Served (8%)



REGION 3 BEHAVIORAL HEALTH SERVICES NETWORK AND SERVICE ARRAY

Families CARE

- Young Adult Care Partner (Transition-age youth and young adults)

Advanced Psychiatric Services

- Medication Management

Center for Psychological Services

- 24-hour Crisis Phone (Y/F)
- Mobile Crisis/Crisis Response (Y/F)
- School-Based Outpatient Therapy (Y/F)

Behavioral Health Specialists/Seekers of Serenity

- Short-Term Residential (A)
- Social Detox (A)

Lutheran Family Services

- At Ease Program for Veterans and their Families (A)

REGION 3 BEHAVIORAL HEALTH SERVICES NETWORK AND SERVICE ARRAY

Catholic Charities of Greater Nebraska

- Dual Diagnosis Residential Treatment (A)

Richard H. Young Hospital

- Acute Inpatient (A)
- Subacute Inpatient (A)
- Post Commitment (A)
- Emergency Protective Custody (A)
- Medication Management (A, Y/F)
- Peer Support (A)
- 24-Hour Crisis Phone (A, Y/F)
- Outpatient Assessment/Access Center (A, Y/F)
- Youth Crisis Inpatient

Mary Lanning Memorial Healthcare

- Acute Inpatient (A)
- Subacute Inpatient (A)
- Emergency Community Support (A)
- Emergency Protective Custody (A)
- Medication Management (A)
- Behavioral Health Consultation and Support for Nursing Homes (A)

REGION 3 BEHAVIORAL HEALTH SERVICES NETWORK AND SERVICE ARRAY

Friendship House/Milne Detox

- Halfway House (A)

Mid-Plains Center for Behavioral Healthcare

- Dual Diagnosis Outpatient Therapy/Assessment (A)
- Medication Management (A)
- Mental Health Outpatient Therapy/Assessment (A, Y/F)
- Substance Abuse Assessment (A)
- Crisis Stabilization Unit (Triage, Treatment & Support)
 - Crisis Response (A, Y/F)
 - Medication Management (A)
 - Outpatient (A)
 - Crisis Stabilization (A)
 - Medically Supported Detox (A)
 - Peer Support (A)
 - Multisystemic Therapy (Y/F)
 - Children's Day Treatment (Y/F)

REGION 3 BEHAVIORAL HEALTH SERVICES NETWORK AND SERVICE ARRAY

The Bridge

- Therapeutic Community for Women and Their Children (A, Y/F)

Goodwill Industries of Greater Nebraska

- Community Support (A)
- Day Rehabilitation (A)
- Day Support (A)
- Emergency Community Support (A)
- Peer Support (A)
- Supported Employment (A, Y/F)
- Projects for Assisting the Homeless (PATH) (A)

Region 3 Behavioral Health Services

- Emergency Community Support (A, Y/F)
- Professional Partner Program (A, Y/F)

St. Francis Drug & Alcohol Treatment Center

- Short-Term Residential (A)
- Specialized Women's Treatment Program (A)
- Substance Abuse Intensive Outpatient (A)
- Substance Abuse Outpatient Therapy/Assessment (A, Y/F)

REGION 3 BEHAVIORAL HEALTH SERVICES NETWORK AND SERVICE ARRAY

South Central Behavioral Services

- Assertive Community Treatment (ACT) (A)
- Community Support (A)
- Crisis Response (A, Y/F)
- Day Rehabilitation (A)
- Day Support (A)
- Medication Management (collaboration with MLMH in Kearney) (A)
- Mental Health Outpatient Therapy/Assessment (A, Y/F)
- Peer Support (A)
- Psychiatric Residential Rehabilitation (A)
- Specialized Women's Treatment Program (A)
- Substance Abuse Intensive Outpatient (A, Y/F)
- Substance Abuse Outpatient Therapy/Assessment (A, Y/F)
- Specialized Adolescent SA Services (Y/F)

REGION 3 BEHAVIORAL HEALTH SERVICES NETWORK PROVIDER OUTCOMES



Region 3 Behavioral Health Services promotes the provision of effective behavioral health services that meet three primary goals:

- Reduction of symptoms for individuals involved in various treatment and support services;
- increase in daily functioning or being able to live and interact with one's community, and
- individuals and families being served are satisfied with the services and supports they receive through network providers.

