[LR413]

The LR413 Task Force on Behavioral and Mental Health met at 1:30 p.m. on Wednesday, September 28, 2016, in Room 1524 of the State Capitol, Lincoln, Nebraska. Senators present: Kate Bolz, Chairperson; Sue Crawford; Sara Howard; John McCollister; Jim Scheer; and Les Seiler. Senators absent: Heath Mello.

SENATOR BOLZ: Okay. I think we'll get started. Thanks, everybody, for being here today. To refresh everyone's memory, this is a hearing of the members of the Behavioral Health Task Force under LR413. And I'll have committee members do self-introductions to get us started, starting on my right.

SENATOR McCOLLISTER: John McCollister, District 20, central Omaha.

SENATOR CRAWFORD: Good afternoon. Senator Sue Crawford, District 45, eastern Sarpy County, Bellevue, and Offutt.

SENATOR HOWARD: Senator Sara Howard. I represent District 9 in midtown Omaha.

SENATOR BOLZ: I'm Senator Kate Bolz. I represent District 29 in south-central Lincoln.

SENATOR SEILER: Les Seiler. I'm a senator from Adams County and the west half and the south half of Hall County, and it's called District 33.

SENATOR SCHEER: Jim Scheer, District 19, which is Madison County and just a little bit of Stanton County.

SENATOR BOLZ: Very good. We'll be joined later by Senator Mello, who is participating in two hearings this afternoon and will join us as he is able. So just to talk about process a little bit, this is a hearing of invited testimony only and I do have a list of testifiers, so I'll call you up as we're able. I won't be using the light system but I would ask for your succinctness and brevity so that we can keep the process moving and spend the majority of our time with questions and answers.

We'll be starting the hearing with a presentation from Dr. Watanabe-Galloway, who is part of the UNMC staff who worked on the gaps and needs assessment of the behavioral health system. So I'll invite you to come on up, Doctor. For the committee and the audience's knowledge, the Performance Audit Committee released a report last year and one of their recommendations was to do a statewide gaps and needs assessment, and this work is the outcome of that recommendation. So without further ado, I'll turn the microphone over to you. And we're eager to hear what you have to say. [LR413]

SHINOBU WATANABE-GALLOWAY: (Exhibit 1) Thank you very much for this opportunity to present main findings and recommendations from the statewide needs assessment we conducted. My name is Shinobu Watanabe-Galloway. I am an associate professor in College of Public Health. And this project became possible with my colleagues from College of Public Health, so I'd like to acknowledge them as well. [LR413]

SENATOR BOLZ: Very good. And I should have asked you to--and I will ask the other testifiers as well--please state and say your name for the record. We will be...sorry, state and spell your name. We will be transcribing this hearing for the record. [LR413]

SHINOBU WATANABE-GALLOWAY: Okay. So would you like me to spell? S-h-i-n-o-b-u W-a-t-a-n-a-b-e-hyphen-G-a-l-l-o-w-a-y. So the purpose of this needs assessment was to conduct very comprehensive assessment of behavioral health system. Could you please excuse me for a moment. Okay. I have to make some corrections with the slides. If you can excuse me to just stay with the handout copy, I really apologize for this inconvenience, but the slides that I brought today appear to be the shortened version and not the complete version that I was preparing this morning. So I apologize to the audience for the inconvenience but, Senators, you all do have the printout of the handout. So if you could please follow those slides, we will go over those slides one by one. Thank you for the understanding. Okay. So the main purpose of this needs assessment was to provide objective data to inform planning process for DHHS Behavioral Health Division for them to further determine what steps they need to take in order to strengthen behavioral health system. So in order for us to conduct very comprehensive assessment, six areas were covered in this study. One is to estimate the burden of behavioral health problems in Nebraska general population. Second is to identify strengths and gaps in Nebraska's public

behavioral health system. Third is to identify needs of special population, such as persons with developmental disabilities, persons involved in the criminal justice system, and the homeless population. Fourth is to describe the current status of behavioral health work force in Nebraska and identify areas for improvement. The fifth objective was to discuss national- and state-level initiatives for integrated care; lastly, to engage consumers, families, and stakeholders to understand their point of view in order to strengthen Nebraska's behavioral health system. Now, Senator, if you can move to the next slide, key findings that we are presenting here. As you all know, in 2015 we had 1.9 million people living in Nebraska; 20 percent of them living in rural areas. When we compare Nebraska's statistics to U.S. statistics in terms of socioeconomic status, 11 percent of Nebraskans did not have health insurance, which was slightly lower than U.S. average of 14 percent. Unemployment rate was also lower in Nebraska compared to U.S. These statistics are very important in terms of understanding how economic status may affect person's ability to access and use behavioral healthcare. Although these statistics are very positive, we also need to understand some areas of concern. For example, African-Americans and Hispanic individuals do experience more of the socioeconomic burden. For instance, poverty rates have been higher in Omaha metropolitan areas compared to national average for African-Americans and Hispanics. And also poverty rates in these two population groups are increasing since 2010. Now going to the next slide of behavioral health regions characteristics, again, as you all know, except Region 6, all other regions primarily comprise rural counties. This point is also very important in terms of access to different types of behavioral healthcare. Region 6 has the highest percentage of minority population. However, when we examine Hispanic population's concentration, actually other regions do have high concentration of very diverse, including Hispanic, population. This speaks to the need for more cultural and linguistically appropriate service in the rural as well as urban areas. And when we compare some other socioeconomic status across different regions, we observed in Region 1, one in four children, which is 24 percent, were living in poverty. Okay. Now moving on to statistics on burden of behavioral health problems in Nebraska general population and to what extent people are using treatment in these areas. Mental illness is one of the most common chronic health conditions in the United States and Nebraska. We observed from national surveys which were conducted in each state, so we do have information about Nebraska specifically, we observed, for instance, females tend to have much poorer mental health status compared to males. High school students experience high prevalence of depression and suicide. American Indian individuals are at high risk of depression

