

Nebraska's Children's Mental Health and Substance Abuse State Infrastructure Grant (SIG)

STEERING COMMITTEE MEETING

Thursday, February 15, 2007—10:00-2:00 (Working Lunch Provided)

Garrat Room, Cornhusker Hotel—333 S. 13th Street, Lincoln (474-7474)

➤ **10:00—Start Up :**

▪ Welcome & roll call to establish a meeting quorum

➤ Call to order: 10:09 a.m.

➤ Members Present:

Kathy Anderson

Beth Baxter

Ellen Brokofsky

Linda Bucher

John Clark

Pat Connell

Elizabeth Dugger

Jerry Easterday

Brandon Fletcher

Gary Henrie

Kathy Kelley

Candy Kennedy

Michelle Marsh

Todd Reckling

➤ Quorum reached.

➤ Others in Attendance:

John Ferrone

Janice Walker

Joe Wright

Mary Jo Pankoke

Sue Adams

Denise Bulling

David Cygan

Mark DeKraai

Richard Mettler

Pat Lopez

Ken Gallagher

JoAnn Schaefer

Harriet Lambrecht

Leslie Byers

Mike Epstein

➤ **10:05 - Updates:**

▪ Developments within the HHSS as related to SIG

➤ **10:10 - Briefing:**

➤ **SIG priorities & goals** (Materials: SIG Purpose – Goals Graphic; SIG Work Team Recommendations)

➤ We will review the previously approved recommendations and provide updates on the progress of those recommendations. The worksheets are available on the website.

➤ The first time this [steering] committee met was in August-05, and formed the 5 committees. The recommendations from these committees were approved in March. The finance and organizational teams were formed after that, and they worked together to form recommendations, which were approved at the last meeting. These are the 10 goals / recommendations that were approved. Each member should have a copy of these, but it is available on the site. We are working on implementing those strategies now.

- **Phase I Strategies** (Materials: Progress on Nebraska's Child & Adolescent Mental Health Substance Abuse SIG Phase I Strategies; PowerPoint handout on Nebraska Perinatal depression project; Marketing recommendations & results)
- **Overview of Perinatal Depression Project – Early Childhood Education Committee; Paula Eurek and Sue Huffman, Program Manager for Perinatal Mental Health within HHS.**
 - About the time the SIG was funded, we also received a grant from HRSA for a one year grant, congressionally mandated funding to pre-screen women for perinatal depression. Nebraska was one of 5 states in 2005 to receive funding from HRSA for this grant that ends 05/07.
 - Identify because of its relationship between perinatal depression and child development.
 - We are getting very close to the end of the 2nd year period, which ends in May. We are almost ready to deliver a number of products related to Perinatal depression.
 - Project coincides with the priorities laid out by the Early Childhood Committee.17.25
 - Perinatal refers to the time during pregnancy and up to 12 months after giving birth. To begin the project, a Steering committee and four workgroups met for the duration of this time that made recommendations.
 - Last spring we delivered a competitive RFP. The first component, provider education, received \$80K was given to Nebraska Nurses and they adapted an interactive curriculum online.
 - On the HHS website and will be interactive and available for CEUs.
 - We conducted several interviews with women and their families 18-45 years old. Snitley-Carr wrote a report for us on what they found out from doing these interviews and focus groups, so we could develop recommendations.
 - Mothers have trouble finding resources to help them with the way we are feeling. Perinatal depression has a negative connotation.
 - Snitley-Carr then created recommendations including:
 - using case studies to relate to women
 - develop a consistent message
 - develop a newsletter
 - develop and support local support groups; women to other women
 - create a speakers bureau
 - education providers on importance of diagnosis
 - Create training programs.
 - We have created brochures, posters, fliers, PSAs, and more in English and Spanish; developing an exhibit for women and their families like the Women's health symposium; website for women and families that will have information like treatment options, strategies, stories from other women, symptoms, and a section for families to support women. We will utilize our Title V, 1-800 numbers and have a contract with Methodist in Omaha where nurses will answer the phones.