Recovery and Consumer Involvement and Consumer Satisfaction.

- 89.5% of consumers perceived the services they received improved the quality of their life.
- 91.8% of consumers were satisfied with accessibility of services.
- 93.4% of consumers had general satisfaction with services.
- 91.7% of consumers would recommend the providers or return to the agency.

Outcomes specific to levels of care:

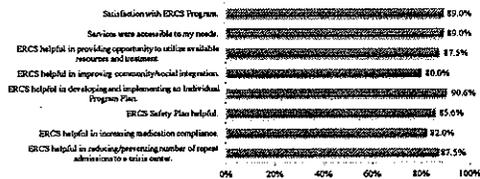


- **Reduction in Emergency Crisis (Emergency Community Support)**
 - 95.1% of consumers had no EPC (Emergency Protective Custody) while enrolled.
 - 32.2% of consumers achieved and 45.6% partially achieved their goals.
- **Life Functioning (Intensive Outpatient, Halfway House, and Therapeutic Community)**
 - 73.1% of consumers reported increased employment/return to school.
 - 90.1% of consumers reported abstinence from illicit drug use and alcohol use.
 - 60.6% of consumers reported prevented or decreased criminal justice involvement.
 - 86.1% of consumers reported increased stabilization of family and living conditions.
- **Treatment Goal Attainment (Outpatient Therapy)**
 - 31.6% of consumers achieved and 31.6% partially achieved their goals.
- **Crisis Stabilization Unit (CSU) (safe environment for mental health stabilization and/or medically assisted detoxification.)**
 - 95.8% diverted from an EPC.
 - 90.5% were face-to-face contacts and 0.5% were phone contacts.

EMERGENCY COMMUNITY SUPPORT

Voluntary case management program for youth and adults who have experienced a behavioral health crisis.

Satisfaction of Consumers Enrolled in ERCS



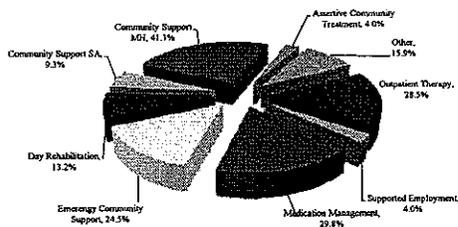
HOUSING ASSISTANCE PROGRAM



Region 3 Housing Assistance Program provides rental assistance for adults who are very low income and experience a serious mental illness to obtain safe and decent housing at an affordable cost.

- Served 151 consumers during FY2011
- 58% of the consumers were successfully discharged from the program due to increased income, transition to public housing or a move.
- Only 13% of the consumers in the program moved to a more restrictive level of care.
- Reduced waitlist from 14.5 consumers per month to an average of 3.5 per month.

