



**DEPARTMENT OF HEALTH & HUMAN SERVICES  
HEALTH RESOURCES AND SERVICES ADMINISTRATION**

**Office of Performance Review  
Kansas City Regional Division  
601 East 12<sup>th</sup> Street, Room 1728  
Kansas City, Missouri**

**State Strategic Partnership Session  
FINAL REPORT**

**for the**

**State of Nebraska**

**Date of State Summit – November 15, 2007**

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## SUMMARY FOR STATE OF NEBRASKA STRATEGIC PARTNERSHIP SESSION

The purpose of the Nebraska State Strategic Partnership Session (SPS) was to convene HRSA grantees, appropriate stakeholders, and state and federal officials to work collaboratively on an issue vital to the state.

The Nebraska Department of Health and Humans Services (DHHS) was approached by representatives from HRSA/OPR earlier in 2007 asking Nebraska DHHS to partner with HRSA/OPR on important public health issues in Nebraska. In August, a second meeting occurred where agreement was reached to conduct a facilitated conversation on two related behavioral health topics. The first topic was “how to improve the Emergency Protective Custody (EPC) process” given the closure of the Regional Behavioral Health (BH) Treatment Centers throughout Nebraska. The second topic was “how to improve the overall systems of care in Nebraska’s Behavioral Health Model.”

The objectives of this strategic partnership session included the following:

1. Assess Emergency Protective Custody (EPC) issues in Nebraska and identify suggested changes.
2. Address how a community-based system of care can provide solutions.
3. Define what a community-based system of care should look like (telehealth, hubs.)
4. Provide conversation on Nebraska’s mental health workforce shortages (both current and projected) and the mal-distribution of that workforce statewide.
5. Share potential resources and best practices among stakeholders to help overcome current challenges.
6. Identify “lessons learned.”
7. Include feedback on policy or programmatic change within HRSA that can better support state-level grantees during health care reform.

The SPS agenda started by setting the stage with Nebraska’s current status and the current challenges occurring within the behavioral health care services sector. There were a number of speakers who discussed various aspects and shared best practices. This was followed with a focused discussion in breakout sessions on the two overarching issues selected by the Nebraska DHHS and HRSA/OPR.

The current status in Nebraska with respect to EPC is a critical issue. Local, county, and state law enforcement officers are having difficulty accessing crisis beds in the hospitals contracted with behavioral health regions for Emergency Protective Custody care. Law Enforcement officials on occasion must contact more than one facility to find an available bed and transport persons who have been placed in EPC.

A number of possible causes for the limited access to emergency beds have been identified:

- Capacity in community-based services is not adequate to meet demand and provide for timely discharge of individuals from hospitals;

- Extended lengths-of-stay at community-based services that serve as the step-down from hospitals and regional centers limit access to services;
- The diversionary services necessary to prevent the need for individuals to be EPC'd are inadequate;
- There is not a centralized management of “Emergency System”;
- There is increased demand for hospital beds for persons not being EPC'd;
- There is limited access to community-based services that support living in the community; and
- Consumers cannot access services because of lack of funding (lack of insurance coverage).

The objective of the second breakout session was the identification of potential strategies for developing community-based mental health/behavioral health services for Nebraska residents.

## EXECUTIVE SUMMARY AND CONCLUSIONS

Both breakout sessions had similar responses regarding EPC and behavioral health issues. Seven major categories summarized the issues, needs, and actions requested by the participants. **Clearly, the highest priority for Nebraska is developing a statewide, as well as regional, strategic plan to address their critical issues and bring parity to the system.**

- 1) Attendees requested an overall State plan to (1) eliminate regional disparities; (2) create a uniform definition of roles, responsibilities, and handoffs; and (3) discuss the economic impact. Primary issues here were the disparity between the two major urban areas' challenges and the rural areas of Nebraska. A state strategic plan would not only have to introduce financial parity for providers and law enforcement agencies but also address the issues of remote Nebraska regions crossing state borders to provide behavioral health (BH) facilities and services. Regions wanted to help develop the plan at the regional level on a preliminary basis and then have ideas rolled into a comprehensive strategic plan.
- 2) The State Strategic Plan should not only provide vision, mission, and purpose for BH, but use the “Logic Model” presented by C.J. Johnson to create appropriate benchmarks for data driven decisions. Each region should have some specific benchmarks based on their demographics and level of services but other benchmarks should be based on statewide initiatives for improving the BH system.
- 3) The plan should also address and implement some methodology for single point of contact for service delivery, bed availability, and entry into the system. A web-based system or call-in hotline number were both considered. Such a system could also be helpful in communicating additional resources, such as peer services, services for wait-listed clients, and community alternative services, such as clerical counseling or homeless shelters.

