The LEWIN GROUP

The Road to Recovery: Balancing New Adult Behavioral Health Community Supports

January 22, 2004

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I. EXECUTIVE SUMMARY

Governor Mike Johanns and Senator Jim Jensen recently unveiled a thoughtful plan to restructure Nebraska's behavioral health system. Called the Road to Recovery, the centerpiece of the plan is the development of additional community-based services to support the residents who would transition from the Hastings and Norfolk Regional Centers to the community, concomitant with the closure of the two Regional Centers.

Nebraska Health and Human Services System (HHSS) officials retained The Lewin Group (Lewin) to offer recommendations as Nebraska embarks on this laudable plan. Before highlighting our recommendations, a simple statement is in order: Lewin not only believes that the Road to Recovery is a highly principled plan that will advance the dignity and independence of the adults with severe mental illness (SMI) who now are served by the two Regional Centers, we believe that the Road to Recovery is achievable on the timeline, and for the budget, laid out by Governor Johanns and Senator Jensen.

The Road to Recovery builds on significant enhancements made to the state's support system for persons with SMI, including legislation previously enacted as Legislative Bills (LB) 692, LB 543, and LB 724.

As described in the full report, the success of the Road to Recovery depends on developing implementation strategies for each of the following:

- Appropriate and individualized behavioral health services must be identified for each individual currently in the Hastings and Norfolk Regional Centers;
- Service capacity must be established in each region of the state to provide necessary services in the communities into which the residents move;
- Service capacity in rural areas must be developed for this plan to succeed;
- Housing opportunities must be identified and/or developed in each region and community;
- Education about community living services must be available for residents, family, and friends;
- Current workers at the Hastings and Norfolk Regional Centers should be given the opportunity to participate in the delivery of community-based services;
- HHSS and the Regional Governing Boards must cooperate and coordinate, to develop resources and oversight mechanisms;
- Communities must be engaged to support the success of the initiative;
- Significant financial resources related to the Hastings and Norfolk Regional Centers must be reinvested in developing appropriate community-based services; and

- An administrative infrastructure (e.g., tracking, quality assurance, individual service planning, provider payment) must be developed to address the points above and to coordinate and monitor their implementation.

Highlighted by Governor Johanns in his recent State of the State address, the rationale behind the Road to Recovery is straightforward. In Governor Johann's words, "we have a compelling moral responsibility to see that [adults with SMI] are cared for in the least restrictive environment." The planning report that follows demonstrates that this can and should be achieved.

Nebraska has a long history of supporting seniors and persons with disabilities who wish to live more independently in the community. Lewin is confident that the Road to Recovery will take its place alongside earlier efforts as another significant milestone in serving adults with SMI.

II. INTRODUCTION

In November 2003, Governor Mike Johanns and Senator Jim Jensen, Chair of the Health and Human Services Committee of the Nebraska Legislature, announced a collaborative venture to continue Nebraska's practice of expanding community-based service options for seniors and persons with disabilities. A key component of Governor Johanns' and Senator Jensen's proposal, entitled the Road to Recovery, is the expansion of community-based services for Nebraskans with SMI. [1]

Under the Road to Recovery, the Hastings and Norfolk Regional Centers will be closed. New services and expansions to existing services will facilitate the transition of most Regional Center residents back to their homes and communities; the Road to Recovery also will offer individuals with SMI who are committed to Regional Centers enhanced opportunities to receive their services in the community.

This proposal honors a growing national movement to deinstitutionalize and develop community alternatives for persons with disabilities. Many states, including Nebraska, have offered more community-based long-term support options in response to: 1) a consumer's preference to reside and receive services in the community among his/her friends and family; 2) workforce development opportunities for working age persons with disabilities; and 3) the Supreme Court's June 1999 decision in ***L.C. v. Olmstead.***

A. Purpose

The following report is a planning document for the Road to Recovery initiative. It reflects recommendations by Lewin on a planning process to engage policymakers, consumers, families, communities, Regional Center workers, and the entire mental health stakeholder community. It is important to note that this is a planning document to present a decision-making process (including forthcoming detailed analyses); it does not purport to answer all questions that will emerge as the implementation plan is finalized over the coming months. Thus, the final plan and future Road to Recovery implementation strategy will be crafted through an inclusive process developed by the Nebraska Health and Human Services System (HHSS) and will include representatives from all facets of the Nebraska behavioral health community, including consumers and families, policy makers, providers, behavioral health professionals, and local, regional, and state staff.

This document suggests steps for closing the Hastings and Norfolk Regional Centers, a transition strategy for moving long term residents to the community, as well as methods for identifying appropriate community-based supports for the approximately 1,100 individuals who are committed to a Regional Center annually for short term reasons. Also discussed are strategies for building and sustaining the new community-based service capacity that will be needed to replace Hastings and Norfolk Regional Center services.

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[1] The U.S. Department of Health and Human Services Center for Mental Health Services (CMHS) defines persons with severe mental illness (SMI) as (1) age 18 and over and (2) who currently have, or at any time during the past year, had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. Finally, the condition has resulted in functional impairment, which substantially interferes with or limits one or more major life activities.

B. Report Structure and Methodology

In November 2003, HHSS contracted with The Lewin Group to develop a planning report to frame important considerations for Road to Recovery implementation and to suggest strategies for addressing barriers and opportunities. This resulting planning report is structured as follows:

Section III - Nebraska Behavioral Health

Section III provides a snapshot of Nebraska's current behavioral health system and recent initiatives aimed at increasing services to persons with SMI.

Section IV - Road to Recovery Concept

Section IV outlines the vision and values of the Road to Recovery and discusses what steps should be taken to ensure members of the behavioral health community (e.g., consumers and their families, service providers, behavioral health professionals, and local community leaders) have ongoing, meaningful opportunities to shape the final implementation plan for the Road to Recovery.

Section V - Road to Recovery Implementation Considerations

After providing the context for the Road to Recovery as well as a description of the proposal architects' vision, Section V discusses key considerations for Road to Recovery implementation, including strategies to: a) transition Regional Center residents into the community, as well as to reduce the demand for lengthy Regional Center stays; b) develop services consumers will need in the community to replace the current services they receive at Hastings and Norfolk Regional Centers; c) finance the Road to Recovery initiative and related economic development opportunities; and d) measure the performance of the initiative.

Section VI - Conclusion

Section VI provides a framework for developing the implementation report for the Road to Recovery over the next several months.

Most of the data contained in this report was provided to Lewin by HHSS, which provided Lewin with information on Nebraska's behavioral health service system.[2] No quantitative data were developed by Lewin staff for this report; instead, summary level information provided by HHSS was used. This information was generated by HHSS' Office of Mental Health, Substance Abuse and Addiction Services' (OMHSAAS) administrative services organization, Magellan Behavioral Health, Inc., and from the HHSS Regional Center database. Under contract with OMHSAAS, Magellan verifies clinical and financial eligibility, authorizes services, and assists OMHSAAS and the Behavioral Health Regions, described below, in reviewing and monitoring service utilization.

[2] In this report, the term "behavioral health system" encompasses mental health services for persons with SMI and substance abuse services for persons with SMI who are dually diagnosed with both a SMI and substance dependence.

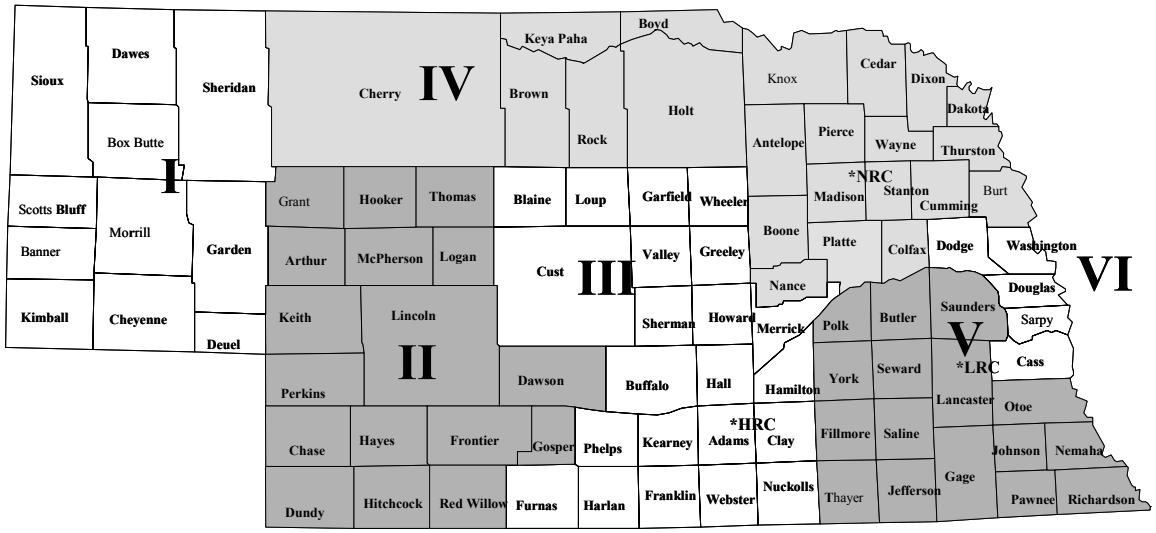
III. NEBRASKA BEHAVIORAL HEALTH

When systems change initiatives are proposed, it is important to first understand the current service system and supporting administrative infrastructure. The section below provides a brief overview of Nebraska's behavioral health system today and highlights recent efforts to enhance the service system that the Road to Recovery will build upon.

A. Background

In 1974, Nebraska enacted legislation creating a statewide regional system to coordinate and/or deliver mental health services and substance abuse services (i.e., behavioral health services), administer behavioral health programs, and operate behavioral health facilities with oversight from OMHSAAS. See Figure 1 for a map of the six regions.