- We are getting providers talking to each other, but we will compile the results and hopefully will be able to present at the next meeting to talk about social / emotional development. HHS will continue to develop their website.
- **Pat Lopez, Update**
 - We will be working with community groups on a quick-screening process; this process was approved in the SIG recommendations. This would be the piece with which SIG can help.
 - Early childhood screening, well-child checks, EPSTD
 - SIG has contracted with the Nebraska Medical Association to gain input on this.
 - Mark DeKraai and Todd Glover will be going in on some of these focus groups
 - Dr. Marsh and Jerry Easterday will be doing some curriculum review to get something developed into the infrastructure.
 - We will be working with providers / caregivers to be able to speak up to parents. WE will continue to build on the contacts and that information and work with perinatal depression. We will add some more highlights to this and email it out. The next logical step is to do more research.
- **David Cygan, with Medicaid** – Update on project with Medicaid, NMA, SIG, Magellan, which is an outgrowth of a Medicaid reform program involving a number of people.
 - Original project that started was looking at isotropic, multiple prescriptions from the same or multiple prescribers.
 - Sent letters to practitioners writing prescriptions for anti-psychotic drugs for multiples, etc. The criterion was use of anti-depressants, anti-psychotics, and anti-stimulants for children under 4 years of age.
 - We will be outreaching children across the state of Nebraska who show up in our Med Stat database.
 - The first steps will be letters then phone calls. We will provide support to these practitioners. We will collect data back to make sure that the rate is declining.
 - One thing of importance was to establish a best practice, which is one of our goals. We also noticed the psychotropic medication spending in our budget, so this seems like a good idea to go ahead and act on it and get some results in.
- **Betty Meninger - Mental Health Force / Positive Behavioral Supports**
 - NE is 7th lowest in the nation on unemployment.
 - The logic is that we need to work together with caregivers using training, coaching, intervention, support, etc. – not just training.
 - Putting together various funding streams to provide for training and do the frontline work.
 - Need SIG to bring in “train the trainers” and help with evaluation.

- Using the expertise of other organizations like Head Start, Early Childhood Education Center, etc. The DOE has been doing this with school-age care, but we wish the kids were getting this earlier on.
- SIG is helping with the Positive Behavioral Supports in early childhood training and evaluation. More information is on the HHS website under childcare.
- **Academic Group update, Mark DeKraai**
 - We have expanding the academic committee to get some more input. Our group is up to about 20 and includes family and providers.
 - We have also expanded by having Kate go out and do focus groups.
 - We are asking providers what the barriers are to getting to implementing evidence based practices.
 - We think APA is a good method for NE because it identifies the 5 tiers of evidence based practices.
 - The database at Hawaii has been developed with multiple coders, coding ability, and tons of data. We are figuring out how to identify this in Nebraska.
 - We will be doing a couple of national presentations on EBP. This will include JMATE, where we have several people presenting.
 - Implementing a nominating process – it's not just what the research says nationally.
 - **Data Work Group, Ken Gallagher**
 - Taking input from a number of different perspectives, NE collects mounds of data. We are pulling from that what relates to children's mental health.
 - We will modify the outcomes from SAMSHA as a way of collecting unified systems of care for our measures.
 - **Youth Committee Update, Mark DeKraai.**
 - John Ferrone will be working to provide technical assistant to the family organizations.
 - Ken Gallagher will be analyzing the data from the various focus groups that we are doing with Kate Speck.
 - **Family Centered Practice**
 - Held the Family Centered Practice Conference and looked at policies and procedures with Medicaid and Behavioral Health
 - The core continuum of services will incorporate in the pilot projects.
 - Bring in juvenile justice to this system of care. We are trying to work at the local level to ensure that we aren't duplicating services, etc.

Phase II Strategies

- **Update from the Organizational Work Team**
 - Materials: Proposal for Organizational Structures at The State, Regional, and Local Levels
- **Update from the Finance Work Team**
 - Materials: Organizational Structures and Financing Models; State Initiatives Relevant to Nebraska's Children's Mental Health and Substance Abuse SIG Project; Proposed Charge to the SIG Organizational Structure and Finance Work Teams

- Finance groups talk about proposals and protocols. These sheets should be a refresher as this information came back to the steering committee and the steering committee formed 10 recommendations from them.
 - Need to move forward on the steps, such as if we had a pilot project to test some of these, what those would look like.
 - Proposed Charge to SIG organization Structure and Finance Work team sheet.
 - SAMSHA will be asking the state to move away from restricted levels of care to more community levels of care
 - Want to look at cross funding streams, so that you can look at data across a state through cross funding.
 - We want to make sure that everyone has geographic, cultural, and financial access to services.
 - Increasing the use of EBPs without sacrificing the choice of families and individualization of care
 - Create stable living environments for children.
 - Better reach to special populations like young children and transition-age youth or difficult to serve.
- We want to make sure we're coordinating across groups and teams.
 - We'd like to create a cross-system so orgs can share information.
 - We also want to make sure that care is individualized while integrating systems.
 - Braided / coordinated funding – we have been looking at this from other states such as performance based funding, incentive funding, etc. Incentive based funding. Lastly, we want to look at integrated system structure to communicate cross-agency to get agencies to work together.
- **Update from Dr. JoAnn Schaffer**
 - The governor's reorganization bill came to the floor today, which will have some impact, but hopefully not a lot, on the organizational structure. We will hopefully continue to see improvements. It is my understanding that children's mental health will still be in behavioral health, but will require tremendous integration with Medicaid, etc. This, of course, doesn't come as a big surprise. The bill will hopefully be coming out again next week and will go through with an emergency clause to get this going on July 1. It's been difficult to get this going and keep it afloat.
 - Scot Adams will start on March 1.
 - We are still looking for Dick Nelson's replacement, but right now, it's Chris Peterson and I doing a show that's usually 7-8 people. Your patience and understanding is appreciated during this time as this is very important.
 - We want to separate out children and family services so it gets its own director so it gets its own focus, as it is difficult for someone to be spread so thin. Services have quite a bit of the share, and we want to spread that out. It's hard to see from the outside, but many programs overlap and it would be better to have a supervisor / coordinator for each program and divide out the programs, but still have one CEO up top. I think it's a great thing.
- *Break into small groups: Organizational Structure and Finance Work Teams*
 - **Organizational work group break out session:**