- 4) A critical issue was training, not only for Law Enforcement, but also for providers and community services. De-criminalizing the process of entry into the BH system was paramount to clients and service agencies as well. The Crisis Intervention Team training (CIT) received the highest recommendation at each breakout session. Extending this training to awareness of other services, processes and new tools would create a stronger network of support for the BH system. Increasing the Assertive Community Training (ACT) teams was mentioned by a third of the breakout groups, as well as the use of CRT (Crisis Response Teams) who have CIT training and full awareness of area services.
- 5) Using state employees from previous BH state facilities as Regional Treatment Staff would be an effective and economic answer for many rural regions. Following Minnesota's lead of selling or donating the old regional centers back to the communities for re-use was also well received.
- 6) Minnesota's 16-bed facilities that were highlighted in Wes Kooistra's presentation were referenced frequently throughout the day. There appeared to be a high level of support by the respondents that this regionalized approach should be considered in the Nebraska State Strategic Plan.
- 7) Address the issues surrounding patients who are discharged from acute in-patient care with only seven days of medications, yet are unable to schedule follow-up outpatient psychiatric appointment for 4-6 weeks. The audience identified this circumstance as the key factor in patients having to "re-enter" the BH system, mainly via another EPC. The benefit of managing these patients through medication and quicker follow-up appointments would, the group felt, assist in alleviating the bed shortages and would result in fewer EPC calls for law enforcement.
- 8) Recommended **Next Steps**:
  - a. Convene a working group, led by Nebraska DHHS, to develop a list of standards.
  - b. Gain individual and regional feedback through the development of an Implementation Plan. Each region would work with Nebraska DHHS to define critical needs, prioritize budgeting and support allocation requests, and establish the implementation timeline. Nebraska DHHS will suggest plan adjustments as appropriate.
  - c. Roll the regional plans and innovations into the Nebraska Statewide Plan.

## **POPULATION-BASED INDICATOR #1:**

### ***“How to Improve the EPC Model for Nebraska”***

Local, county, and state law enforcement officers are having difficulty accessing crisis beds in the hospitals contracted with behavioral health regions for Emergency Protective Custody care. Law enforcement officials on occasion must contact more than one facility to find an available bed and transport persons who have been placed in EPC. Although the information provided by law enforcement officials is largely anecdotal there is a history of complaints from law enforcement regarding the availability of emergency beds in the state’s emergency behavioral health system.

Meetings with hospital administrators and regional representatives to develop solutions to the problem began in September, 2006. The plan focused on three major strategies: (1) increase the number of acute hospital beds in order to provide easier access to services; (2) reduce the length of hospital stays; and (3) adjust the service array and capacity within the regions to facilitate the movement of consumers out of the hospitals. The following additional information further clarifies the current situation:

1. More than 200 regional center beds have been closed since FY 2003.
2. A fundamental element of the emergency system is the participation of private hospitals. The decision was made early in the Behavioral Health reform planning process to replace the inpatient services at regional centers by contracting with hospitals for an average of 25 days of inpatient care prior to the consumer returning to the community or being moved to the regional center. The number of reported EPCs has decreased from FY02 to FY07. The first significant decrease in EPCs occurred between FY02 and FY04 when the total was reduced by 329 (-11 %.) In FY 2007, the number of EPCs decreased by 12.5%.
3. Available hospital information indicates although the number of EPCs has been reduced over time these individuals are remaining in the emergency department longer. In one hospital persons who have been committed now have an average length of stay 3 days longer than the length of stay for committed individuals in 2005. The length of stay for individuals who were “voluntary” (not EPC’d) or about 75% of the admissions, has remained steady.
4. Access to hospital beds for persons needing to be EPC’d has been reduced over the last few months. Mary Lanning Hospital in Hastings has reduced capacity by 5 beds because of remodeling. Faith Regional Hospital capacity in Norfolk has been reduced by 3 beds for the renovation required to add 10 new beds. Douglas County Hospital has reduced capacity by 10 beds for remodeling. Assuming the average length of stay for each consumer is 10 days, approximately 650 more people could have been served in these beds
5. Hospitals have proposed opening Norfolk Regional Center (NRC) beds temporarily to handle “overflow” when the system was at its peak demand for inpatient beds. Funding and psychiatric coverage is not available for the expansion of NRC services.