Figure 1. Nebraska Behavioral Health Regions



Source: HHSS

The intervening years have seen substantial changes to the behavioral health system. Facility-based behavioral services have decreased, private hospital capacity to serve consumers has been substantially reduced and, at the same time, more effective community-based behavioral health support systems have been developed. Nationally, the number of people in public psychiatric hospitals has decreased 90 percent from a high point of over 500,000 in the mid-twentieth century to approximately 72,000 by the mid-1990's.[3] In Nebraska, the average length of stay in a Regional Center has dropped from approximately 215.7 days in state fiscal year (FY) 2000 to 159.0 days in FY 2003. At Norfolk Regional Center, the average length of stay in FY 2003 was 210.2 days.

[3] Fisher WH, Barreira PJ, Geller JL, White AW, Lincoln AK, Sudders M. "Long-Stay Patients in State Psychiatric Hospitals at the End of the 20th Century." *Psychiatric Services* 52:1051-1056, 2001.

The U.S. Department of Health and Human Services, Center for Mental Health Services (CMHS) estimates that 62,066 (5.4 percent) of the adults in Nebraska have a mental illness. CMHS also estimates that 31,033 adults in Nebraska have a severe mental illness, or SMI. Information provided by Magellan Behavioral Health, Inc. indicates that the Nebraska behavioral health system serves over 22,000 persons per year between community and institutional placements. This number breaks out as follows: in a given year, the vast majority – close to 20,000 individuals – are served in the community, without touching the Regional Centers. In addition, about 2,500 are served annually by and through the three Regional Centers (Hastings, Norfolk and Lincoln). Thus, the present community-based system provides a foundation upon which to expand and develop additional services in order to accommodate individuals leaving the Norfolk and Hastings Regional Centers.

Behavioral health services for adults with SMI are funded through a combination of state, local, and federal funds. The primary sources of federal funds are the mental health block grant, the substance abuse block grant, and federal Medicaid matching dollars. Local county governments also contribute tax funds to supplement state and federal funds.

B. Recent Service Expansion Efforts

In recent years, policymakers have taken steps to significantly enhance Nebraska's behavioral health system. In 2001, the Legislature passed LB 692 and LB 543. In these measures, lawmakers increased funding for adult behavioral health services by $3 million in state general funds as well as an additional $10.6 million in Tobacco Settlement Funds to grow community-based behavioral health services (e.g., provider rate increases, and service expansions including emergency services).

LB 692 and LB 543 resulted in an overall 17.6 percent increase in spending on behavioral health services between FY 2001 and FY 2002. For Nebraskans with mental illness, this resulted in a 14.8 percent per person increase in spending. LB 692 and LB 543 also resulted in an overall 35.7 percent increase in spending for substance abuse services between FY 2001 and FY 2002. For Nebraskans with substance abuse, this resulted in a 24 percent per person increase.[4]

C. Other Behavioral Health Community-Based Initiatives

In addition to funding increases and service expansions, Nebraska also has established two work groups aimed at increasing opportunities for persons with SMI to live and work in the community. The Nebraska Housing Coalition, formed as a partnership among OMHSAAS, HHSS Community Block Grant Staff, and the Department of Economic Development to identify housing gaps in community living for individuals with SMI, has developed a report on housing gaps for persons with SMI (i.e., "Statewide Consumer Housing Needs Study," September 2003, Hanna : Keelan Associates).

Second, Nebraska has an initiative underway among OMHSAAS, the Nebraska Office of Vocational Rehabilitation, employment supports' providers, and consumers. To date the work group has developed a Nebraska-specific report on barriers to employment for persons with

[4] FY 2002 OMHSAAS Annual Report

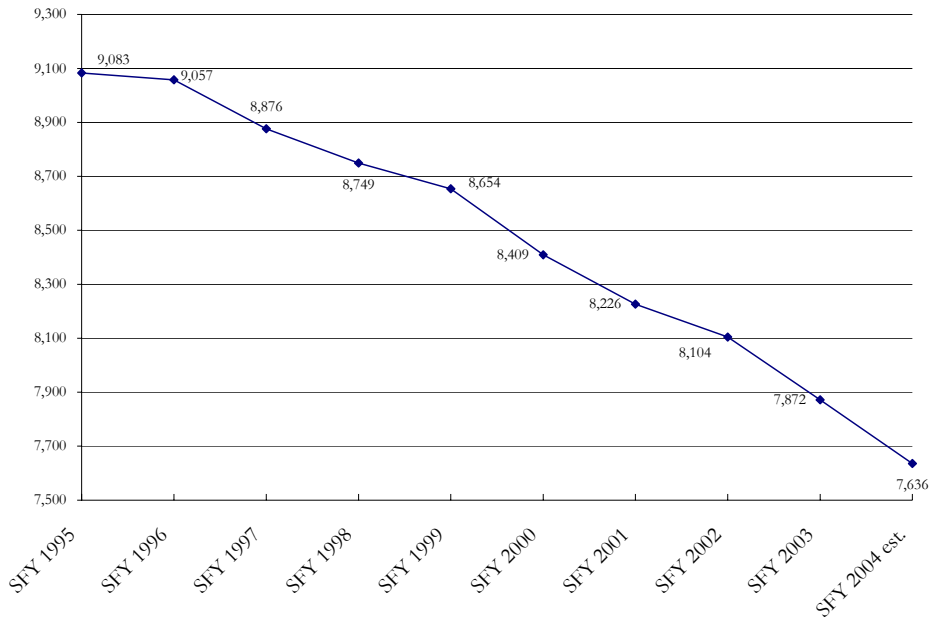
SMI (i.e., "Employment 2003," June 2003, OMHSAAS). Nebraska also is the recipient of a Medicaid Infrastructure Grant (MIG) from the Centers for Medicare and Medicaid Services (CMS) to build programs that support persons with disabilities in obtaining and retaining paid work as well as increasing their level of employment while retaining important health care coverage.

Additionally, Nebraska was one of the first states to implement a Medicaid Buy-In (MBI) program for working persons with disabilities. The MBI program enables individuals with disabilities to earn and save above the regular Medicaid financial eligibility limits while retaining Medicaid coverage for which they pay a monthly premium. MBI provides critical health care benefits that these individuals otherwise would not have access to while working. Nationally, almost 80 percent of MBI participants are persons with mental illness.[5]

D. Foundations For the Road to Recovery

Well before the ***Olmstead*** decision, HHSS demonstrated that it is possible to reduce the use of institutional services for older adults and people with disabilities. A May 1997 report, entitled "Nebraska's Long-Term Care Plan," documented the need to reduce the use of nursing facilities and to replace those services with home and community-based supports such as assisted living. The implementation of this plan resulted in a broad array of in-home and assisted living services that today serve thousands of elderly Nebraskans and persons with disabilities. As presented in Chart 1, since 1997 the average number of nursing facility residents supported by Medicaid has decreased by nearly 15 percent.

Chart 1. Nursing Facility Average Number of Medicaid Residents Per Day



Source: HHSS

[5] "Extending Medicaid to Workers with Disabilities: A Look at the Medicaid Buy-In Program." Mathematica Policy Research, Inc., October 2003.

Building on this success, as well as long standing deinstitutionalization efforts for persons with mental retardation and related developmental disabilities (MR/DD), government leaders now propose to focus on further reducing reliance on institutional services for persons with SMI. In June 2003, Governor Mike Johanns announced that "revamping the current [mental health service] system, providing more housing and treatment services in local communities" is a top priority for his administration. Senator Jim Jensen affirmed this priority and stated that he was looking for ways to provide more housing and treatment services in local communities as well as to examine the extent of the need for the state's three Regional Centers, located in Hastings, Lincoln, and Norfolk.

Additionally, both Governor Johanns and Senator Jensen participated in the development of an important measure enacted last session by the Nebraska Legislature, the "Nebraska Behavioral Health Reform Act " (LB 724). In the measure's findings, Nebraska policymakers concluded that:

- Many persons with behavioral health disorders are admitted for inpatient treatment when outpatient treatment would be a clinically appropriate and less restrictive treatment alternative;

- Separate and distinct funding and administrative mechanisms of the Regional Centers and the county regional governance system present significant barriers to statewide coordination of behavioral health services;

- The number of inpatient residents at the regional centers is significantly less than the originally designed capacity of such centers and many regional center buildings are uninhabitable or require significant expenditures of state funds for maintenance and renovation;

- The size and scope of the administrative bureaucracy in each behavioral health region has significantly expanded and each regional board both provides behavioral health services and administers state and other funds for the provision of such services; and

- Without the infusion of new funds from some source, the availability of community-based behavioral health services in the state is inadequate to meet the need for such service.

These assertions and the important behavioral health system improvements described above set the stage for another wave of significant enhancements to the state's system for supporting persons with SMI.

IV. ROAD TO RECOVERY CONCEPT

The Road to Recovery vision is built upon important values already articulated by the state's behavioral health system including: a) being consumer driven; b) providing access to needed services; c) focusing on consumer outcomes; d) providing strength-based services; e) ensuring competent staff; and f) employing a continuous improvement philosophy.

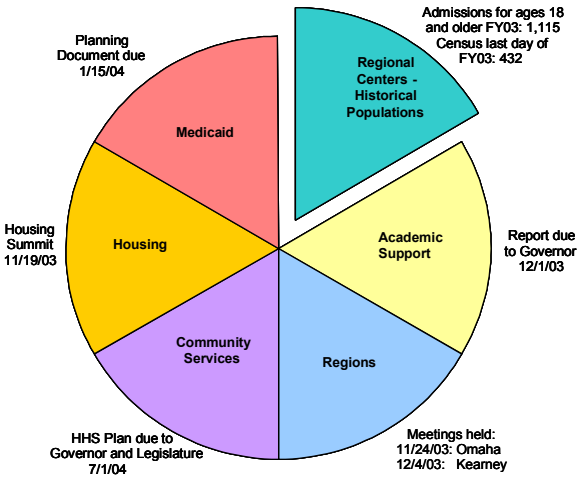
Section IV discusses the Road to Recovery genesis and its guiding principles as they build on the current behavioral health system values. It also discusses what steps will be taken to ensure members of the behavioral health community (e.g., consumers and their families, service providers, behavioral health professionals, and local community leaders) have ongoing, meaningful opportunities to shape the Road to Recovery.