- The first goal:
 - I. Have a common screening / assessment process.
 - a. Stakeholders need to be involved at interagency level.
 - b. Screening needs to be brief
 - c. Expertise needs to be available.
 - II. Array of EBPs
 - a. Reward what is good.
 - b. We know there are services that won't be supported by this funding, so we need to decide how, organizationally, we can support these projects.
 - i. Need to base on a popular need.
 - III. Access and Portability of the information
 - a. Data portability: records
 - b. Improved access
 - c. Family centered practice
 - d. People need to get help at the time that they need it. (timely help) (the right kind of help at the right time)
 - e. Measurable outcomes
 - f. Use pre-existing infrastructure
 - g. Plan for human resources.
 - h. Let's say that in general, we want infrastructure and organizational structure around the family / child, that it's clear, accessible, and portable.

Group reconvenes at 1:45 p.m., reports to be presented on outcomes of the break out session.

❖ **Organizational Structure:**

The major things we were talking about are:

1. Access to services
2. Family centered
3. Use existing structure (like expanding an assisted living facility)
4. Standardization of data, measure and assessments
5. Portability of the data

❖ **Topics for next meeting:**

- Law enforcement training and mental health
- Braided Funding

Adjourn, 2:00 PM. Next Meeting, April 19.

SIG Purpose – Goals Graphic

Nebraska's Children's Mental Health and Substance Abuse State Infrastructure Grant

Purpose

Develop infrastructure for a system of mental health and substance abuse care at the state, regional and local levels

Goals

Support evidence-based interventions

Ensure cultural competence and family-centered approaches at all levels

Integrate across child and family serving agencies

Committee Charters

Steering Committee: set priorities, identify focus areas, establish subcommittees, coordinate and oversee the work of the subcommittees, and prepare final recommendations to further SIG goals

Youth Subcommittee: Develop state infrastructure needed to support community efforts to meet mental health and substance abuse needs of youth and their families.
Recommendations approved 2/27/06

Early Childhood Subcommittee: Develop state infrastructure needed to address the mental health needs of young children (ages 0-5) and their families
Recommendations approved 2/27/06

Academic Subcommittee: Promote the use of evidence-based practices and provide a forum for researchers, policy makers, consumers and service providers to plan and conduct relevant, collaborative research

Finance Work Team: Develop state and regional financing structures to support local systems of care for children with mental health and substance abuse issues and their families.

Organizational Structure Work Team: Develop state and regional organizational structures to support local systems of care for children with mental health and substance abuse issues and their families