6. The lack of access to emergency and acute care in private hospitals has become a national issue. Hospitals are inundated with individuals seeking psychiatric and health care as a result of inadequate community resources, reduction in insurance coverage, and other structural issues resulting from a wide variety of causes.

### **BREAKOUT GROUP FEEDBACK:**

With over 100 participants and 12 tables of breakout responses, the feedback has been condensed to reflect the most popular reactions from the groups. The first section denotes suggestions given by more than five (5) tables to highlight the majority voice and to allow a more effective action plan. The full feedback responses are found in **Addendum A**, which lists all additional feedback within the context of the eight questions used to guide discussion during the breakout sessions.

The group consensus said that **Nebraska should:**

- A. Develop a public commitment at all levels to the vision, values, and principles of the NBHS with true collaboration of stakeholders, building on common ground, providers included and state as an integral partner (Minnesota model).
- B. Implement the following ideas from the presentation by CJ Johnson (see attached addendum for full presentation):
  - ✓ Use of data to drive decisions.
  - ✓ Critical Response Teams in rural areas.
  - ✓ Consumer input.
- C. Implement the Minnesota model for web-based database (a central access system for bed availability) to allow tracking of available bed space.
- D. Replace the closed/closing large hospital facilities with regionally located, 16-bed units in the communities. Move existing state staff to the facilities. Encourage a competitive process for where facilities will be built or located (Minnesota model). This includes the use of the Intensive Residential Treatment (IRTS), which move patients to lower level of care but not “dumping” them out of care.
- E. The Omaha Police Department’s CIT program should be replicated statewide.
- F. Develop a “consumer-driven” proposal for county partnerships with social services with the objective being to de-criminalize the EPC process.
- G. Shift the negative stigma of addictions (chemical health) and mental health. This keeps people from seeking early intervention and prevention. Need earlier intervention at situational level.

- H. Develop a comprehensive, statewide strategy to address the following issues:
- ✓ Addressing geriatric psychology to help with nursing home issues, enhanced assisted living, and nursing home care;
  - ✓ Funding and availability of affordable medication (including psychotropic medications);
  - ✓ Turning the focus to prevention;
  - ✓ Developing more acute bed and transitional housing;
  - ✓ Developing a comprehensive strategy for better integration with primary care;
  - ✓ Seamless process between all levels of care and ability to start at the necessary level (not always starting with in-patient level); and
  - ✓ Assisting to forge a better relationship with Magellan/Nebraska Medicaid.
- I. Develop transportation services other than police for EPC.

### **NEXT STEPS:**

Two ideas were identified during the Nebraska SPS that gained verbal approval for immediate consideration by Nebraska DHHS. They are:

- 1) Replicate the Omaha Police Department's CIT program statewide; and**
- 2) Develop and implement a Nebraska central access system (*whether it be a phone number, a hotline/switchboard concept, or a website*) to track available bed space for immediate determination of bed availability for law enforcement and hospital officials.**

## **POPULATION-BASED INDICATOR #2:**

### ***“How to Improve Nebraska’s Behavioral Health System of Care”***

The objective of this session was the identification of potential strategies for developing community-based mental health/behavioral health services for Nebraska residents. Seven (7) questions were examined by the group as a whole (no breakout sessions or tables were utilized during this facilitation). Responses from attendees to the breakout session questions were as follows:

- 1. What critical issues must be addressed in making Nebraska’s BH Model more effective and efficient? (Examples: personnel, transportation, critical access hospitals, etc.)**
  - Telehealth manned with dedicated health professionals 24x7; effective deployment process using university as support system.
  - Determine how to access “The System” with more planning to kickoff more answers.
  - Create a new vision for the State based on the Whole Individual.
  - Create a pool of reliable interpreters as our population becomes more diverse.
  
- 2. Building on ideas from the morning’s discussion, what ideas could best support these issues?**
  - Day House in Omaha provides support for EPC and may be an asset to others; usually has 250-400 consumers per day with a homeless shelter for nights. This is a privately funded center.
  - 60% of EPC has chemical dependencies and a significant number with dual diagnoses.
  - Prisons are often used as a venue for initial interaction by counselors.
  - Need to address appropriate geriatric help (nursing homes and assisted living facilities).
  
- 3. Thinking outside the box: What idea could most improve or enhance the current system?**
  - More early intervention and prevention – it’s cheaper than crisis intervention.
  - Use of state employees for psychiatric support and community integration of services.
  - EPC is frequently uninsured or underinsured and medication management is a critical issue.
  - 50% co-pay for mental health is *more* out of pocket costs – parity is required.
  