A. Initiative Background

In November 2003, Governor Johanns and Senator Jensen announced the broad parameters of a plan that will build on the findings of LB 724 and reform Nebraska's service system for persons with SMI who have been committed. The desired outcome of the Road to Recovery is to enhance community-based behavioral health services for people currently committed to the state's Regional Centers.

As part of the plan to shift services to the community, the Norfolk and Hastings Regional Centers will be closed during 2005; however, the Lincoln Regional Center will remain open. Research indicates that not all consumers with SMI will succeed in the community and that, for some individuals, inpatient settings remain the most clinically appropriate setting.[6] Governor Johanns and Senator Jensen propose implementing this portion of the Road to Recovery over the next two years with significant planning efforts in the first six months of 2004. Figure 2 offers an overview of the six major components.

Figure 2. Road to Recovery Snapshot



[6] Okin RL, Borus JF, Baer L, Jones AL. "Long Term Outcomes of State Hospital Patients Discharged Into Structured Community Residential Settings." *Psychiatric Services* 1995 Jan; 46(1):73-8.

The Road to Recovery builds on past deinstitutionalization efforts and recent strides in the development of community-based behavioral health services. At the heart of the Road to Recovery are goals to reduce service system fragmentation and to concurrently increase the coordinated provision of community-based recovery and support services to persons with SMI, in all six regions throughout the state. The catalyst and funding for achieving many of these changes is the closure of the Hastings and Norfolk Regional Centers.

B. Guiding Principles

Addressing its goals of reduced fragmentation and enhanced access to coordinated community-based supports, the Road to Recovery initiative stands on four principles.

1. Individualized services

The initiative amplifies the state's trend towards providing community-based recovery services by providing non-institutional options in a person-centered fashion to the people currently being served in the Norfolk and Hastings Regional Centers.

2. Recovery focus

The initiative also recognizes that people still will need access to the full array of recovery services and that some still will need Regional Center-level services; however, research and deinstitutionalization initiatives in other states demonstrate that the vast majority can be served in the community closer to their families and friends.[7]

3. Realignment of stakeholder responsibilities

The Road to Recovery initiative recognizes that responsibilities will shift in the new service paradigm. Consumers will lead more independent lives with more autonomy and with more involvement in the direction of their community-based supports. While the roles and responsibilities of the Regional Governing Boards will remain the same, they will have larger arrays of community-based providers to develop, recruit, train, and oversee. The state ultimately is responsible for ensuring that there are adequate, high quality services for persons with SMI who currently are reliant on Regional Centers.

4. Leveraging resources

The initiative will create new resources by leveraging relationships with the University of Nebraska and Creighton University and by forging stronger partnerships among local, regional, and state behavioral health stakeholders. The Road to Recovery also will redirect capital and funds currently invested in Regional Centers into more efficient community-based services. Under the Road to Recovery, opportunities for drawing down additional federal Medicaid dollars will also be explored.

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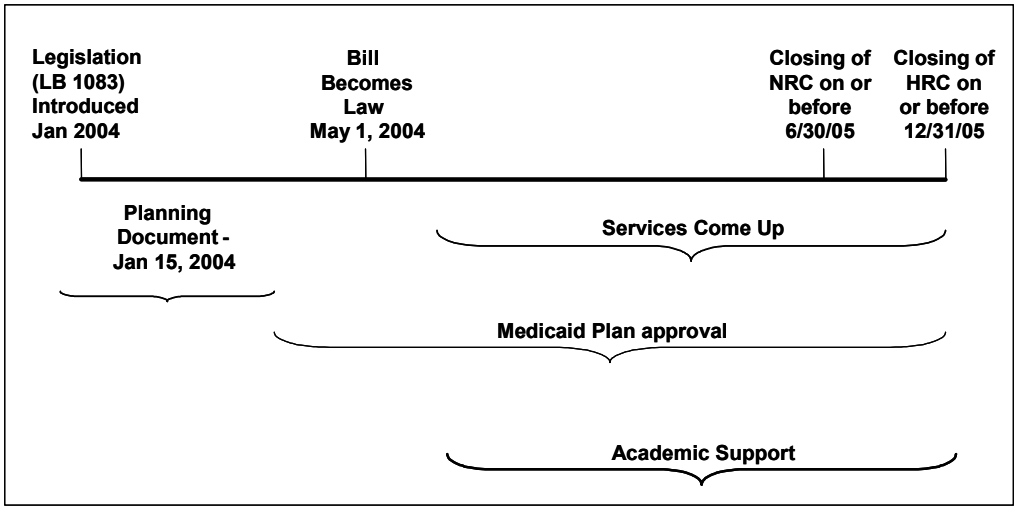
[7] Orkin RL, Pearsall D. "Patients' Perceptions of Their Quality of Life 11 Years after Discharge from a State Hospital." *Hospital and Community Psychiatry.* 1993 March; 44(3): 236-40.

C. Preliminary Timeline

As noted above, the critical issue for the Road to Recovery is ensuring that the community service capacity is able to absorb the additional demand generated by the closure of the Regional Centers in Hastings and Norfolk. The timeline for the Road to Recovery implementation (see Figure 3 below) is sequenced to ensure that roles and responsibilities have shifted before the Hastings and Norfolk Regional Centers are closed. As consumers transition from Hastings and Norfolk to alternative settings across the state, officials also will need to ensure that financial and staffing resources are redistributed statewide; HHSS and the Regional Governing Boards jointly must bear this responsibility.

Figure 3. Road to Recovery Timeline



Prepared by HHSS

A number of considerations must be taken into account in the next few months as the implementation plan is finalized. These issues will be addressed in a subsequent, more detailed report describing the Road to Recovery implementation plan (see Section VI). Briefly, some key points include:

- Appropriate and individualized behavioral health services must be identified for each individual currently in the Hastings and Norfolk Regional Centers;
- Service capacity must be established in each region of the state to provide necessary services in the communities into which the residents move;
- Service capacity in rural areas must be developed for this plan to succeed;
- Housing opportunities must be identified and/or developed in each region and community;
- Education about community living services must be available for residents, family, and friends;

- Current workers at the Hastings and Norfolk Regional Centers should be given the opportunity to participate in the delivery of community-based services;

- HHSS and the Regional Governing Boards must cooperate and coordinate, to develop resources and oversight mechanisms;

- Communities must be engaged to support the success of the initiative;

- Significant financial resources related to the Hastings and Norfolk Regional Centers must be reinvested in developing appropriate community-based services; and

- An administrative infrastructure (e.g., tracking, quality assurance, individual service planning, provider payment) must be developed to address the points above and to coordinate and monitor their implementation.

HHSS will have to develop final dates for ceasing new admissions to Hastings and Norfolk, determine how to minimize operating expenses there, and optimally utilize Regional Center resources during the downsizing process. Steps also must be taken to ensure sufficient staffing at the Regional Centers as the number of residents begins to diminish.

All of this work will require significant cooperation and coordination among many state and local government entities as well as families, consumers, and private organizations. Concurrent with the steps above, HHSS also will need to enhance crisis team capacity and establish new operating procedures for behavioral health services to support individuals who might experience psychiatric distress as they move into more integrated community settings. Crisis teams might also be called upon to provide more intensive services or short-term stabilization services as former Regional Center residents return to their homes and communities.

D. Ensuring Stakeholder Input

An important consideration when planning a systems change initiative like the Road to Recovery is a plan to communicate with affected individuals and communities. Important elements of such a plan for stakeholder participation include strategies to inform people and communities about proposed changes, provide opportunities for them to participate in the change process, and create opportunities for stakeholders to provide feedback on the changes once implemented.

Key stakeholders for the Road to Recovery include consumers and family members both in Regional Centers and those currently being served in the community, Regional Center staff and community-based service providers, behavioral health professionals, representatives of local governments, and Regional Governing Boards. For stakeholders to meaningfully participate in the Road to Recovery initiative, ample information on the proposal and concepts must be shared in a user-friendly form for lay-persons. These efforts, while often time consuming, are imperative to facilitate a broader coalition for Road to Recovery development and to ensure inclusion of valuable stakeholder perspectives. HHSS and the Regional Governing Boards must plan and coordinate these efforts collaboratively.

1. Ongoing Public Meetings

People and communities directly impacted by closure of Hastings and Norfolk must continue to be informed and engaged in a dialogue about the Road to Recovery vision and goals before implementation planning is finalized. Regional Governing Boards must continue to organize ongoing public meetings among stakeholder groups to provide background information on the Road to Recovery, including why the state is pursuing the initiative and preliminary ideas about the process. At these meetings, state and local officials will continue to receive valuable information about potential barriers and challenges as well as identify opportunities and resources for Road to Recovery implementation.

There should be additional meetings for specific stakeholder groups, including at least one meeting for current Regional Center consumers and their families, at least one for Regional Center staff, at least one for local and regional officials, and at least one for general communities. Meeting proceedings should be recorded and synthesized into recommendations. At these meetings, HHSS also must solicit participation in regional work groups on local Road to Recovery efforts.

2. Ongoing Participation

As stakeholders continue to be educated about the initiative concept and their participation has been secured, HHSS officials should embark on crafting strategies to operationalize the Road to Recovery. Simultaneously, strategies must be developed to ensure ongoing stakeholder participation; these will include regional representatives' participation in Road to Recovery advisory groups or work groups, a Road to Recovery website with the capacity to receive comments from community members and to provide reports to HHSS staff summarizing comments, and regularly scheduled update meetings on the initiative to keep stakeholders abreast of developments. These events and media should be tailored to specific groups including providers, consumers, and families.

3. Public Information

Once an implementation plan for the Road to Recovery has been finalized, HHSS should craft a public information campaign articulating the initiative's mission, desired outcomes, and the opportunities it creates for local communities. A carefully planned public information campaign will ensure message consistency and reduce misinformation about the Hastings and Norfolk Regional Center closures as well as community-based expansions. An effective public outreach campaign also will help to attract new community-based providers, housing providers, and individuals interested in being direct support professionals.

The inclusive community planning concepts described above and other avenues of communication will help to demystify the Road to Recovery plan and development process, increase trust among stakeholders, and likely reduce concerns about the initiative. Finally, stakeholders who will participate in these events are among the experts on Nebraska's behavioral health system; they will provide invaluable insights on how the Road to Recovery should be framed and implemented. Their input must be taken into account.