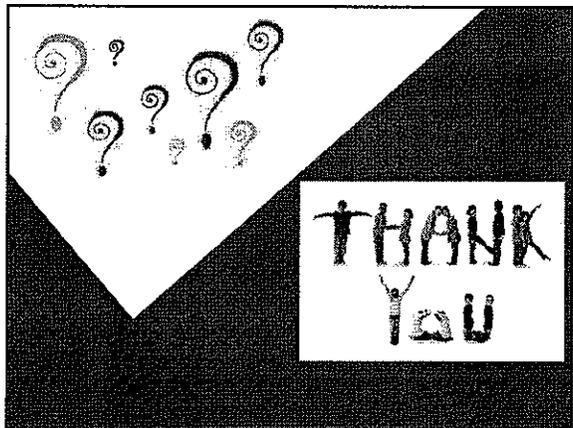
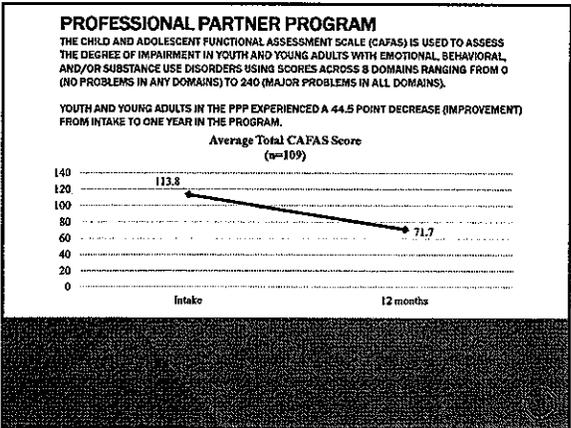
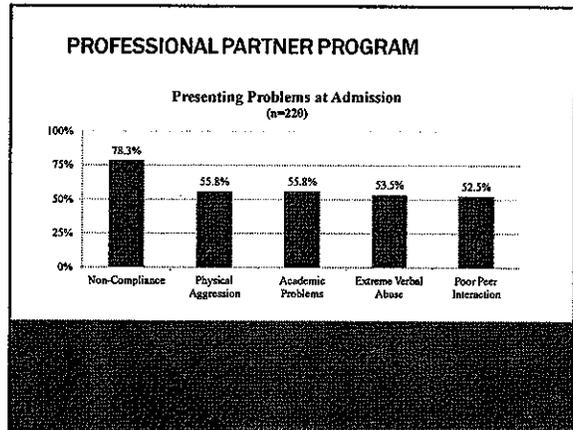
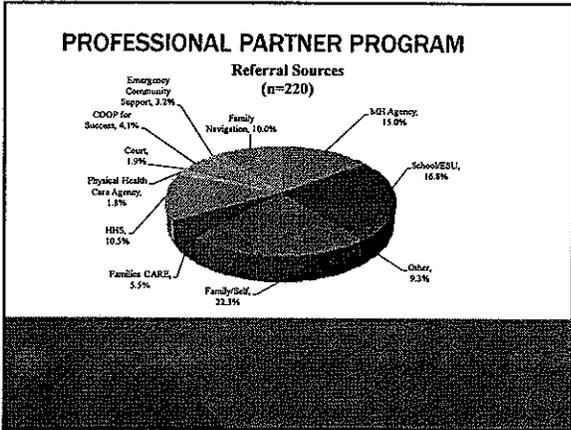
BEHAVIORAL HEALTH SERVICES OF INDIVIDUALS SERVED IN THE HAP



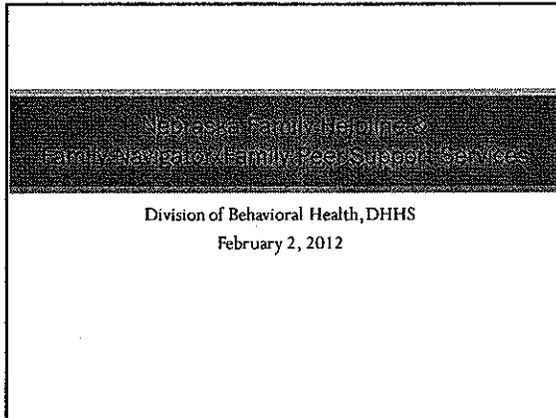
Numbers add to over 100% due to consumers receiving more than one service.

PROFESSIONAL PARTNER PROGRAM

- Is strengths-based, family-centered, and acknowledges families as equal partners.
- Provides intensive case management for children and adolescents utilizing the wraparound approach to service delivery and promotes the least restrictive, least intrusive, developmentally appropriate interventions in accordance with the needs of the youth and his or her family within the most normalized environment. The program serves individuals under the age of 21 with the addition of specific programming for transition-aged youth up to age 26 who meet specific eligibility and program expectations.
- The program assists families who have a child with a serious emotional disorder and are at high-risk of:
 - being placed out of the home for services as a result of behavioral challenges,
 - becoming a state ward specifically in order to access behavioral health services,
 - becoming involved in the juvenile justice system, and/or
 - dropping out of school.
- Served 220 Youth
- Ages range from 3 through 23 years
- Average age was 13.6 years
- 82.3% were boys
- 37.7% were girls