- 4. What one (to three) system components most need changing to help you do your job more effectively and efficiently?**
  - Different funding measures for geriatric psychiatry for long term care (embed it in culture).
  - Increase funding for Telehealth – Medicare currently pays \$26 for a 15 minute visit or Medicaid pays 4 cents a minute. Not adequate for provider reimbursement.
  - Conduct Critical Access Hospital meetings throughout state for hospital administration to allow good networking support. Attendance is critical for information sharing, idea transfers, and support services development.
  - Primary Care Doctors are a critical link for psychological support. Need to create more integration into the system.
  - Consumer wants and needs to have a life in the community. Creating earlier intervention with fresh ideas that match the needs of the consumer.
  
- 5. How could these changes be made easily and with the least cost to the overall infrastructure?**
  - Telehealth requires broadband so we need to piggy back on education’s broadband. “T-1” lines will not serve capacity.

- Primary Care and BH integration will be cheaper and touch more consumers earlier.
- Stop criminalizing the consumer to eliminate or reduce the policy of handcuffs and shackles.
- Increase Medicaid payments for step-down services and prevention.
- Peer Specialists can be paid by Medicaid as a link to services and early intervention. Nebraska may need to change regulatory policies.
- Integrate Medicaid into the other systems (Minnesota has placed Medicaid through out the state services system as a policy component).
- Stop functioning independently.
- More effectively transition adolescents into adult system (Crisis Intervention, Respite Care)
- Create a Statewide Vision for prevention.
- More comprehensive planning and follow-through (as needed).
- Need to message the “vision and mission” by creating working definitions.
- Break down silos in order to create integrated care for safety net systems.
- Establish benchmarks to establish next steps intelligently (*i.e. what is a legitimate amount of time for emergency response?*)

#### **6. Who would need to be at the table (in the next meeting) to help move these initiatives forward?**

- UN Lincoln, UN Kearney, UNMC, and Creighton University.
- Providers at all license levels.
- Nebraska Medical Associations including Nebraska Psychiatric Association, Nebraska Chapter of the National Association of Social Workers, and any other state association as appropriate.
- Governor and Legislator Representation.
- Informal Educators (public libraries, museums, zoos, etc.) for education of public to new vision, services, and policies.
- Media (to educate them).
- Regional Representation!

#### **7. What do you see as the next step(s) following this meeting?**

- Create a “table” for the consumer.
- Jump off President’s “Freedom” Plan.
- Using the Nebraska Behavioral Health Services Act: Sections 71-806 and -809 (*see Addendum*), create a comprehensive statewide plan to create a vision, action plan, and implementation plan.

### **CONCLUSIONS:**

Community-based mental health systems of care involve innovative approaches to improve outcomes through access, utilization, financing, clinical efficacy, and cost-effectiveness of behavioral health services provided to families within the context of their home communities. This model offers numerous advantages as rising needs for behavioral health services in an increasingly diverse population of children and families are recognized, while public and private resources are increasingly stressed. The intent of this session was to provide a catalyst for future conversations on this important best practice.

## **Appendix A**

### **All Notes from EPC Breakout Tables**

#### **1. What did you hear from the speakers that could be useful in dealing with Nebraska's new BH Model?**

- Sincere commitment at all levels to the vision, values, and principles of the NBHS with true collaboration of stakeholders, building on common ground, providers included and state as an integral partner (Minnesota model)
- Increase ACT teams
- Embrace an economic vitality concept within plan to assist communities who are losing facilities and those who are gaining facilities. (RFP process for any new facilities)
- Identify needs and create support that fits.
- Use RTC staff for community service provision (question whether these facilities serve involuntary commitments)
- Use the model related by CJ Johnson for data driven decisions. More information and perhaps training to duplicate CJ's model in other regions should be considered.
- Use a Logic Model
- Use the Minnesota model for web-based database for all hospitals to allow tracking of available bed space.
- Make a greater connection to Managed Care (based on the Minnesota Model for Systems of Care – Hospitals linked to CHC and other provider models)
- The 16 Bed Units in Communities/Crisis Centers in communities using state staff (Minnesota model)
- Training is a major issue. CIT program should be broadened to include all regions. Training on all services available so provider and LE can make informed decisions and better serve the patient
- (Minnesota) state money was transitioned to community based care. Money needs to be in Community first
- Critical Response Teams in rural areas (CJ Johnson's model) – attached in addendums
- Need more community based facilities (smaller areas of coverage)
- Reasonable funding for care providers; increase reimbursement rates
- Intensive Residential Treatment (IRTS) – moving patients to lower level of care but not dumping them out of care
- Consumer driven RFP for the health plan county partnerships with coordination of social services. It's a multi-faceted response approach that comes together for person in crisis – need to de-criminalize process
- Representatives from different agencies coming together to problem solve
- Monthly emergency meetings
- Need for networking among agencies (community and statewide)
- Consultations between Regions for more development in areas outside Omaha/Lincoln
- Central access system for bed availability
- Minnesota MHAG (professional group) outside government
- Look at front-end services to decrease ER need
- Establish clear expectations of each professional's role in the crisis response team approach.
- Single point of entry.