Priorities

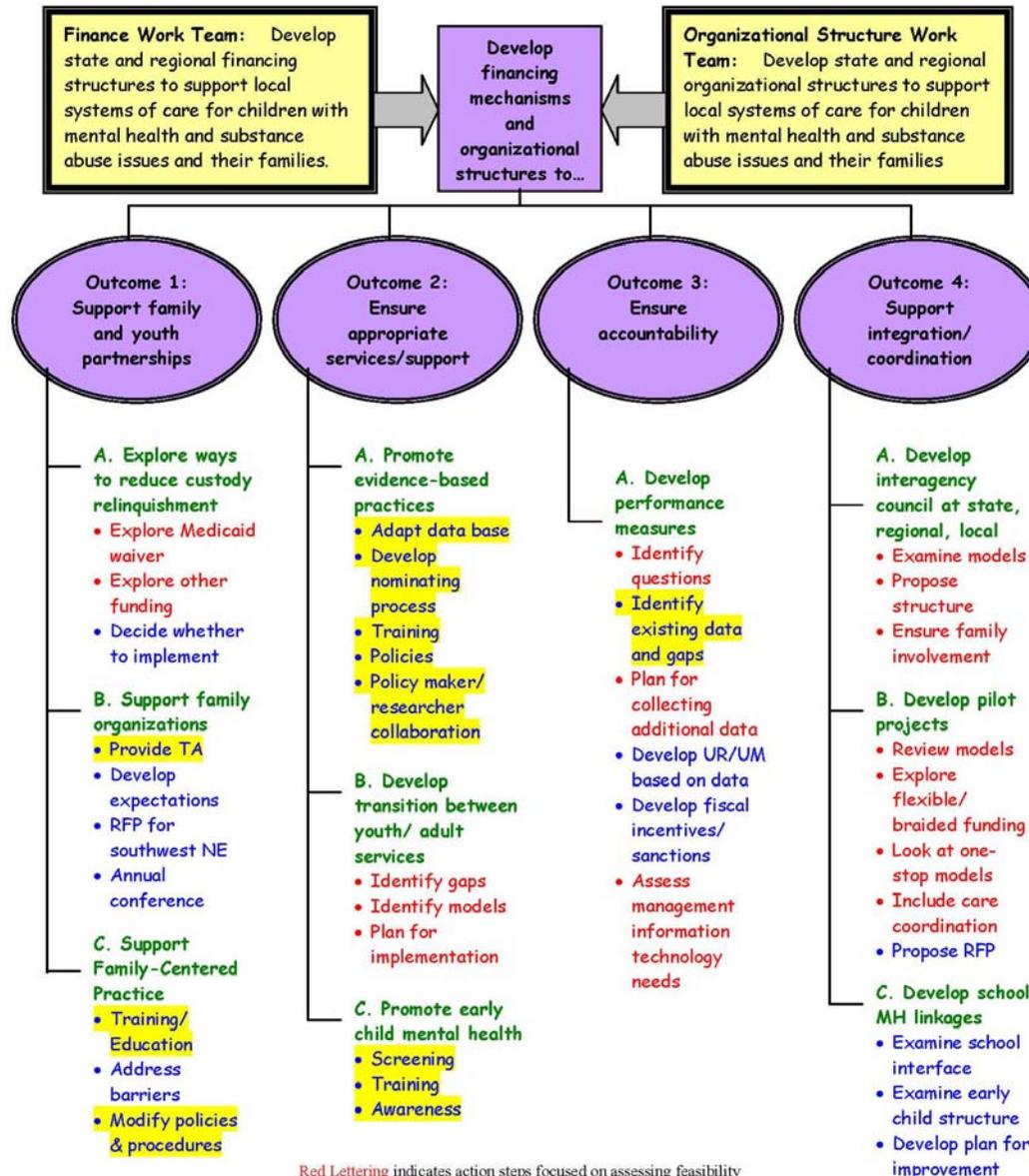
Develop financing mechanisms and organizational structures to ...

- 1support family and youth partnerships
- 2ensure appropriate services and supports
- 3ensure accountability
- 4support realignment/integration

SIG Work Team Recommendations

SIG Finance and Organizational Structure Work Team Recommendations

Red = assess feasibility
Highlight = work in progress



Red Lettering indicates action steps focused on assessing feasibility
Highlighting indicates work already in progress

Charge to SIG Organizational Structure and Finance Work Teams

Develop specifications for integrated/coordinated structures and financing mechanisms to achieve the following outcomes:

- Reduce number of youth in RTCs/psychiatric inpatient
- Reduce number of youth becoming state wards
- Improve child and family outcomes
- Improve access to services
- Improve cost effectiveness
- Increase use of evidence-based practices
- Improve school attendance
- Reduce juvenile justice involvement
- Increase stability in living situations
- Improve coordination across services and systems
- Improved service delivery for special populations
 - Young children
 - Transition-aged youth
 - Low functioning
 - Difficult to serve (sex offender, aggressive youth)
 - Co-occurring disorders

Propose specifications for pilot projects that would have:

I. Common Screening/Assessment Processes

- A. Early childhood mental health screening
- B. Maternal depression screening
- C. Youth screening and assessment
 - 1. Substance abuse
 - 2. Mental Health

II. Array of Evidence-Based Practices

- A. Mobile Crisis Team
- B. Multisystemic Therapy
- C. Others (Multi-dimensional Treatment Foster Care, Functional Family Therapy)
- D. Transition Services – promising practices

III. Integrated Care Coordination

- A. One care coordinator
- B. One plan of care meeting requirements of multiple systems
- C. One intake form
- D. No wrong door
- E. Family-centered care approach

IV. Integrated information management

- A. Exchange of information
- B. Defined and measured outcomes
- C. Quality improvement process
- D. Accountability

V. Braided/Coordinated Funding

- A. Funding streams (Behavioral Health, Medicaid, Protection & Safety, etc.)
- B. Mechanisms for coordinating

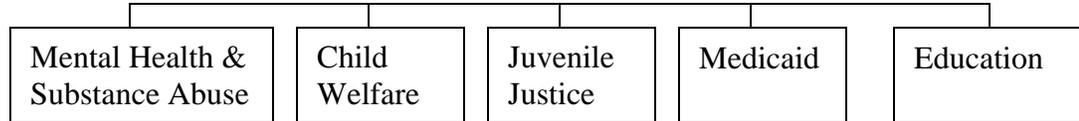
VI. Integrated System Structure

- A. Establish local interagency structure
- B. Identify participants (Mental Health, Substance Abuse, Protection and Safety, Health, Schools, Voc Rehab, Probation, Law Enforcement, Families/Youth, Service Providers, etc.)
- C. Functions (needs assessment, planning, system evaluation, utilization review, financing, information and referral, strategic communications, etc.)