ATTACHMENT 5



Nebraska Family Helpline

- A **single point of access** to children's behavioral health services in Nebraska: crisis intervention and support services to families, information and referrals for other formal and informal services and supports.
- The **primary target population is parents** --guardians--primary caregivers of youth experiencing behavioral health challenges, although youth may also utilize the Helpline for their own assistance.
- Operated by Boys Town

Nebraska Family Helpline

- 24/7/365 crisis intervention and support
- Screening for immediate safety needs; connecting with first-responders
- Identification of and referrals to local resources
- Development of strategies with families
- Collaborative problem solving
- Empowerment of youth and families
- Helping youth and families make informed decisions
- Assistance to families navigating the system

FY11 Year End -Helpline

- FY11 Total Helpline Calls: 3,861 by 2,717 unique families
- Family Navigator offered to 686 families(25%) – 460 accepted the service
- 6,185 total service referrals provided (representing 8,097 service referral types)
- 42% parent callers in single-parent household
- 81% of callers were female
- 46% of callers reported having Medicaid/KidsConnection

FY11 Year End - Helpline

- Calls from 79 Nebraska counties
- 30% identified children on helpline call reported at least one Mental Health treatment prior to call, 20% report having a previous diagnosis
 - while only 14% report having a previous evaluation
- 60% of identified children in call were male
- Three most cited problem behaviors:
 - Not following family rules
 - Being aggressive in the home
 - Arguing with parents, guardians or other authority figures

1st Q FY12 Helpline

- 627 families made 915 calls
- 1,027 referrals provided for a range of services
- 40% of callers report single family households
- 29% report previous Mental Health treatment
- 167 families offered Family Navigator (27% of calls)
 - 105 accepted
- 51% report having Medicaid/KidsConnection
 - 38% report private insurance

2nd Q FY12 Helpline

- 627 families made 896 calls
- 896 referrals provided for a range of services
- 40% of callers report single family households
- 58% of children were male, 80% of callers were female
- 29% report previous Mental Health treatment
- 182 families offered Family Navigator (29% of calls)
 - 126 accepted
- 46% report having Medicaid/ Kids Connection
 - 45% report private insurance

Top 5 Child Issues

- Family Rules – 16% (84% of families reported as top)
- Aggression in Home – 13%
- Arguing – 12%
- School Authority – 9%
- Grades – 8%
- Additional Family Stressors: relationship with child, need for supervision for child, trouble accessing services, parent expectations of child (all reported in over 45% of calls)

1st Q – 2nd Q FY12 Helpline

- Most common barrier to accessing Mental Health services as reported by callers:
 - 1st Q: Appointment availability
 - 2nd Q: Cost of services

Families that did access services prior to call report:

- Counseling and/or medication was ineffective
- Child wouldn't attend sessions or treatment or stopped attending/stopped taking meds

Helpline Call Volume

- Highest call volume by far in Region 6 – 62%
 - Region 5 – 18%
 - Region 3 – 11%
 - Region 4 – 6%
 - Region 2 and Region 1 – 1% each
- 16% of families called multiple times
 - Of these, 65% cite continuation of previous issue/crisis

Family Navigator & Family Peer Support Services

FY12 Contract with:
Nebraska Federation of Families
for Children's Mental Health

Family Navigator (FN)

- Utilizes family peer support specialists to provide further support and assistance after a caller is referred from their Helpline call.
- Provides time limited services of approximately eight (8) contact hours per family over a period of forty-five (45) - sixty (60) days to families of youth experiencing an urgent behavioral health situation.
- The Family Navigator must be made available to the Helpline caller within 24-72 hours from referral by Helpline staff.