V. ROAD TO RECOVERY IMPLEMENTATION

In the preceding sections, the foundations of Nebraska's behavioral health system have been summarized as well as how the Road to Recovery complements this foundation and fits with recent systems changes and improvements.

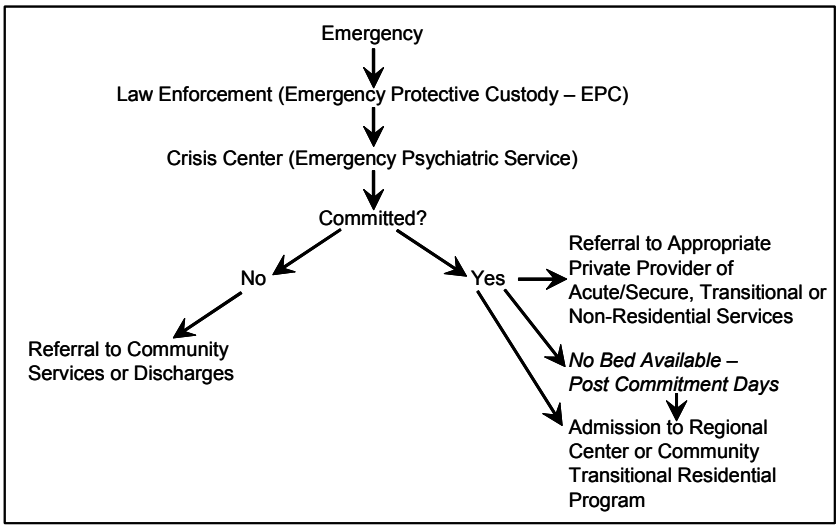
Section V provides an overview of key considerations for Road to Recovery implementation including: a) how persons with SMI will access community-based services that replace Hastings and Norfolk Regional Center services; b) what services currently are available in the community and what will be needed to support persons with SMI leaving the Hastings and Norfolk Regional Centers; c) Road to Recovery goals, indicators of progress and a system for measuring progress; and d) strategies for financially sustaining the Road to Recovery (as well as the financial implications for the state and localities).

A. Accessing Services on the Road to Recovery

Of key concern for Road to Recovery implementation is service provision to the approximately 1,100 individuals who are committed to the Regional Centers annually. Typically, these are individuals who find themselves in a psychiatric crisis or emergency and are moved through the committal process for inpatient placement and stabilization services. For some individuals, inpatient stays and committal may be necessary to ensure their safety and stabilization while others might be able to return to their homes with only modifications to their service plans.

To explore the probability of safe and healthy returns to the community, HHSS should introduce additional reviews by a consumer's interdisciplinary team (e.g., family members, mental health professionals, case manager, and crisis intervention team members). Reviews should be conducted at regularly scheduled intervals over the course of inpatient stays for committed consumers. See Figure 4 for a consumer intake flow chart under the current service model.

Figure 4. Behavioral Health Consumer – Simplified Current Involuntary Consumer Flow



Source: HHSS

For a complete discussion of the services noted in Figure 4, see subsection "B," entitled "Community Capacity," below.

In addition to the increased number of consumer reviews, HHSS should continue its detailed consumer-specific planning to ensure that individuals are appropriately placed and that community supports are identified, available, and accessed. If a consumer requires acute or secure residential services, there must be strategies to regularly evaluate potential discharge into the community or into a less restrictive service setting.

Below are key considerations for transitioning the current residents of Hastings and Norfolk Regional Centers into community settings. These consumer transition activities should occur through the joint efforts of interdisciplinary teams (IDT) comprised of staff from HHSS, Regional Centers, HHSS managed care program staff, Regional Governing Board representatives, and community-based providers. Before individuals can transition from the Regional Centers to the community, each consumer will need an in-depth assessment to identify his or her community-based behavioral health needs. Assessments will involve consumers, family, and friends (where appropriate) as well as an IDT.

Based on these assessments, a formal service plan should be developed to describe the array of behavioral health services as well as non-medical supports needed for safe and healthy community living. Again, the plan should be developed by the IDT including the individual, family, and friends. Once the individualized services have been identified, the consumer should be asked about their preference for a service provider. To the extent possible and practical, an individual's preferences must be honored. This may be an initial step in empowering the individual to help direct his or her services or at least partner with others as a community-based program is identified.

Once the service plan has been developed and agreed to by the individual, a case manager with special training on transition and Road to Recovery transition services should be assigned to ensure that all the necessary housing and services are arranged. Case managers with transition responsibilities should be assigned through behavioral regions.

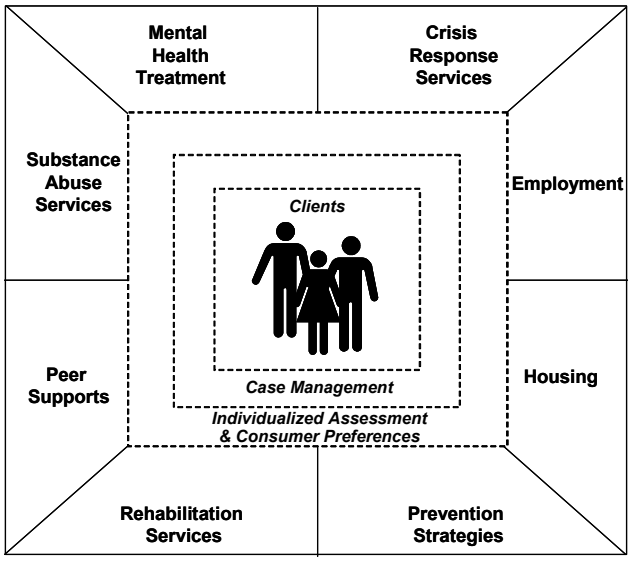
B. Community Capacity

People with SMI need access to a broad range of behavioral health services and supports to transition successfully from institutional to community-based settings. Figure 5 illustrates key elements of a community-based spectrum of support, as adapted from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Community Support System framework. [8] Key services include case management, crisis response, residential/housing services, and a wide array of behavioral health treatment and rehabilitation services. [9]

[8] Stroul, B. (1989). Community Support Systems for Persons with Long-Term Mental Illness: A Conceptual Framework. *Psychosocial Rehabilitation Journal, 12(3), 9-26.*

[9] The term "case management" is synonymous with the Nebraska behavioral health service called "Community Support."

Figure 5. Community Support System



1. Behavioral Health Services Currently Offered in Nebraska

Consistent with the SAMHSA community support system framework, HHSS currently offers an array of community-based behavioral health services to consumers with SMI. The current service system provides a foundation from which to expand and develop additional emergency, treatment, rehabilitation, and support resources to accommodate individuals being discharged from Norfolk and Hastings Regional Centers.

The following section provides more detail on each of the available residential and non-residential services. Services are grouped as residential services, case management/community support services, crisis response/emergency services, and non-residential behavioral health services. Each grouping is discussed separately and accompanied by an illustrative table. Appendix A to this report provides a complete overview of current behavioral health services by region.

a. Residential and Transitional Residential Services

HHSS offers both longer-term residential services as well as shorter-term transitional residential services for consumers. For the majority of individuals being discharged from regional centers, an intermediate or transitional residential setting will be appropriate. These settings focus on stabilizing residents and providing rehabilitation services to prepare them for more permanent, independent placements. In addition, facilities are integrated into the community and every effort is made for these residences to approximate other homes in their neighborhoods. In Nebraska, example services include psychiatric residential rehabilitation programs which provide training in community living skills, daily living skills, and medication management. Other facilities at this level include short term residential (21-45 days) detoxification programs for persons with substance dependence and dual disorder residential programs, which provide simultaneous integrated treatment to individuals with SMI and co-occurring substance dependence.

Although more broadly available in areas of higher population density, Table 1 below shows that intermediate and transitional residential facilities are available in all regions. These facilities provide round-the-clock support with a focus on stabilizing residents and providing rehabilitation services to prepare them for more permanent, independent placements. While intermediate residential programs currently are available only in Regions V and VI, some transitional residential services, such as short-term residential programs, are available throughout the state. Other transitional residential services, such as dual residential, therapeutic community, halfway houses, and psychiatric residential rehabilitation are available in some regions. Some regions may choose to partner with neighboring regions to offer some services.

In addition, the Regional Governing Boards must use the closure of the Hastings and Norfolk Regional Centers — with the resulting dispersement of financial resources into community-based settings — to develop additional service capacity throughout the state. In short, Table 1 should be utilized as a gap analysis tool by which the Regional Governing Boards should identify services they need to develop in their regions. The Road to Recovery will fail if the result is an "urbanized" solution. Also described in Table 1 is the availability of residential substance abuse services.

Table 1. Current Residential and Transitional Services

Community Services	Required Staff to Consumer Ratio	Persons Served Fiscal Year 2003					
		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Residential Services							
Intermediate Residential (SA)	1:9	none	none	none	none	30	95
Transitional Residential Services							
Short Term Residential (SA)	1:4	164	125	262	127	159	330
Dual Residential (MH/SA)	1:2, 1:7	none	none	none	22	32	none
Therapeutic Community (SA)	1:10	none	7	32	none	70	40
Halfway House (SA)	1:9	none	none	64	75	85	128
Psychiatric Residential Rehabilitation (PRR) (MH)	1:4, 1:10	none	none	23	18	20	120

Source: HHSS

The recently completed study of statewide consumer housing needs for low-income persons with SMI, prepared by Hanna:Keelan Associates for the Department of Economic Development and HHSS, identified three broad housing types that need development: 1) crisis/respite care-emergency shelter; 2) group intermediate/transitional residential; and 3) independent residential. While the target types are defined broadly, they accurately represent the types of housing that will be needed to serve the individuals currently served at the Regional Centers. For individuals transitioning from Norfolk and Hastings Regional Centers to the community, the focus will center on group residential and independent residential housing as the best means to achieve safe and affordable housing.