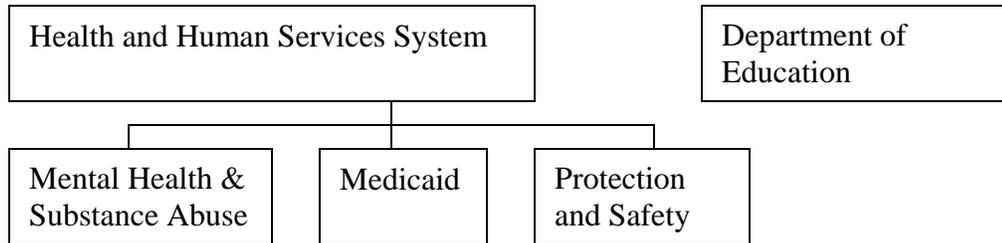
Organizational Structures and Financing Models

1. State Agency Structures

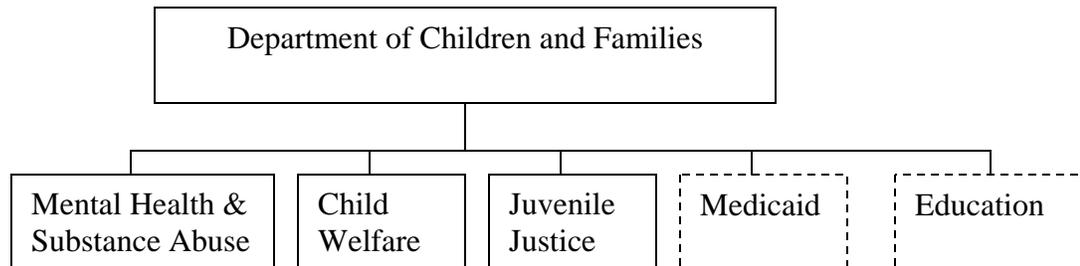
A. Separate Agencies (e.g., Nebraska before 1997):



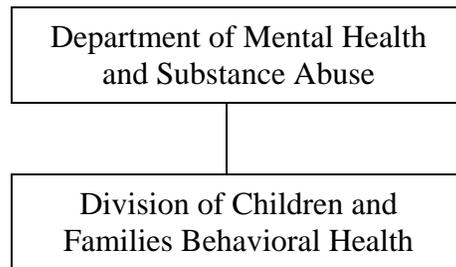
B. Separate Divisions within Single Agency or System (Partial NE Model)