Family Peer Support Services (FPS)

- Utilizes family peer support specialists to provide a variety of services and supports such as mentoring, advocacy, parent education, support groups, resource referrals, etc.
- Service is not time limited, and referrals come from a variety of sources such as self, community agency, Region, etc
- Established service standards similar to the Family Navigator such as contact within 72 hours from referral.
- Many Family Navigator families will transfer into FPS

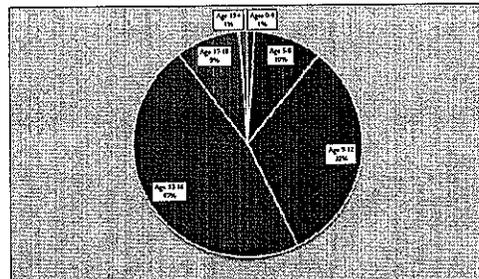
1st Q FN/FPS

- Served a total of 266 families
 - 104 Family Navigator
 - 39 new Family Peer Support, 120 transitioned from previous yr
- 16yr olds most common age served in FN at 17%, 14yr old at 12%
- Region 6 Family Org served most FN referrals (52%)
- Region 6 (48%) and Region 4 (27%) Family Org served most FPS families
- Average length of stay in FN service 45-55 days

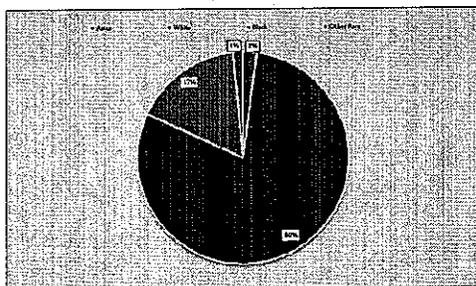
2nd Q FN/FPS

- Served a total of 266 families
 - 124 Family Navigator
 - 56 new Family Peer Support
 - 52% Self Referral
 - 18% Region Referral
 - 16% from Child Welfare closed or unsubstantiated cases
- 13-16yr olds most common age group served – 44%
 - 62% males
- Average length of stay in FN service 45-55 days

Age Ranges of Youth Served



Race/Ethnicity



2nd Q Utilization by Family Org

- Neb Family Support Network (region 6)
 - FN – 50%
 - FPS – 36.8%
- Families Inspiring Families (region 5)
 - FN – 27.4%
 - FPS – 25%
- Families Care (region 3)
 - FN – 11.3%
 - FPS – 19.6%
- Parent2Parent (region 4)
 - FN – 7.3%
 - FPS – 1.8%
- Speak Out (region 1)
 - FN – 2.4%
 - FPS – 7.1%
- Voices 4 Families (region 2)
 - FN – 1.6%
 - FPS – 19.6%

Top 5 as reported at Intake

Diagnosis	Stressors
1. ADHD Disruptive Type	1. Mental Health
2. ADHD - or Hyperactive Impulsive	2. Income
3. ADD	3. Social connections
4. Oppositional Defiant	4. Marital relationship
5. Bipolar Disorder, NOS	5. Housing needs

Top 5 Child Related Stressors

- Aggression/anger
- Not following rules
- Lying
- School rules
- School grades

Any questions?

Program Fiscal Year end Reports and
Hornby Zeller Evaluation Reports
available on DHHS website at:
http://dhs.nc.gov/behavioral_health/Pages/beh_ah_c4d4db.aspx

Continuous Quality Improvement (CQI)



DBH – Vision and Mission

- **VISION** - The vision of the Division of Behavioral Health (DBH) CQI program is to be nationally recognized as a state leader and provider of quality Behavioral Health services.
- **MISSION** - DBH leads Nebraska in the improvement of services and supports for people affected by behavioral health challenges.

Our Commitment

- DBH is committed to creating a culture that fosters improvement and sets clear direction through an annual plan.
- Our CQI program establishes accountability for continually improving:
 - DBH as an organization.
 - the service provided to consumers and families in the state of Nebraska.

CQI Defined

- CQI is an *ongoing* process in which we:
 - use data to plan.
 - identify opportunities for improvement.
 - implement changes.
 - study and analyze results.
 - celebrate improvements!!!

Why Continuous?

- There is no finish line.
- No matter how good we are, there is always room for improvement.
- Focus on systems and processes.
- Small, incremental changes.
- Move away from Band-aids and fighting fires.

CQI is ultimately about learning!

The Challenge

- Holding ourselves to be ACCOUNTABLE to delivering the highest quality services to the community and state's consumers and families in a cost effective manner
- Can quality and having cost effective systems co-exist?

YES! Through Continuous Quality Improvement!