#### **2. How could these ideas be more successful for you?**

- Statewide vision is needed to proceed
- Create education within the system on all services (so they can be better utilized)

- Need to shift the negative stigma of addictions (chemical health) and mental health. This keeps people from seeking early intervention and prevention. Need earlier intervention at situational level
- Keep using beds as transitional beds to less restrictive outpatient treatment and keep EPC beds rotating
- Patients treated closer to home and shorter distances for Law Enforcement (LE) to drive
- More efficient use of beds and a way to find beds for LE
- CIT-NSPTA training by Omaha Police Department
- Minimize hospital level of care as much as possible to get better return on money.
- Develop a health care system for uninsured and underinsured.
- Can LB 95 reform the how services are paid for, with the goal of making EPC a secondary option
- Need to know how Minnesota made it work (funding and cooperation of the health plan in the model) so that it can be successfully replicated in Nebraska or determine if the same model would work.
- Reimburse in a way that covers cost of service
- CRT for other areas than Omaha
- Strategic Planning to focus on Emergency Psychological System with all stakeholders
- Changing the law and changing the delivery service policy. Remove the onus from law enforcement of diagnosing mental illness.
- Team approach to developing resources when only part time providers are available. Address how to go beyond what is currently available.

### **3. What would you do more of, better or differently to better fit the needs of Nebraska?**

- More attention to substance abuse and adolescent services
- Need to address geriatric psychology to help with nursing home issues. Enhanced assisted living and Nursing Home Care for Behavioral Services
- Need to address placement of sex offenders.
- Transport service for EPC (possible subunit of State Patrol) or alternative transportation (non-police) of consumers to services.
- Better utilization of Telehealth
- Focus on prevention – funding for psychotropic meds (lots cheaper than hospitalization)
- Solicit consumer response.
- Have a program in place for persons waiting for services with at least minimal self-help group or other interventions (AA, day shelters, peer services, etc.) to reduce chance of decomposition. Create a safety net for wait listed
- Need to address issues consumers face in obtaining affordable medication
- Training to address issues – CIT, Services available, Peer Services
- Increase crisis capacity with better and faster acute treatment and a place for patients to go once stabilized (more detoxification access and peer support services)
- Psych Acute Units request too extensive a medical evaluation and seem to stall
- Utilize Wellness Recovery Action Plan (WRAP)
- Support services need to be available 24/7
- 16-bed strategically located facilities
- Close huge old in-patient facilities (Norfolk and Hastings)
- More funding from Medicaid and better continuity of care
- More flexibility of funding
- State should remain vital player in planning and funding
- Major uniformity issue in state policy – need to develop local plans and determine where funding comes from
- Restructure the Mental Health Law, taking cops out of the equation and leave providers in
- Who pays as care is being received/sought across state lines?

#### **4. What would help you most?**

- Crisis Response Teams
- More acute beds, housing (long waits in Emergency Departments [18 hours -> 7 days] because of no beds); long waits (up to 4 months) for transfer, tying up acute care beds
- Better connection between Medicaid and services
- State law change for EPC?
- Transportation alternatives in rural areas
- Clear guidance for control of Mental Health Boards
- BIG \$ (staff, capacity, training, etc.)
- Better integration with Primary Care
- Transport services other than police for EPC
- Call center for available beds
- Seamless process between all levels of care and ability to start at the necessary level (not always starting with in-patient level)
- Provide more lower level care services
- A single force communicating and educating consumers and providers on the services available and ensuring the safety net is in place.
- Medication Management
- Supportive Environment
- More funding for psychiatric meds/referrals
- Flexibility
- Staff/System stakeholder training
- Need to change system philosophy that a person must be EPC'd or under a mental health board commitment to access needed services
- Crisis Intervention Programs at local level with support services available after hours, acute intervention available 24/7 and up to 24 hours for stabilization
- Front-end services need to be available 24/7 (emergency care services, Peer Support, Crisis Programs, and Traditional care services)
- What incentive is there for MH providers to respond before the required 24 hour period when there is no compensation?