C. Single Child-Service Agency (e.g., Florida)



D. Behavioral Health Agency with Children's Division (e.g., Missouri)

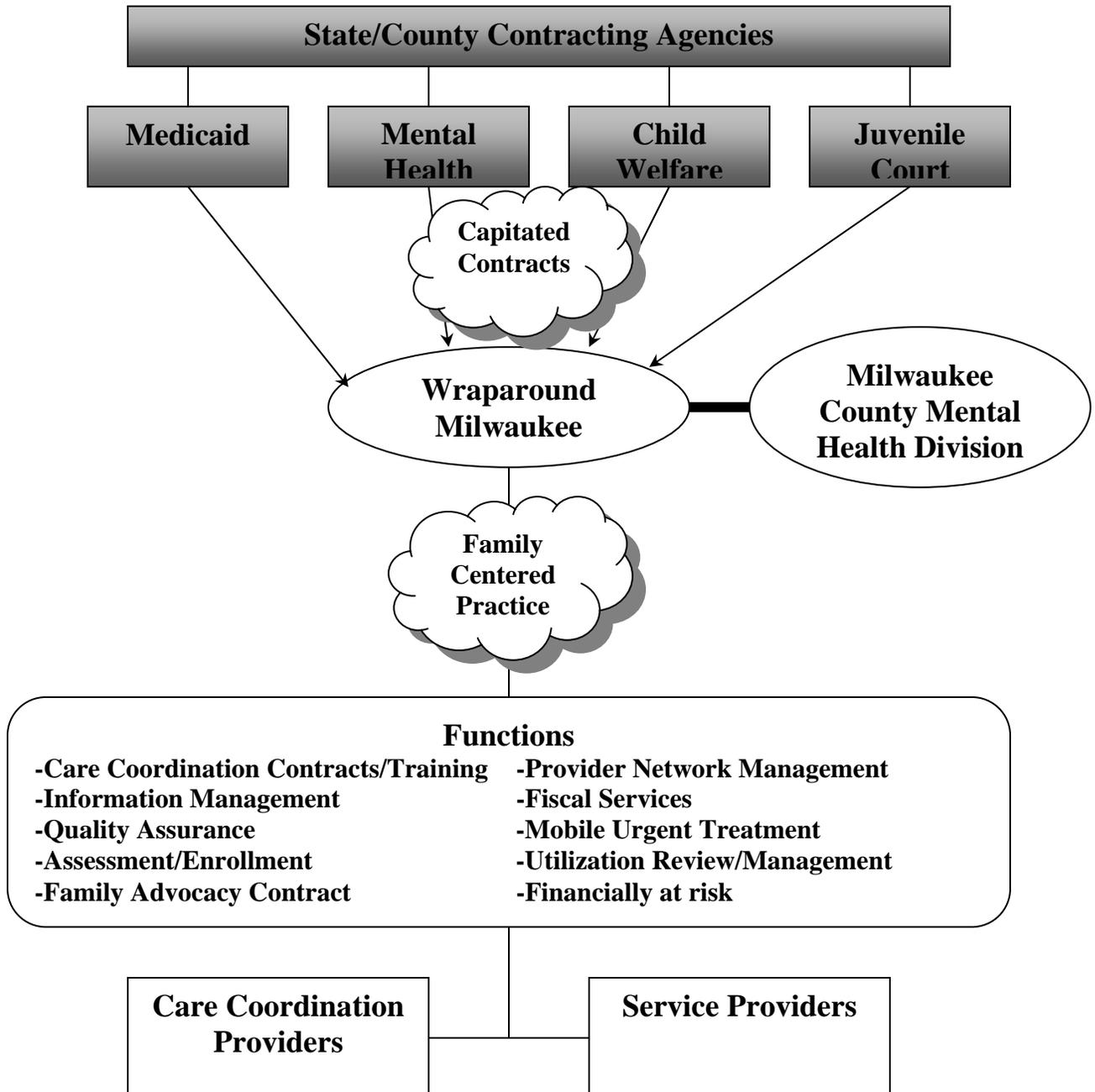


2. Use of Managed Care Structures

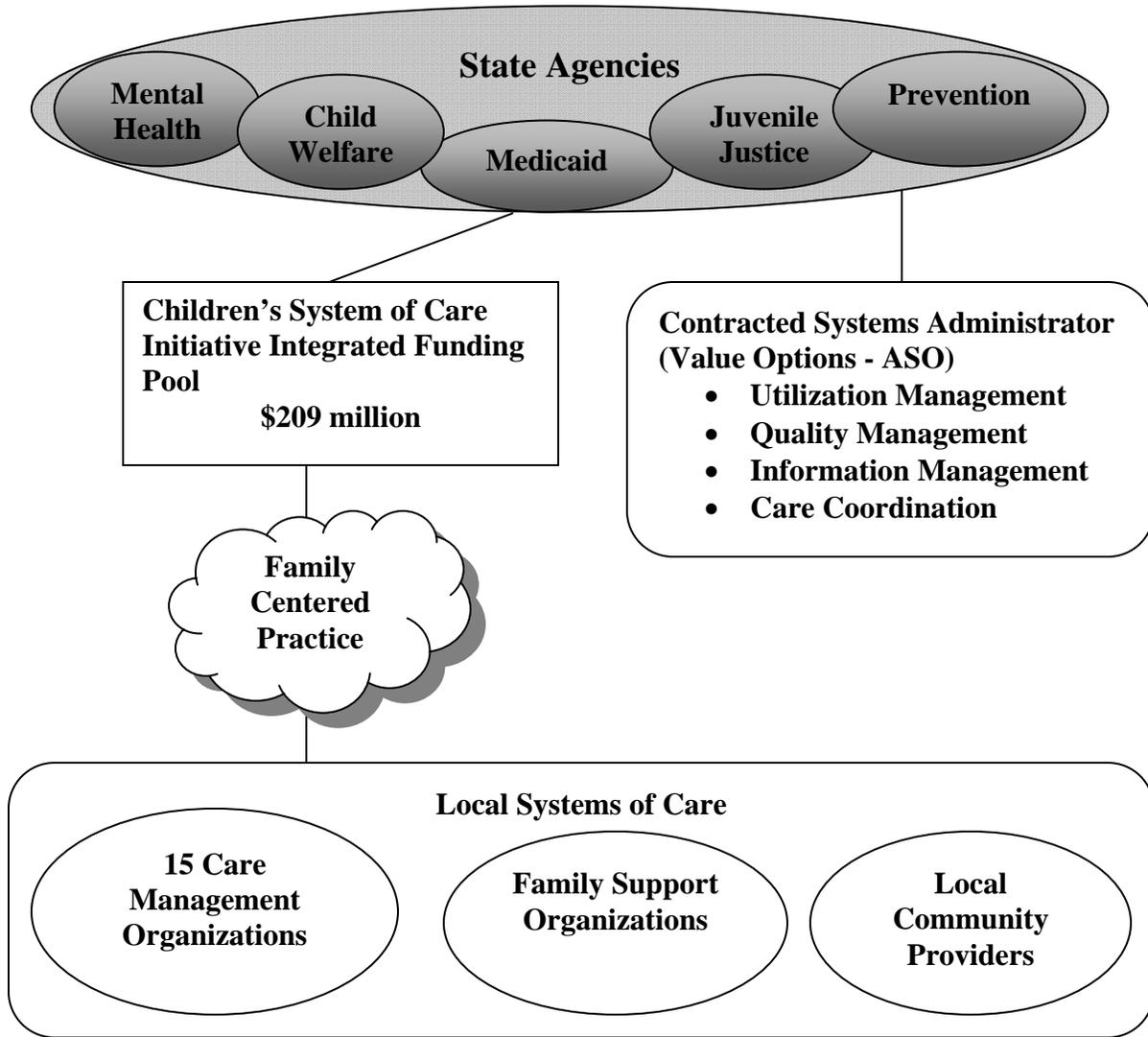
- A. Managed Care Organization vs. Administrative Services Organization
- B. Statewide Organization vs. Multiple Regional Organizations
- C. Multi-Agency Purchasing Authority vs. Single Agency
- D. Public Organization vs. Private Organization