Assumptions

- If you've seen one provider, you've seen **one** provider.
- Working together creates a system of **coordinated** services to better meet the needs of individuals and families.
- Co-occurring is the **expectation**, not the exception.
- We **want** to improve outcomes.
- **Providers participate** in monitoring services and in data evaluation and reporting.

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CQI Program

- Links:
 - Data
 - Knowledge
 - Structures
 - Processes
 - Outcomes
- Which allows for us to improve *throughout* a system.

8

Key Aspects

- Services are designed to meet consumer/family need and are **accessible** when needed.
- **Consumers and families participate** in all processes of the CQI program and their views and perspectives are valued.
- The services provided incorporate **evidenced based practices, best and promising practices.**
- Services are of **high quality** and provided in a **cost-effective** manner.

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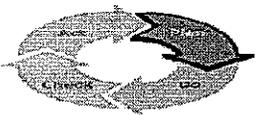
CQI Core Principles

- Customer Focused
- Strength Based
- Recovery Oriented
- Representative Participation and Active Involvement
- Data Informed Practice
- Use of Statistical Tools
- Continuous Quality Improvement Activities

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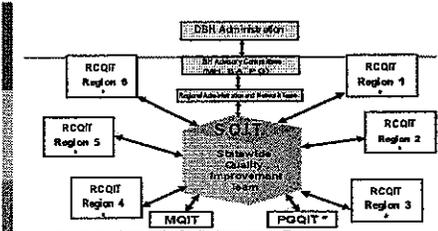
Plan-Do-Check-Act (PDCA)

- **Plan** - Plan for a specific improvement activity
- **Do** - Do carry out the plan for improvement.
- **Check** - Check the data again.
- **Act** - Action for full implementation or reject and try again.



11

Leadership and Stakeholders

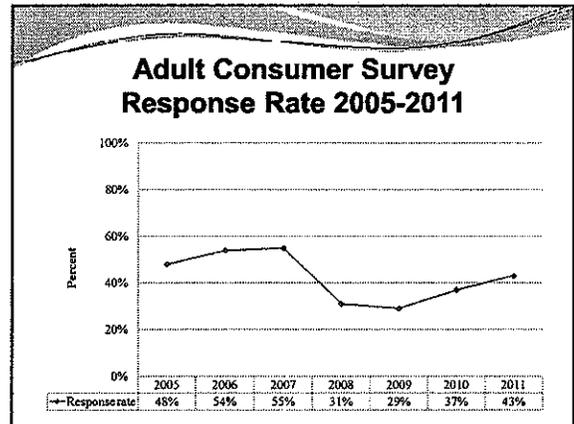


RCQIT = Regional Community Quality Improvement Team
 PQQIT = Problems Combining Quality Improvement Team
 MQIT = Magellan Quality Improvement Team
 * Each QIT has identified a process for sharing information with stakeholders.

12

Consumer Survey Review

- Statewide Quality Improvement Team (SQIT)
 - Consumer Survey Review
 - Recommendations for changes to the consumer/family surveys, methodology, use, and distribution of survey results
 - Review and analysis of the 119 consumer surveys in use within the six RBHA networks
 - Led to recommendations for the 2010, 2011 and 2012 surveys