#### **5. What issues might keep you from doing an effective hand-off for EPC?**

- Rural setting and connection for Telemedicine in Rural Hospitals
- Arbitrary administrative rules
- Blurred roles of team members
- NOTE Capt. Wright's memo – well defined issues (ATTACHED)
- Transfers from one county to next or hospital to hospital
- Small counties have little manpower to transport EPC (especially long distances and without database for available beds)
- In some regions there is no single point of entry/contact
- Lack of information on bed availability (need a single source)
- Unresponsive or under-responsive Mental Health Region – not able to provide adequate assistance
- Lack of resources in rural areas (disparity in availability of services)
- Insufficient safety net in place
- Rural hospitals worry about liability issues and don't feel they are equipped to deal with EPC issues
- If other forms of transportation, who is responsible for time/cost?
- Need identification (clarification) of roles and responsibilities (law enforcement, hospitals, primary care, etc)

- Utilization of WRAP
- Utilization of Peer Support for EPC
- Not all psych hospitals are part of the “public system” (NBHS)
- No place for “them” to go especially after business hours
- COBRA/EMTALA regulations<sup>1</sup>
- Lack of community services for immediate follow-up
- Inconsistencies between counties as patients move between counties
- Transport orders from judges
- Who is responsible in an “escape” in case of active warrant?
- Conflict between public and private options for community based programs

## **6. What solutions have already been made to create more effective hand-offs of EPC?**

- Crisis Response Teams
- Region 3 has been having meetings and South Central is now available as a resource
- Set rate for beds so hospitals can maintain profit to continue services
- Psych evaluations in jail and prisons
- Triage in Region 3
- Need for quality training for healthcare providers
- Single point of contact and entry (as mentioned by CJ Johnson)
- In Lincoln and Omaha LE officers have been trained to be the 1<sup>st</sup> buffer, especially if it is substance abuse as opposed to threat to self or others. In Omaha, peer volunteers are used as well and trust is established quickly with this role as opposed to a staff person.
- The more you spend on high end services, the less dollars you have for lower end services and prevention
- Minnesota committed significant financial resources to address the problems and put thought into building a new BH system
- Mental Health Practitioner input
- Emergency community support
- Region 4 developing pilot transportation program (considering reimbursement for law enforcement overtime costs to help out smaller jurisdictions)

## **7. Who would need to be at the table for a further discussion on building a more effective infrastructure?**

- Use the info from this session to address the necessary next steps for developing regional response teams for EPC
- Medicaid - Magellan
- More legislators
- County Attorneys
- Chaplains and religious leaders
- Is there a way to streamline HHS so that we can make decisions?
- Other funding sources: Warren Buffet, Wal-Mart, Nebraska foundations
- Consumer and Family Representatives, Title 204 requires consumer feedback on adequate treatment being received.
- All level of Care Providers (representatives) (BH, Hospitals, and acute care staff, primary care physicians, social service agencies, public health, rural health)
- LE representatives

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<sup>1</sup> <http://www.medlaw.com/regs.htm>

- Start at regional basis first
- Safety net providers
- Transportation services
- Regional Team process involving Emergency Psych to include APS and System Stakeholders
- Governor and legislators
- Insurance Companies
- Clerk for District Courts (keeper of records info)

## 8. What do you see as the next steps following this meeting?

- More discussions on other alternatives
- Create statewide vision and pilot project to see what works (care system in community)
- Look at grants for transportation alternatives for regions
- Create statewide data system to provide evidence based decisions and planning
- CIT Training throughout state and beyond law enforcement
- Contacts/phone numbers for networking people
- Review of roles and responsibilities, hand-offs
- Regional meetings with all stakeholders including State DHHS representation
- After regional meetings follow through with recommendations (Action!)
- Survey consumers as to their needs and gaps in services and about what worked
- Legislative buy-in to more beds and increased funding, “real world” understanding of what is actually happening.
- Re-convene to see what progress has been made and create next steps
- Decrease EPC and create a day center and create more treatment capacity.
- Continued meetings/conference calls incorporating all regions
- Look at current funding – increase state funding (Are we spending most amount of money on least effective treatment?)
- Start at Regional level and go up; Create Regional Strategic Planning Meetings with an outside facilitator utilizing the Logic Model.
- Identify ways to create flexibility to meet individual consumer needs (fund needs not service types)
- Increase state development of mental health services
- Continue to focus on what is working. Pay attention to all needs of populations served.
- Improve access to immediate crisis intervention
- Develop enhanced “front-end” services – Peer Support, WRAP, Emergency Community Support
- Look at statutory changes re: EPC
- Look into validity of CR Teams for rural areas
- Create one place to call
- State Patrol and Sheriff tag teams for transport
- Look into primary care model and appropriate training and/or support (Telehealth) for providers to overcome skills deficit and treatment concerns
- Medical Home Concept