Using data gathered for the August 2003 snapshot of Norfolk and Hastings Regional Center residents, 147 individuals (64%) had been in the Regional Centers for over 90 days. Based on this Regional Center information, and in conjunction with the Regional Governing Boards and Magellan, HHSS projected residential placements for these individuals. According to this information, some individuals will be placed in behavioral health residential service settings such as residential rehabilitation or dual diagnosis, while other individuals will be served in alternate residential service settings. Table 2, below, provides a summary of projected placements for the Hastings and Norfolk Regional Center residents as of the dates of the August 2003 snapshots.

Table 2. Projected Services for Hastings and Norfolk Patients Based on Snapshot[/a]

Services	Estimated # Consumers by Region						By Regional Center		TOTAL
	1	2	3	4	5	6	@ NRC	@ HRC	
Inpatient (Beds)									
Acute	0	0	1	1	1	3	4	2	6
Secure	1	1	12	16	6	35	54	17	71
TOTAL	**1**	**1**	**13**	**17**	**7**	**38**	**58**	**19**	**77**
Residential (Beds)[/b]									
Psych Nursing Facility	0	0	3	5	2	11	16	5	21
Psych Res Rehab	0	1	4	5	2	12	20	4	24
Dual Disorder	0	1	5	7	3	16	24	8	32
Short Term Residential	0	0	1	0	0	1	1	1	2
TOTAL	**0**	**2**	**13**	**17**	**7**	**40**	**61**	**18**	**79**
Care Management and Support Services[/c]									
ACT	1	1	8	14	5	31	44	16	60
Com Supt/Case Mgmt	0	0	3	3	1	8	7	8	15
TOTAL	**1**	**1**	**11**	**17**	**6**	**39**	**51**	**24**	**75**
TOTAL	**2**	**4**	**37**	**51**	**20**	**117**	**170**	**61**	**231**

Source: Regional Center, HHSS, and Magellan analysis

/a This does not include discharges from the Lincoln Regional Center.

/b Of the 154 patients who would move to community-based settings, 79 are projected to move to licensed behavioral health settings. The remaining 75 are projected to move to independent living or assisted living settings.

/c The 79 individuals projected to move to licensed behavioral health settings also would receive Care Management and Support Services, which could include day services, medication management and crisis/emergency. These figures, however, only reflect the care management and support services projected for the 75 individuals in independent living or assisted living settings.

Table 2 reflects the likely long-term placements; these estimates vary from the snapshot projections because occasionally a given consumer may require a short-term stay in a transitional setting (after Regional Center discharge) before moving to his or her more appropriate long-term setting. What follows are the projections from the snapshots themselves.

i) Nursing Home

Over 20 people were identified for transition from the Regional Centers into a long-term nursing facility. The interdisciplinary team should reassess these placement recommendations in the transition process to determine eligibility (including the Pre-Admission Screening and Resident Review – PASRR) for nursing facility care. Throughout the state, nursing facilities are currently serving individuals with co-occurring medical and psychiatric conditions.

ii) Assisted Living

HHSS' snapshot identified nearly 80 people who upon discharge will require long-term assisted living with supports. Because of this high number, HHSS will need to carefully coordinate with assisted living providers and behavioral health providers to assess current and potential capacity, and with Regional Center staff to identify the support service needs of individuals recommended for this setting. HHSS support services workers, e.g., Community Support workers or Personal Service workers (Medicaid), could be assigned to help coordinate and/or provide the support service needs.

iii) Psychiatric Residential Rehabilitation (PRR)

HHSS' snapshot identified over 30 individuals who would require psychiatric residential rehabilitation upon discharge. This service is provided in existing small residences, usually 8 people or fewer, which are integrated into the community. To place these individuals it will be important to assess whether existing community capability exists or whether a handful of new settings must be developed. The expense of opening two to four new facilities can include the cost of purchasing a house and bringing it into compliance with all local zoning and residential housing regulations.

iv) Dual Diagnosis

HHSS' snapshot identified over 40 individuals as having a diagnosis of both SMI and substance dependence. For some, it will be necessary to move from the Regional Center into a dual disorder residential program, which provides integrated treatment for both conditions. The average length of service in a dual disorder residential program is 6 months. For others, supported housing or independent living may suffice, with an appropriate array of supports available in the community. HHSS' interdisciplinary team will need to reassess the treatment needs and diagnoses of these consumers to determine the need for primary dual treatment. To place these individuals it will be important to assess whether existing community capability exists or whether additional bed capacity should be developed.

v) Short-term Residential

HHSS' snapshot has identified 3 individuals who would require short term residential substance abuse services upon discharge. Short Term Residential substance abuse services are 24-hour, non-medical residential facilities for persons with primary substance dependence. To place these individuals it will be important to assess whether existing community capability exists or whether additional bed capacity should be developed.

vi) Independent Living

HHSS' snapshot recommends independent living for 18 current residents. This type of residence is appropriate for high functioning individuals who can live independently with minimal community supports. Because of the lack of appropriate affordable housing, HHSS is working closely with Department of Economic Development to explore options for publicly funded housing.

vii) Other Secure Settings

HHSS' snapshot reports that five felons who are current residents will be returned to jail to complete their sentences once their conditions are stabilized and the Regional Centers are closed. Also, in October 2001, the Lincoln Regional Center opened a 21-bed transitional sex offender unit. With the closure of the other two Regional Centers, 18 sex offenders were identified and will be moved to the Lincoln Regional Center program. As part of the transition, this unit will need to be expanded to absorb these additional individuals.

viii) Traumatic Brain Injury/ Developmental Disabilities

Five individuals have been identified with a traumatic brain injury or a developmental disability. These individuals will most likely be Medicaid eligible and could be served with community services under an existing Medicaid waiver.

In Nebraska, several other residential settings are available in the community but were not included in the placement recommendations for current Regional Center residents; they include therapeutic community and halfway houses. These programs serve consumers with substance dependence. Therapeutic communities provide long-term comprehensive treatment, whereas halfway houses provide less restrictive and shorter-term services. Services in both settings are designed to improve independent living skills.

It is important to note that as individuals are transitioned from Regional Centers into the community, coordinated efforts to plan housing will need to begin immediately. Issues to be addressed include affordability, safety, proximity to family and friends, access to appropriate medical services, transportation, and access to employment opportunities.

b. Community Support Services

In addition to residential services, community support and case management services are provided to individuals throughout the state, while ACT programs are being piloted in Omaha and Hastings in Behavioral Health Regions III and VI (see Table 3).

Table 3. Current Community Support Services

Community Services	Required Staff to Consumer Ratio	Persons Served Fiscal Year 2003					
		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Community Support							
Community Support (MH)	1:20	166	238	289	126	1185	488
Community Support (SA)	1:25	76	78	92	229	455	28
ACT	1:10	none	none	62	none	none	85

Source: HHSS

Community support, or case management, is often viewed as the glue that binds together the array of services constituting a comprehensive system of care. Case managers can perform a variety of roles including service brokering, helping consumers to build important daily living skills, and providing supportive therapy. Consumers with the highest level of need are served through ACT programs comprised of multi-disciplinary clinical teams directly providing comprehensive treatment, rehabilitation, and support services to high-risk individuals, such as those with co-occurring disorders. For those consumers requiring less intense case management, Nebraska offers community support services that help consumers facilitate the coordination of necessary resources to achieve community and social integration, such as providing consumers with rehabilitation and skills training. Case monitoring services are provided to those consumers whose conditions are largely stabilized and who are functioning at relatively high level.

c. Emergency Services/ Crisis Response

All six regions offer some type of crisis response/emergency services. Crisis treatment services are the most commonly available behavioral health services throughout the state, followed by crisis assessment services and crisis respite services (see Table 4 below).

Table 4. Current Emergency/Crisis Response Services

Community Services	Required Staff to Consumer Ratio	Persons Served Fiscal Year 2003					
		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Emergency/ Crisis Response							
Crisis Lines	NA	1141	none	208	none	5544	none
Crisis Assessment/Treatment/ Stabilization	NA	83	138	774	494	800	1212
Crisis Assessment (SA)	NA	231	12	11	121	475	114
Crisis Respite	NA	none	8	Data Not Available	Data Not Available	25	146
Social Detoxification	NA	290	None	176	91	1995	2627
Emergency Community Support	NA	Data Not Available	Data Not Available	Data Not Available	Data Not Available	Data Not Available	74
Mobile Crisis Response Teams	NA	Data Not Available	114	4	Data Not Available	none	none

Source: HHSS

The goals of emergency services are both to prevent hospitalization and to assist individuals in psychiatric crises to resume functioning in the community. Service intensity can be considered high across a range of essential crisis response functions, including assessment, treatment, and overnight respite services. Example services include 24-hour crisis hotlines, crisis assessment and intervention teams, emergency protective custody, walk-in or mobile crisis outreach services, and overnight 24-hour respite beds. In addition, acute inpatient hospitalization in community settings may be needed when individuals are dangerous or have complicated medical conditions necessitating maximum levels of stabilization and supervision. As noted above, as Hastings and Norfolk Regional Center residents transition back into their homes and communities, crisis services will need to increase their service capacity to ensure successful movement and reduce the need for return to a Regional Center or other more restrictive service setting.

d. Non-Residential Community-Based Services

Finally, Table 5 displays information on the array of non-residential support services that are available to consumers. The regions provide these services at varying levels of effort, but most are available statewide.