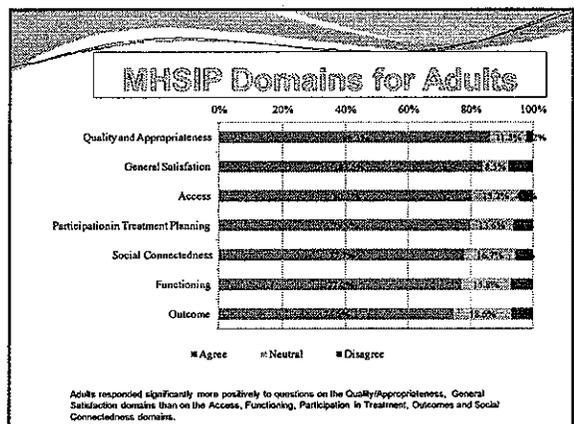
2011 Adult Consumer Survey

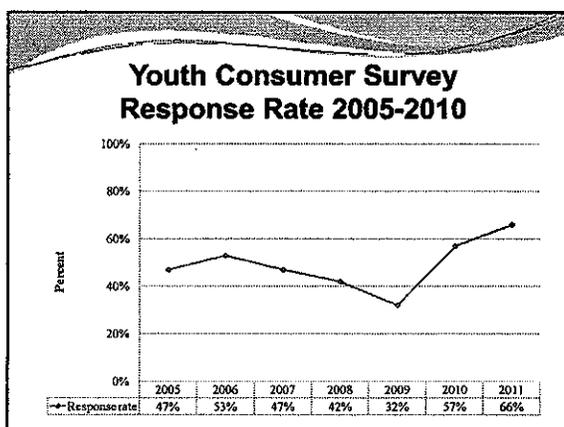
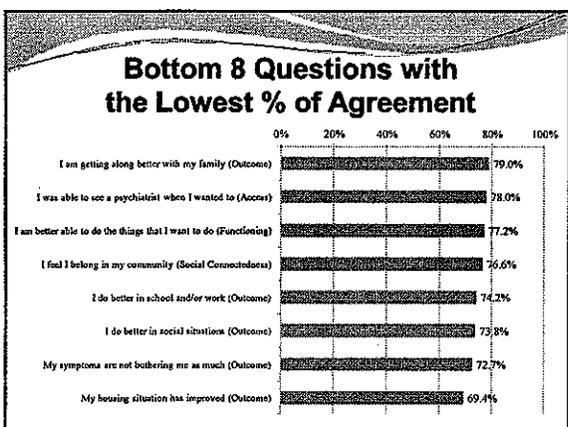
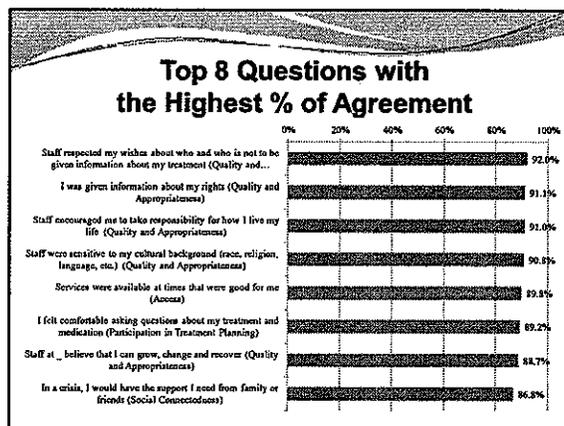
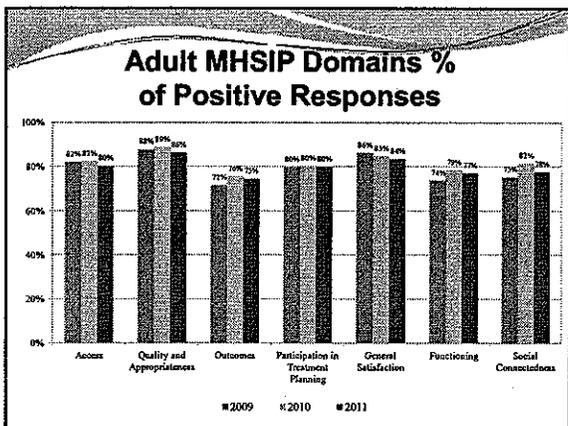
- # of adult survey contacts were made: 3,257
- # of adult surveys were completed: 1,404

Provider Location:	n	%
Metro	710	50.6%
Non-Metro	694	49.4%
Region 1	62	4.4%
Region 2	101	7.2%
Region 3	232	16.5%
Region 4	158	11.3%
Region 5	429	30.6%
Region 6	422	30.1%

- ### 2011 Adult Consumer Survey (cont.)
- Age:
 - 19-24 years : 128 (9.3%)
 - 25-44 years : 630 (45.9%)
 - 45-64 years : 562 (40.9%)
 - 65+ years : 53 (3.9%)
 - Gender:
 - Male: 675 (48.1%)
 - Female: 729 (51.9%)