**Addendum B**  
**CJ Johnson Slides on Region V CRT**



## Crisis Response Teams (CRT)

- ✓ Direct response to LB 1083
- ✓ Mental health professionals are available at the request of law enforcement
- ✓ Provides 24-hours, 7 days a week access for law enforcement
- ✓ Significantly decreased hospitalizations
- ✓ Assist in coordination and integration between providers



## Outcomes

- ✓ Decreased rates of acute hospitalization for individuals
- ✓ Reduced recidivism for arrest and use of emergency mental health services
- ✓ Community confidence in police response to psychiatric crisis

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## Enacting CRT

1. An officer calls the law enforcement crisis line.
2. The crisis line connects the officer to the therapist on-call for immediate access.
3. The therapist consults with the officer regarding the identified individual.
4. The therapist goes to the scene.
5. Upon consulting with the officer and the individual, a crisis plan and recommendations are developed.
6. An Emergency Community Support Worker follows up with the individual.

## ADDENDUM C

### INTEROFFICE MEMORANDUM

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**TO:** C J JOHNSON  
**FROM:** JOE WRIGHT  
**SUBJECT:** DHHS MEETING/NOVEMBER 15  
**DATE:** 01/18/2008

There are several issues which are common among the regions. This is what I hear from the cops around Lincoln as well as the officers and deputies I train in Grand Island.

**Problem:** Many receiving agencies (Regional Centers or Hospitals) do not recognize that the EPC decision is made by law enforcement. Although triage services are often needed, once a person has been taken into custody Law Enforcement should not have to barter with anyone to obtain a bed assignment. I often hear from officers and deputies who tell me they wanted to EPC someone but the hospital wouldn't let them do it. **Solution:** *Our Single Point of Entry works well. One telephone call can inform the officer where to take the client; there is a clear understanding the EPC decision has already been made.*

**Problem:** Mental health providers generate too many EPC situations which are administrative in nature. Law enforcement is often drawn into situations in which clients are being moved from *safe harbors* (group homes, hospitals, residential programs) to a different program or level of care. Providers criminalize the mentally ill by abandoning their patients and/or clients to law enforcement officers. The client is forced to leave his program and re-enter the system by way of EPC creating an unnecessary break in care where too often the client loses his bed and is unable to stay on his medication regime. **Solution:** *Hospitals and providers must be held accountable for accessing law enforcement only when a true emergency exists. Clients can be managed by means other than EPC in many instances. Revocation of out-patient commitment, guardianship, court order, and mental health warrants generated by the provider are all options which allow the client to be moved in a responsible fashion from one level to another without divorcing the client from all care and leaving the client's welfare to the creative efforts of a police officer. Our respite program is a good but insufficient response to this issue.*

**Problem:** Law enforcement continues to take children into EPC. Unbelievably, law enforcement often EPC children who are Wards of the State. The County Attorney never files a petition but instead re-files the case placing the child under temporary guardianship of DHHS—exactly where the child already exists. This is another instance of abandonment by a system of care and the criminalization of the mentally ill. **Solution:** *All children in the State of Nebraska (all people under the age of nineteen) are already in the custody of their guardian. Any necessary care, including mental health treatment, can be mandated by the child's guardian. A parent or the on-call DHHS supervisor can direct any hospital to admit a child for mental health treatment.*

**Problem:** The developmentally disabled are often left to law enforcement when the client is in crisis. DD providers are unwilling to make any effort to see their client transition to an appropriate level of care and expect law enforcement to take custody on the grounds that the client is *mentally ill* and

dangerous. Once again, a client in a system of care is being abandoned to law enforcement—the client’s behavior is criminalized and an appropriate outcome is far from certain. **Solution:** *DHHS should mandate that the Developmental Disabilities Court-Ordered Custody Act (NRS 71-1101 to 71-1134) be utilized in all applicable circumstances. Providers can also develop guardianship and court order strategies which can help mobilize clients to any level of care. This applies to brain injury and dementia clients as well.*