Table 5. Current Non-Residential Community-Based Services

Community Services	Required Staff to Consumer Ratio	Persons Served Fiscal Year 2003					
		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Non-Residential Community-Based Services							
Day Treatment (MH)	1:5	none	none	none	none	50	80
Partial Care (SA)	1:7	none	none	none	none	28	none
Intensive Outpatient Treatment (SA)	NA	74	none	146	507	200	200
Day Rehabilitation (MH)	1:6	90	167	238	154	164	1130
Outpatient Treatment (MH)	NA	624	983	932	1255	2271	3415
Outpatient Treatment (SA)	NA	614	611	732	701	1128	1950
Psychological Testing (MH)	NA	none	353	56	none	none	none
Medication Management (MH)	NA	127	293	643	594	1082	2095
Vocational Support (MH)	1:20	4	none	55	226	27	none
Day Support (MH)	1:20	65	42	91	40	none	none

Source: HHSS

A broad array of non-residential supports is needed to maintain individuals with SMI as well as individuals who have co-occurring substance abuse dependence in the community. Consumers receive services according to their level of need; however, these levels are fluid rather than stepwise. Some consumers will move between levels depending on changes in their condition and others will receive services at multiple levels simultaneously, depending on their individually-assessed needs and goals.

i) Day Treatment, Partial Hospitalization Programs

The day treatment/partial hospitalization program is an intensive non-residential service designed for persons transferred from inpatient services who are not ready for less intensive treatment. These facility-based programs are highly structured and supervised and provide assessment and diagnostic services, medication services, and individual, group, or family therapy.

ii) Partial Care Services

Partial care services provide group-focused services for persons with substance dependence who require a more restrictive treatment than outpatient counseling but do not require a residential placement.

iii) Intensive Outpatient Treatment

The intensive outpatient program provides group-focused services for individuals with high intensity needs, such as those with co-occurring mental health and substance abuse disorders. Services include crisis management, individual and group counseling, and support groups.

iv) Psychosocial/Vocational Day Rehabilitation Programs

An essential component of community support systems, psychosocial rehabilitation programs provide a diverse array of skill-building and support services designed to help people with SMI improve their community functioning. While some psychosocial rehabilitation programs provide skill-building and supports across functional domains, others assist individuals in targeted areas such as vocational, supported employment programs.

v) Outpatient Treatment

Behavioral health services at this level are designed to help consumers manage symptoms and medications, recognize relapse symptoms, and cope more effectively with their illnesses. Example services include psychiatric and psychological evaluations, medication management, and supportive psychosocial therapy.

vi) Medication Management

This service consists of ongoing monitoring of the consumer's tolerance of psychotropic drugs, including management of side effects. It is a service that is provided on an as-needed basis, generally every three months.

vii) Vocational Support

The goal of the vocational support program is to help a consumer obtain and maintain employment. The program can provide assistance in the workplace, if necessary.

viii) Day Support Programs

These are relatively unstructured, unrestrictive settings which can be appropriate for consumers who have already graduated from more intensive day rehabilitation services. They also provide outreach to consumers who are relatively unengaged in the behavioral health system. In Nebraska, the day support program operates as a drop-in center with opportunities for socialization and recreation. At this level, peer and family support programs represent an area for potential expansion in Nebraska. These programs are planned and operated by consumers and encompass consumer empowerment and recovery models.

Regarding the section above, it is important to note that more services are available in Regions V and VI than in other parts of the state. These regions contain higher concentrations of both consumers and behavioral health providers. Nevertheless, even the more rural/frontier areas of the state offer an array of behavioral health services. Other states with large areas designated as "frontier" have downsized and closed institutions while successfully building community-based capacity in rural areas. For example, Iowa recently significantly expanded its array of behavioral health community-based supports. In the late 1980's, the state of Wyoming embarked on a groundbreaking systems change initiative moving from almost complete reliance on a state training center for persons with mental retardation and related developmental disabilities to a robust community-based services system.

C. Opportunities for Systemic Growth

While service capacity issues are discussed above, there are a number of other key community living issues that must be enhanced or developed to ensure safe and healthy transitions.

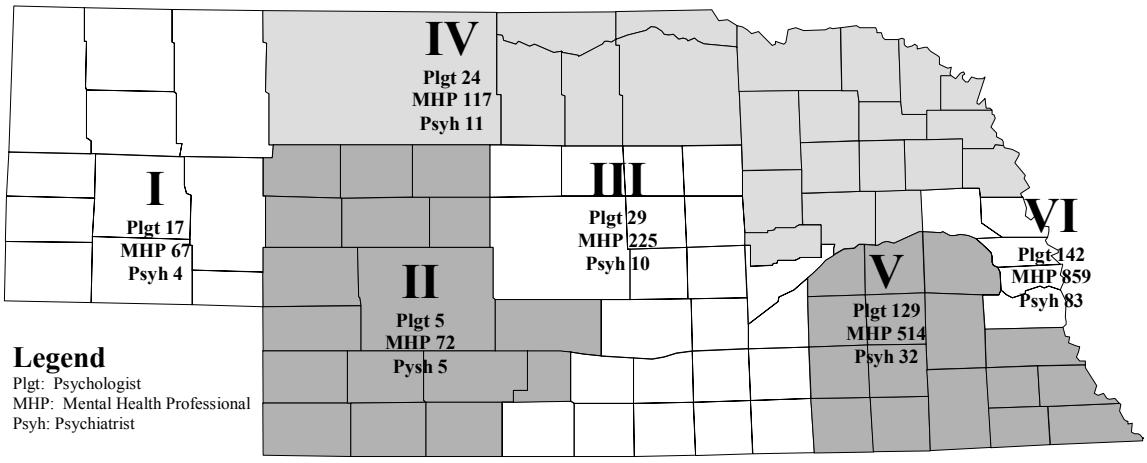
1. Building Housing Capacity

In recent years, HHSS has worked toward the goal of increasing available housing for persons with SMI. In the last year, the Nebraska Statewide Mental Health Housing Coalition was created as a partnership between the OMHSAAS and the Nebraska Department of Economic Development Community and Rural Development Division. In November 2003, the Coalition conducted a statewide consumer housing need survey. With this information, HHSS plans to work in collaboration with the Department of Economic Development to expand housing availability for the behavioral health population. OMHSAAS has also expanded the development of substance abuse recovery homes.

2. Enhancing Access to Providers

The shortage of available direct service providers who will provide indigent consumers with intensive service needs, as well as the shortage of behavioral health professionals, is an ongoing challenge for HHSS and is most notable in the frontier counties of Nebraska. With the closure of the two Regional Centers, it is likely that staff leaving those centers will help fill this need in community-based service agencies. In addition, Nebraska will boost its independent living services for individuals who do not need 24-hour, seven-days-a-week support. Moreover, collaboration between the two medical centers should provide additional training opportunities to expand the pool of health professionals who serve adults with SMI. Other initiatives, such as the expansion of telemedicine for behavioral health, also may address this rural/frontier access issue. Figure 6 illustrates the distribution of behavioral health professionals in Nebraska.

Figure 6. Providers by Region



Source: HHSS

3. Enhancing case management/support coordination

Nebraska has recently included ACT as a service available to consumers through the Medicaid Rehabilitation Option. ACT programs are operating in Regions III and VI and plans have been introduced to add an ACT program in Region V. Community support was expanded in most regions with new tobacco funds in FY 2002 and FY 2003. With the closure of the Norfolk Regional Center, this service should see significant expansion in Region VI. Additional funding could also support the development of less intense care monitoring services in all regions.

4. Using Peer Support

Peer and family support services are recognized as an important component of a comprehensive community support system. OMHSAAS currently funds two peer support staff in day support programs and encourages other day support providers to employ consumers as primary staff in this service. Expansion of peer-related or support services will enhance the support services available to Nebraskans.

5. Expanding Transportation

People transitioning back into the community or moving into more independent living arrangements must have access to safe, reliable transportation. With more individuals soon to be served in the community, HHSS should also consider transportation options such as the state's Medicaid-financed Non-Emergency Medical Transportation program, the accessible transportation services provider array, and the degree to which public transportation staff receive disability sensitivity training.

6. Increasing Access to Employment

For people to increase their levels of self-sufficiency and independence, they must have income to cover their living expenses including food and other household goods, as well as funds for

quality of life items such as entertainment. Nebraska already offers supported employment services for persons with mental illness as well as Medicaid coverage for working persons with disabilities under its Medicaid Buy-In program. As part of its increasing emphasis on community living, HHSS should increase the scope of "Employment 2003," its recent mental health employment initiative, to further examine ways to increase the employability of persons with disabilities as well as create a more receptive employer community.

Finally, other public service organizations must be prepared for an increase in the number of persons with SMI in their communities so they may offer appropriate support either directly or by contacting a branch of the behavioral health service system. Organizations that should be offered renewed or enhanced disability sensitivity training include local and state law enforcement agencies and local social service agencies. Steps also should be taken to engage these organizations in regular forums with behavioral health provider organizations, Regional Governing Boards, and mental health commitment boards.

D. Accountability and Quality

The guiding principles of the Road to Recovery are: a) individualized services; b) a recovery focus; c) the realignment of stakeholder responsibilities to reflect increased community-based service emphasis; and d) the improvement of strategies for leveraging resources. In this section, possible goals related to these principles are discussed. In addition to defining goals, policymakers and other behavioral health stakeholders also must be able to measure progress towards these goals.

Figure 7 displays four possible goals associated with the Regional Center closures and a set of indicators related to each goal. As stated earlier, it is important to note that these are potential goals and indicators as the state implements the Road to Recovery.

Figure 7. Goals and Possible Indicators

Goals	Indicators
Long term Regional Center (RC) residents have the opportunity to receive services in the community and/or a less restrictive setting.	1. A statewide transition plan including consumer education and public outreach on community service options is operational; 2. Total demand for placements in Lincoln and other inpatient facilities does not increase following Hastings and Norfolk closures; 3. Increased number of people receiving community-based residential placements; 4. Increased number of people receiving non-residential services; and 5. Increased supply of community-based services for different levels of care.

Goals	Indicators
Consumers who will have been admitted to a Regional Center receive appropriate services (inpatient, residential or non-residential) and supports in the community as determined by assessment.	1. Regional/local Crisis Intervention Teams (CIT) are operating in all six regions; 2. CIT units have collaborative relationships and established processes with crisis centers, hospitals and other inpatient facilities as well as law enforcement agencies aimed at reducing inappropriate or lengthy placements; 3. Procedures are in place, as well as ongoing staff training, for an intake and crisis intervention process that focuses on providing needed services in the community rather than in a RC; and 4. An alternative referral and commitment process is in place for individuals who do need inpatient services.
Adequate community-based services (e.g., support coordination, non-residential services, residential services, housing options, employment supports) are available to meet demand generated by Hastings and Norfolk Regional Center closure.	1. Community-based capacity has been measured and assessed; 2. Gaps in capacity have been identified and services and providers have been recruited to fill those gaps; and 3. No consumer is moved from a RC without adequate community-based services in place.
Consumers will be partners in decisions about the community-based services received and will be supported in that decision-making process by behavioral health professionals and support staff.	1. A protocol is in place for framing the consumer's and family's (where appropriate) role in decision making; 2. Procedures and services are available to educate consumers and families about their options so they can make educated decisions; and 3. Consumers have the opportunity to provide ongoing input into the design and delivery of services.