Examples:

Wraparound Milwaukee: Regional, Public, Single-agency Managed Care Organization



New Jersey: Statewide, Private, Multi-agency, Administrative Services Organization



3. Financing Strategies to Support Family-Centered Practice and Systems of Care

- A. Braided Funding – e.g., New Jersey
- B. Maximize Use of Federal funding
 - a. Medicaid Waivers – e.g., Kansas Home and Community-Based Waiver
 - b. Title IV E Waivers – e.g., California
- C. Aligning funding with systems of care and family-centered practice – e.g., Vermont
- D. Aligning funding with evidence-based practices – e.g., Oregon, Hawaii
- E. Collaboration between public and private funders (foundations, private insurers, businesses) – e.g., San Diego, California
- F. Managed Care Contracting – e.g., Dawn Project, Indiana
- G. Outcome-based or performance-based funding – e.g., Texas

4. State-Level Interagency Coordinating Structures

Examples:

Minnesota

Interagency Structure: Cross-agency planning led by Mental Health including decision makers, consumers/families/advocates, health plans, hospitals, providers, professional associations, health system, universities

- Payment
- Legislation
- Outcomes/Performance
- Care Coordination/Access
- Co-location/Integration of service delivery
- Consumer Involvement

Missouri

Interagency Structure: Statutory mandated state interagency comprehensive children's mental health service system team. Membership includes:

- Family-run organizations and family members
- Child advocate organizations
- The department of health and senior services
- The department of social services' children's division, division of youth services, and the division of medical services
- The department of elementary and secondary education
- The department of mental health's division of alcohol and drug abuse, division of mental retardation and developmental disabilities, and the division of comprehensive psychiatric services
- The department of public safety
- The office of state courts administrator
- The juvenile justice system
- Local representatives of the member organizations of the state team

Responsibilities include development of a comprehensive plan, monitoring implementation of the plan, and reporting on system outcomes.

5. Local-Level Interagency Coordinating Structures

Examples:

Vermont

Local Interagency Structures: Statutory framework for Local Interagency Teams in 12 areas – intervene when child's treatment team can't agree on coordinated service plan;

State Interagency Team provides technical assistance to Local Interagency Teams. Teams include providers, schools, state agencies and families.

Ohio

Local Interagency Structures: Focus on building interagency networks at the local level (88 Child and Family First Councils); special effort to build school-mental health and primary care-mental health relationships; focus on one child/family – one plan. Statutory basis; includes providers, families, schools and other stakeholders.

Progress on Nebraska’s Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grant Phase I Strategies

I. Academic	
A. Invite additional stakeholders to participate in future discussions and planning related to the promotion of relevant research in policy and practice.	<ul style="list-style-type: none"> • Academic Committee was expanded to include additional parents and providers. • Focus groups planned with providers and policy makers
B. Adapt national lists of reference material for evidence-based practices. Charter the Academic/ Evaluation Subcommittee along with key stakeholders to develop a summary of evidence-based practices for children’s mental health and substance abuse, adapted from national and other state standards	<ul style="list-style-type: none"> • Comprehensive review of EBP definitions. • Recommendation to adopt APA sections 12 & 15 EBP criteria • Identified national data base • Focus groups planned with providers and policy makers • National presentations • Developing white papers on EBPs (e.g., Mobile Crisis)
C. Implement a nominating process for evidence-based practice in Nebraska	<ul style="list-style-type: none"> • Subcommittee formed to refine process
D. The Steering Committee should charter a data team to create a SIG data base.	<ul style="list-style-type: none"> • Review of N-Focus / MMIS data elements completed • Review of Magellen & MedStat capabilities
II. Youth	
A. Conduct stakeholder focus groups to better understand concerns and evaluate funding opportunities.	<ul style="list-style-type: none"> • Focus groups conducted with families • Focus groups with providers conducted starting in February
B. Obtain information needed to support funding strategies through a study of the reasons youth become state wards	<ul style="list-style-type: none"> • Data fields have been mapped • Next step is collecting data from the field to fill gaps
C. Support family organizations	<ul style="list-style-type: none"> • Conduct organizational assessments of family organizations • Provide technical assistance based on organizational assessments • Provide presentations at national conferences
D. Develop standards and accountability mechanisms for family-centered care. Modify policies and regulations to reflect family-centered care. Ensure Requests for Proposals incorporate the standards for family-centered care.	<ul style="list-style-type: none"> • Statewide family-centered practice conference • Review of standards in Medicaid, P&S, BH • Determining comprehensive approach for FCP
E. Evaluate/develop intensive assessment and care coordination pilots with the intent	<ul style="list-style-type: none"> • Charter organizational structure and finance work teams to develop