**Problem:** Hospitals call law enforcement when mentally ill persons who are in crisis come to the emergency department for treatment. Emergency department staff expect police officers to take patients into EPC or find other dispositions rather than meeting the patient’s needs with their own resources; this is often a COBRA and/or EMTALA violation. **Solution:** *Hospitals have the responsibility to receive people who come to the ED for care, stabilize the patient and then admit the client or see that the client is admitted into the proper level of care at another facility. Any patient who "comes to the emergency department" requesting "examination or treatment for a medical condition" must be provided with "an appropriate medical screening examination" to determine if he is suffering from an "emergency medical condition". If he is, then the hospital is obligated to either provide him with treatment until he is stable or to transfer him to another hospital in conformance with the statute's directives. 42 USC 139dd et seq.*

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As more consumers are enrolled in community settings, we will see an increase in the number of law enforcement contacts with the mentally ill. This does not mean there should be an increase in EPCs. All providers have the opportunity to take a pro-active role in the mobility of their clients to a higher level of care when needed. Any client who is contacted by law enforcement can be immediately repatriated with their program’s staff if Law Enforcement is made aware that the person is enrolled in a program and has resources available which can be utilized to avoid EPC. Our flagging system does this very well.

Providers must also be pro-active when they see a client move toward decompensation. Before the dangerousness which justifies and EPC manifests itself, providers should contact their County Attorney to ask the client’s commitment be changed to a different program or that a mental health warrant be created.

Creating training opportunities in which law enforcement and providers work together to troubleshoot and streamline their community’s unique systems of care is the best way to minimize the number of people taken into EPC and to ensure when someone is taken into custody, it is for good reason and that the client receives the best services available. Kim and I helped Region IV do these three times last year and we will be in Columbus at the end of the month. You do it every month at our Emergency Level of Care Meeting. Good luck.

## **Addendum D**

### **Nebraska Behavioral Health Services Act, Section 71-806**

(1) The division shall act as the chief behavioral health authority for the State of Nebraska and shall direct the administration and coordination of the public behavioral health system, including, but not limited to: (a) Administration and management of the division, regional centers, and any other facilities and programs operated by the division; (b) integration and coordination of the public behavioral health system; (c) comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care; (d) coordination and oversight of regional behavioral health authorities, including approval of regional budgets and audits of regional behavioral health authorities; (e) development and management of data and information systems; (f) prioritization and approval of all expenditures of funds received and administered by the division, including the establishment of rates to be paid and reimbursement methodologies for behavioral health services and fees to be paid by consumers of such services; (g) cooperation with the Department of Health and Human Services Regulation and Licensure in the licensure and regulation of behavioral health professionals, programs, and facilities; (h) cooperation with the Department of Health and Human Services Finance and Support in the provision of behavioral health services under the medical assistance program ; (i) audits of behavioral health programs and services; and (j) promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services.

(2) The department shall adopt and promulgate rules and regulations to carry out the Nebraska Behavioral Health Services Act.

### **Nebraska Behavioral Health Services Act, Section 71-809**

*Regional behavioral health authority; behavioral health services; powers and duties.*

(1) Each regional behavioral health authority shall be responsible for the development and coordination of publicly funded behavioral health services within the behavioral health region pursuant to rules and regulations adopted and promulgated by the department, including, but not limited to, (a) administration and management of the regional behavioral health authority, (b) integration and coordination of the public behavioral health system within the behavioral health region, (c) comprehensive planning for the provision of an appropriate array of community-based behavioral health services and continuum of care for the region, (d) submission for approval by the division of an annual budget and a proposed plan for the funding and administration of publicly funded behavioral health services within the region, (e) submission of annual reports and other reports as required by the division, (f) initiation and oversight of contracts for the provision of publicly funded behavioral health services, and (g) coordination with the division in conducting audits of publicly funded behavioral health programs and services.

(2) Except for services being provided by a regional behavioral health authority on July 1, 2004, under applicable state law in effect prior to such date, no regional behavioral health authority shall provide behavioral health services funded in whole or in part with revenue received and administered by the division under the Nebraska Behavioral Health Services Act unless:

- (a) There has been a public competitive bidding process for such services;
- (b) There are no qualified and willing providers to provide such services; and
- (c) The regional behavioral health authority receives written authorization from the administrator and enters into a contract with the division to provide such services.

(3) Each regional behavioral health authority shall comply with all applicable rules and regulations of the department relating to the provision of behavioral health services by such authority, including, but not limited to, rules and regulations which (a) establish definitions of conflicts of interest for regional behavioral health authorities and procedures in the event such conflicts arise, (b) establish uniform and equitable public bidding procedures for such services, and (c) require each regional behavioral health authority to establish and maintain a separate budget and separately account for all revenue and expenditures for the provision of such services.

**Appendix C**  
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