1. Measuring performance

A measurement system (i.e., data collection and analysis strategy) related to each indicator also will need to be established. This system will capture information for each indicator and, in turn, inform decision makers about the performance of the initiative. These measures and information collection systems will be the backbone of the initiative's quality measurement strategy. Generally speaking, such efforts are called "quality management" (QM).

a. Management of the QM Process

A successful quality management system includes strong elements of coordination, consistency, and accountability. A key strategy for consideration is the appointment of a HHSS Road to Recovery Coordinator to oversee the development and implementation of the initiative. The coordinator should be responsible for at least the following activities:

- Developing an overall detailed Transition Plan;
- Developing the needed group residential housing and services;
- Coordinating with and assisting each region's Regional Center transition work group to ensure sufficient availability of residential housing, quality medical and non-medical services;
- Ensuring that resident, family, and friends education efforts are successful;
- Ensuring that assessments and service planning are being performed;
- Developing a tracking system to monitor the progress of housing and services development and individual progress toward community living; and
- Supervising the regional specialists assigned to assist people transitioning from the Regional Centers.

The HHSS Coordinator should be responsible for developing information sources to monitor performance and progress of the Road to Recovery and synthesizing this information into progress reports for Executive and Legislative leadership.

b. Provider Considerations

A quality service system begins with qualified providers; Nebraska already has several mechanisms to ensure the qualifications of providers. Growth in the community-based system may require new providers and new staff for existing providers. Many of the people and entities who will provide services to individuals transitioning from the Regional Centers need to be licensed or certified. Nebraska will continue its current licensure and monitoring practices for these individuals and agencies, keeping direct lines of communication open between responsible oversight agencies and staff responsible for Road to Recovery implementation. The HHSS Road to Recovery Coordinator and the Regional Governing Boards, will need to keep abreast of the number of qualified, licensed providers across the state as part of determining "adequate community capacity."

c. Utilization Review

Additionally, strategies will need to be in place to ensure that services are delivered in the quantity and quality established by individual service plans. Community support workers, care monitor workers, targeted case managers, or support coordinators will be responsible for such oversight along with the individual receiving the services. The case manager will likely need to be in contact with people in independent residential settings and group residential providers will be required to report any "unusual incidents" with individuals and what actions were taken. HHSS should also continue to perform random billing checks to ensure that bills for services match services authorized in the plan and that treatment authorizations are not exceeded.

d. Participant Feedback

A good measure of quality is regular, structured feedback from recipients of services. The state should consider one of many feedback tools available for assessing quality by receivers of service. The new Office of Consumer Affairs will be heavily involved in this effort.

2. Administrative Infrastructure

Behavioral health providers and the Regions will be responsible for reporting data on the Road to Recovery indicators and other measures of recovery that determine whether the initiative is meeting its goals. Before implementing the Road to Recovery, HHSS will need to evaluate the capacity of the state, providers and local administrators to operate the new system, monitor its performance, report on indicators, and make alterations as problems are identified. Generally speaking, the tools a state uses to perform these functions may be called its administrative infrastructure.

Elements that fall under this rubric include adequate local and state staff to oversee services, process assessments and eligibility applications, review plans of care, review claims and billing, and conduct licensure reviews. Programs must have sufficient information technology tools to monitor costs and collect information on performance indicators. The state must have sufficient tools and staff to receive, analyze, and monitor data. Below, we sketch out areas for Road to Recovery infrastructure development.

HHSS will need to evaluate the following items:

a. Client Level Data

The state will need to develop a tracking system for individuals leaving Norfolk and Hastings and individuals who, in the past, have relied upon Regional Center services for short term reasons.

b. Financial Information

Strategies will need to be developed to monitor the financing of this program and ensure that the budget stays within parameters approved by the Legislature.

c. Policy, Rules and Interagency Agreements

HHSS will need to review current rules, policies, provider qualifications, and interagency agreements for the new program to ensure that necessary agreements are in place to support new staff or relocation of staff, data sharing, or necessary authorities to share in day-to-day operating costs.

E. Financing and Sustaining Enhanced Community Capacity

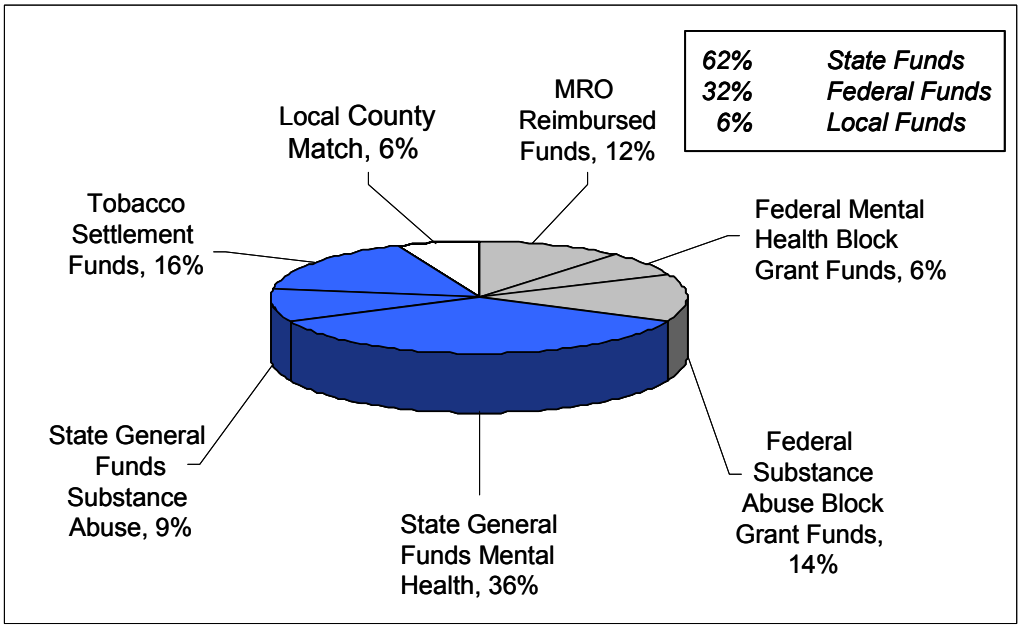
As Nebraska embarks on the Road to Recovery initiative, funds must be identified both to cover the costs of closing the Hastings and Norfolk Regional Centers while also expanding community-based capacity to accommodate former Regional Center residents. Additionally,

sustainable funding streams must be developed to maintain the enhanced community-based services array.

1. Reprogramming Service Dollars

Nebraska's regions use the following funding sources for behavioral health services: a) state general funds; b) federal mental health block grant funds; c) Medicaid Rehabilitation State Plan Option federal funds; d) Tobacco Settlement funds; and e) local tax matching funds. Nebraska also uses Social Services Block Grant funds (Title XX) to support persons with SMI in the community. Total expenditures for community-based behavioral health services in FY 2002 were $49.2 million. Meanwhile, the state also spent $63 million on facility-based services; of that amount, approximately $40 million provided facility-based services for adults with SMI. Figure 8 displays the sources of expenditures for adults with SMI in FY 2002.[10]

Figure 8. Nebraska Expenditure Sources Funded Through the Regions



OMHSAAS administers the public non-Medicaid behavioral health system, managing both state general funds as well as federal block grant funds for community mental health care. The office allocates these funds to the six regional governing boards that, in turn, are responsible for services within their jurisdictions. Medicaid also provides mental health benefits. Clinical and financial eligibility criteria for behavioral health services often differ between OMHSAAS and Medicaid. Some individuals may be eligible for both non-Medicaid and Medicaid services, while those with less severe disabilities or with greater income or resources are likely to not be Medicaid eligible.

[10] Office of Mental Health, Substance Abuse and Addictive Services (OMHSAAS) Annual Report, Fiscal Year 2002, October 2002.

Federal law prohibits Medicaid from paying for certain behavioral health services; specifically, Medicaid funds cannot be used to pay for state inpatient psychiatric hospital stays for adults ages 22-64, such as the Norfolk and Hastings Regional Centers. Medicaid does, however, pay for some services and supports in the community for persons with mental health diagnoses through the Medicaid state plan. The Medicaid Rehab Option covers services for persons with SMI, including community support, day rehabilitation, psychiatric residential rehabilitation, and ACT. In addition to these specific services, Medicaid covers a range of other non-residential behavioral health services including crisis stabilization, individual and group therapy, and medication management.

The transformation in Nebraska's behavioral health system largely will be funded by redirecting funds previously supporting the Norfolk and Hastings Regional Centers. The current funding distribution for the Hastings and Norfolk Regional Centers is heavily skewed toward state general funds, based on the federal rules that prohibit Medicaid funding for inpatient services at psychiatric centers. There also will be cash funds available from consumer benefit payments (e.g., Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or other income support resources). Thus, of the $28.9 million devoted to services at these two sites, $25.8 million derives from state general funds (see Table 6).

Table 6. Current Funding for Inpatient Services

	General Funds	Federal Funds	Cash Funds	Total Funds
Hastings Regional Center	$ 11.0 M	$ .1 M	$1.2 M	$ 12.3 M
Norfolk Regional Center	$ 14.8 M	$ 1.1 M	$.7 M	$ 16.6 M
Total	**$ 25.8 M**	**$ 1.2 M**	**$1.9 M**	**$ 28.9 M**

Source: HHSS

In August 2003, at the time the "snapshots" were taken at Hastings and Norfolk, 231 individuals were receiving inpatient/secure residential services or intermediate/transitional residential services. Nebraska's behavioral health contractor, Magellan Behavioral Health, Inc., developed an estimate of where these individuals will need to be served, if the Hastings and Norfolk Regional Centers close. These estimates were based on clinical data supplied by Regional Centers. HHSS estimated that 77 people will continue to require inpatient services (either at the Lincoln Regional Center or at a community hospital) and 154 people will safely and effectively be served in community-based settings.