to appropriately and immediately meet the needs of child and family.	specifications
F. Develop a permanent state-level structure (through MOUs, legislation, etc.) to oversee ongoing system of care development to ensure sustainability of the SIG project. Develop incentives and capacity building for communities or regions to establish interagency structures to support family-centered practice.	<ul style="list-style-type: none"> • Charter organizational structure work team to develop specifications
G. Identify the core continuum of services/supports including an assessment of the effectiveness of mobile crisis teams and feasibility of developing teams for the state of Nebraska.	<ul style="list-style-type: none"> • Including as part of pilot projects • Academic work team developing concept paper on mobile crisis
H. Access expert consultation on funding including Medicaid and ways to prevent youth from becoming state wards	<ul style="list-style-type: none"> • Background research on initiatives in other states presented to Steering Committee, Finance & Org Structure Teams; TA Calls; Can bring in experts to help with pilots
III. Early Childhood	
A. Encourage early childhood screening through well child checks	<ul style="list-style-type: none"> • Curriculum development in process through Nebraska Medical Association
B. Medication review for young children	<ul style="list-style-type: none"> • Review process for psychotropic prescriptions for young children
C. Build competency of mental health workforce to assess/treat social, emotional, and behavioral problems in young children	<ul style="list-style-type: none"> • Conduct workforce development on PBS and to evaluate the process
D. Survey mental health practitioners in the state to determine capacity for treating women for depression, social, emotional, behavioral problems and substance abuse.	<ul style="list-style-type: none"> • Focus groups and surveys conducted through Prairie Lands Addiction
E. Invest in development of marketing plan to physicians, physicians in training, and families about the importance of screening for 1) Social, emotional, and behavioral development at well child checks and 2) Perinatal Depression	<ul style="list-style-type: none"> • Through Nebraska Medical Association Contract • Collaboration / Funding event (April) for perinatal depression
F. Develop protocol for using perinatal depression “quick screen” tools. Expand training/TA to health care providers in the use of a perinatal depression screening tools	<ul style="list-style-type: none"> • Conduct through perinatal depression grant
G. Work with medical schools and residency programs in incorporating perinatal depression into programs	<ul style="list-style-type: none"> • Through Nebraska Medical Association Contract

**State Initiatives Relevant to Nebraska's Children's
Mental Health and Substance Abuse
SIG Project**

State	Finance Mechanisms	Organizational Structures	Strategies to Support Family Centered Practice	Strategies to Prevent Custody Relinquishment	Strategies to Support Evidence-Based Practice	Strategies to Support Early Childhood Mental Health
Arizona	Managed care – capitated rates	Regional Behavioral Health Authorities	State standards for FCP			
California	Title IVE Waiver		Title IVE Standards for FCP			Developed Compendium of Screening Tools
Florida		Combined State Children's Agency				
Hawaii					Data base of evidence-based practices; definition of EBPs	
Indiana	Dawn Project – single local private nonprofit agency with capitated contracts	Single community consortium	Funding streams aligned to support FCP			
Kansas	Home and Community Based Medicaid Waiver		Included FCP in Medicaid waiver			
Minnesota	Working with private insurers to standardize outcomes	State level interagency planning structure			Using Hawaii data base for training; developing outcome measures; developing centers of excellence	Statewide use of Ages and Stages
Missouri		State Interagency Legislation for Children's BH		Developed mechanism for Voluntary Placement Agreements		State-wide training on Bright Futures

New Jersey	State Pooled Funding for Children's BH	Collaborative state structure with ASO with 15 local care management orgs	FCP standards incorporated in ASO and CMO contracts			
Ohio		Statutory creation of 88 Child and Family First Councils	Focus on one child/one plan, linkage with schools			
Oregon					Statutory mandate to adopt EBPs	
Vermont	Home and Community-Based Medicaid Waiver – align funding streams to promote SOC/FCP	Legislation creating state interagency team and 12 local interagency teams	Funding streams aligned to support FCP			The first Early Childhood Mental Health System of Care Grantee
Wisconsin	Wraparound Milwaukee – single local public agency with capitated contracts	Single Community Public Authority	Funding streams aligned to support FCP			