- ### 2011 Adult Consumer Survey (cont.)
- Race:
 - White: 1180 (84.1%)
 - Non-White: 106 (7.5%)
 - Multi-racial: 39 (2.8%)
 - Ethnicity:
 - Hispanic: 83 (5.9%)
 - Non-Hispanic: 1304 (92.9%)



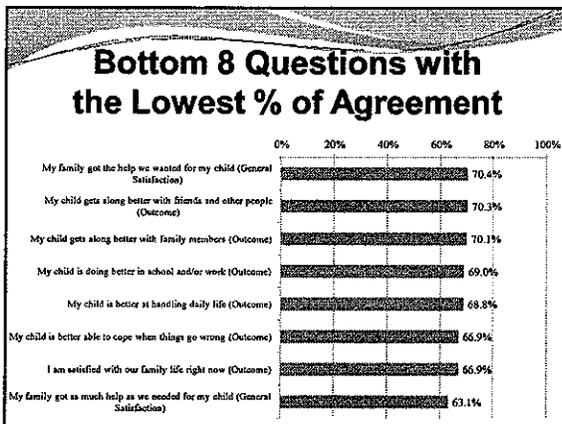
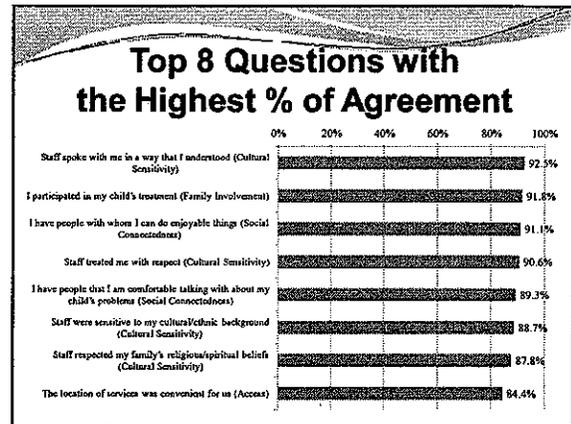
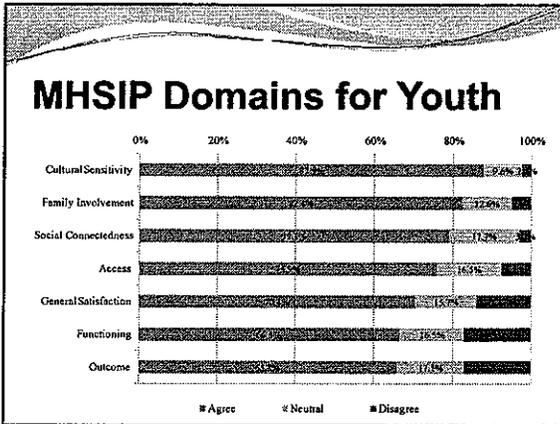


2011 Youth Consumer Survey

- # of youth survey contacts were made: 243
- # of adult surveys were completed: 161
- Age:
 - <6 years: 1 (0.6%)
 - 6-9 years: 13 (8.1%)
 - 10-14 years: 51 (31.7%)
 - 15-18 years: 88 (54.7%)
- Gender:
 - Boy: 102 (63.4%)
 - Girl: 59 (36.6%)

2011 Youth Consumer Survey (cont.)

- Race:
 - White: 127 (78.9%)
 - Non-White: 24 (14.9%)
 - Multi-racial: 10 (6.2%)
- Ethnicity:
 - Hispanic: 41 (25.6%)
 - Non-Hispanic: 119 (74.4%)



- ### The 2012 Consumer Survey
- 2012:
 - Consumer Survey Requirements
 - DBH prepared these requirements for consideration by qualified survey operations
 - College of Public Health at the University of Nebraska Medical Center (UNMC)
 - University of Nebraska-Lincoln – Department of Sociology – Bureau of Sociological Research (UNL)
 - Officially given to UNMC and UNL on October 5, 2011
 - Bids were received, reviewed and the 2012 vendor was selected – UNMC
 - 2012 survey field period will run mid-February through May
 - Basic report expected in July 2012

Thank you!

Questions?
Comment?
Feedback?

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