HHSS projections show that the reprogrammed Regional Center funds, along with additional federal Medicaid funds, will enable the Road to Recovery to proceed within the current funding proposals. Lewin has performed a preliminary review of HHSS' projections and we find them to be reasonable. HHSS' projections are shown in Table 7.

Table 7. Projected Funding for 231 Patients in Snapshots

	General Funds	Proposed New Federal Funds	Estimated Services Cost Per Day
Acute, Secure: Non-Medicaid	$10.2M	--	$450
Acute, Secure: Medicaid[/a]	$1.3M	$2.0M	$600
Community-Based: Non Medicaid	$2.2M	--	$200
Community-Based: Medicaid[/b]	$3.6M	$5.4M	$200
Total	**$17.3M**	**$7.4M**	

Source: HHSS

a/ Projects that 20 percent of individuals in acute, secure settings would be Medicaid-eligible.

b/ Projects that 80 percent of individuals in community-based settings would be Medicaid-eligible.

By comparing the current general fund obligation for the Hastings and Norfolk Regional Centers in the amount of $25.8M (Table 6) against the projected general fund obligation post-closures of $17.3M (Table 7), it is apparent that the closures will not burden the general fund. In short, closing Hastings and Norfolk may be a true win-win: consumers will be able to live with independence and dignity in the community, and the state may have up to $8.5M annually to reinvest in new community services. Moreover, in January 2004, Governor Johanns proposed additional funding to bring up new community-based services.

2. Reinvesting Resources and Other Economic Development Opportunities

Closure of the Norfolk and Hastings Regional Centers allows for reinvestment of existing resources, both monetary and the human capital of the existing staff. The final determination of re-allocation of staff and resources will require a collaborative process among HHSS and regional and local stakeholders. As community-based services are expanded throughout the state, local areas will experience an influx of new dollars – both those currently invested in the behavioral health system as well as increased federal funds due to a more strategic use of (matched) Medicaid funding. This section outlines possible strategies for reinvesting staff and capital resources based on experiences in other states after the closure of similar large facilities.

Before the centers are closed, community-based services and supports must expand to meet demand. Enhancement and expansion of existing providers and services, as well as the addition of new services, will create employment opportunities for displaced regional center staff. For staff remaining in communities around the centers, the opportunity to continue to work with the same clients may present itself. Some capital goods, such as buildings and large equipment from the Regional Centers, may no longer be needed. These items could be sold by the state or the buildings could be used as shorter-term rehabilitative facilities or day support drop-in centers. The facilities also could be refurbished to provide other state services outside the behavioral health system, for example as a facility for off-site staff training or retreats.

Additionally, it is possible that some current residents of the two Regional Centers will be able to join the workforce. As part of the "Employment 2003" initiative, HHSS has made strides addressing the issue of employment for individuals with SMI. HHSS will review the

Employment 2003 Steering Committee recommendations for increasing employment opportunities for people with mental illness, submitted to the State Mental Health Planning and Evaluation Council. Additionally, Nebraska has a Medicaid Buy-In program that allows persons with disabilities to work and increase their earnings and savings while still qualifying for Medicaid; they would pay a monthly premium to retain Medicaid coverage. These individuals are participating in the local economy by spending disposable income and paying taxes. Nebraska could use its Medicaid Infrastructure Grant (MIG) funds to further explore employment support strategies for persons with SMI.

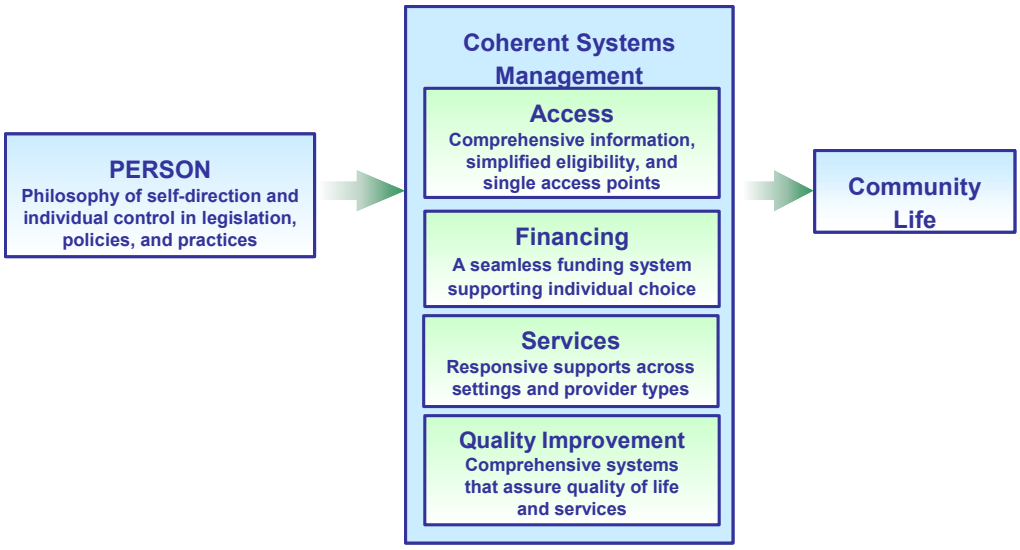
Some important tools for HHSS as it considers reinvestment include:

- Using the ongoing public meetings and subsequent stakeholder meetings as a forum to solicit ideas and input for how to best use Regional Center resources;
- Conducting a careful review of individuals transitioning out of Regional Centers who will be Medicaid eligible and will begin receiving such benefits;
- Developing a job matching plan between current Regional Center employees and community-based providers, many of whom consistently experience worker shortages;
- Developing a projection, based on discharge transition plans, of where residents will be moving in order to target provider development efforts and consider building incentives for providers to expand to those locations; and
- Ensuring that there is a plan to allocate resources appropriately between urban and rural settings.

VI. CONCLUSION

Expanding the opportunities for persons with SMI to live and work in their communities near family and friends, while empowering these consumers to make informed choices about their services, is at the heart of the Road to Recovery initiative. However, the state also recognizes the need to offer an array of flexible services that responds to consumers' changing needs and desires. Other states have successfully developed and implemented strategies that offer a range of services from institutional settings to highly individualized support systems. The critical elements in these states are systemic flexibility that allows individuals with disabilities to move between levels of service as their needs change, and to be able to move geographically around the state as well. Figure 9 offers a conceptual model for a framework of analyzing these issues.[11]

Figure 9. Key Building Blocks of the Road to Recovery Implementation Framework



Nebraska has a long history of supporting persons with disabilities who wish to live more independently in the community. Going forward, as the Road to Recovery is discussed and shaped, behavioral health stakeholders will make important decisions about where and how persons with SMI will receive services. This should inform stakeholder discussions on what steps must be taken to assess the current system and to plan for implementing the Road to Recovery.

However, before real work may begin, Nebraska will need to conduct careful research and study as well as convene numerous stakeholder discussions to better understand the implications of the Road to Recovery proposal as well as to define implementation steps; this planning report is a first step in beginning those exploratory efforts.

In his State of the State address on January 15, Governor Johanns said, "We have an historic opportunity to effect substantial and necessary change." Nebraska is moving forward to

[11] Adapted from the Centers for Medicare and Medicaid Services (CMS) "Money Follows the Person" flow chart.

develop a highly detailed implementation plan by July 1, 2004 that is built on input from consumers, advocates, providers, and other stakeholders. The Road to Recovery commits Nebraska to a course of recovery, serving consumers closer to their support systems, creating a statewide system of excellence through our medical centers, and accessing previously untapped federal Medicaid dollars. We believe this is the right course of action, and that it is achievable.

Appendix A

Appendix A: Persons Served in Community by Region FY03

Community Services	Required Staff to Consumer Ratio	Persons Served Fiscal Year 2003					
		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Residential Services							
Intermediate Residential (SA)	1:9	none	none	none	none	30	95
Transitional Residential Services							
Short Term Residential (SA)	1:4	164	125	262	127	159	330
Dual Residential (MH/SA)	1:2, 1:7	none	none	none	22	32	none
Therapeutic Community (SA)	1:10	none	7	32	none	70	40
Halfway House (SA)	1:9	none	none	64	75	85	128
Psychiatric Residential Rehabilitation (PRR) (MH)	1:4, 1:10	none	none	23	18	20	120
Community Support							
Community Support (MH)	1:20	166	238	289	126	1185	488
Community Support (SA)	1:25	76	78	92	229	455	28
ACT	1:10	none	none	62	none	none	85
Emergency/ Crisis Response							
Crisis Lines	NA	1141	none	208	none	5544	none
Crisis Assessment / Treatment / Stabilization	NA	83	138	774	494	800	1212
Crisis Assessment (SA)	NA	231	12	11	121	475	114
Crisis Respite	NA	none	8	Data Not Available	Data Not Available	25	146
Social Detoxification	NA	290	None	176	91	1995	2627
Emergency Community Support	NA	Data Not Available	Data Not Available	Data Not Available	Data Not Available	Data Not Available	74
Mobile Crisis Response Teams	NA	Data Not Available	114	4	Data Not Available	none	none
Non-Residential Community-Based Services							
Day Treatment (MH)	1:5	none	none	none	none	50	80
Partial Care (SA)	1:7	none	none	none	none	28	none
Intensive Outpatient Treatment (SA)	NA	74	none	146	507	200	200
Day Rehabilitation (MH)	1:6	90	167	238	154	164	1130
Outpatient Treatment (MH)	NA	624	983	932	1255	2271	3415
Outpatient Treatment (SA)	NA	614	611	732	701	1128	1950
Psychological Testing (MH)	NA	none	353	56	none	none	none
Medication Management (MH)	NA	127	293	643	594	1082	2095
Vocational Support (MH)	1:20	4	none	55	226	27	none
Day Support (MH)	1:20	65	42	91	40	none	none

*NOTE: Numbers reflect only those persons served in programs managed by OMHSAAS. “None” denotes service not available in Region. “NA” denotes Not Applicable.