and suicide. Drug-related death rates have been lower in Nebraska compared to U.S. average, however, drug-related death rates have steadily increased between 2005 and 2013, which is a concern. Although drug and alcohol use are high, peak among young adults, which is between 18 to 25 years old, it should be noted when it comes to drug-related deaths the rate is actually peaking among adults between 45 to 54. Nebraska has a very high binge drinking rate. In fact, Nebraska's rate is 20 percent, compared to 10 percent, the first, West Virginia, which is doing much better. So twice as the best state. When we look at the statistics, concentration of high binge drinking has been observed in Region 5 area, especially in Lincoln area. About half of Nebraska adults reported, according to the population base data, they did experience some kind of adverse childhood experience, including physical, emotional abuse; separation of parents; incarceration of parents. Overall, national and state statistics show the burden of mental illness is about the same when we compared Nebraska to national average. For example, among those individuals 12 years old and older, about 20 percent of them reported they experienced some kind of mental illness in the past year. Secondly, 4 percent of individuals 12 years and older, they experienced serious mental illness in the past year. Four percent of the individuals thought about committing suicide. When it comes to lifetime prevalence of depression among adults, 17 percent of them reported they ever had experienced depression. We observed from the data, depression and suicide are two major problems among high school students, which call attention for prevention and may be some approach we need to take for middle school and high school age students. For instance, 31 percent of female high school students reported they were depressed in the past year. The rate is lower, 17 percent for males, but that is still a concern. Again, among high school students: for females, 18 percent of them considered committing suicide in the past year; 11 percent was the rate for male high school students. Nationally and in Nebraska, treatment use for mental illness is very low, which is of great concern. We need to better understand why people are not seeking and getting treatment in the general population as well as people with serious mental illness. Of those adults with any mental illness, only 47 percent of them received treatment for mental illness. Of those adolescents with depression, only 43 percent received treatment for depression. Of those individuals 12 years and older with drug problem, only 11 percent of them received care. Now, I'd like to switch a gear from general population statistics to assessment of public behavioral health system. For the audience who may not be familiar with what public behavioral system concepts and how we define, in general, we define public behavioral system is the system designed as a safety net and funded through federal

grants, some state funds, and maybe county or other public funds mainly. When we examine statistics from other states, you will notice--and this is one of the limitations of our study, by the way--is that some states report statistics including Medicaid to consider comprehensive behavioral health systems expenditure and service use in population. We, for our study, we focus on behavioral health services, which are funded by Division of Behavioral Health, so that is an important consideration when you examine the report for your information, because Medicaid is the part that we were not able to use comprehensive data to look at the entire public behavioral health system. Nevertheless, we believe most of the information we are presenting here are reflective of the whole system. So that is an assumption we are making today. But we wanted...I wanted you to understand some limitation of this study and that is something that needs to be further looked into for the future purpose. Okay. So this is a safety net system for people who have serious and persistent mental illness. Some of them do have dual diagnosis, meaning they have co-occurring substance use problem. Okay. As you know, Division of Behavioral Health is serving as chief behavioral health authority to work with regional...behavioral health region authorities and other partners. Behavioral health region authorities' primary role is to administer community-based care. In 2016, the expenditure data we received from the DHHS was $94 million. That is only for the DBH-funded services for mental health and substance use. Each year, about 32,000 consumers are served through Division of Behavioral Health funded program: 8 percent of them are children under 18 years old; 17 percent of them are young adults 19 to 24 years; 74 percent, adults 25 to 64; and 2 percent older adults, 65 and older. We examined service capacity data, for example, wait time, to see whether there are adequate level of services available for consumers who have serious mental illness and dual diagnosis problems. The data show that wait time for community-based mental health services is average of 20 days; however, it ranges from anywhere between zero to over 100 days. So it really depends on which services and what population that we examined the data for. Over 60 percent of waits were for short-term residential services, indicating maybe this is one of the area that needs more attention for expansion. When we look at the data for substance use disorder priority populations, which include HIV/AIDS patients, TB treatment, women with dependent child, so on and so forth, we found longest wait was for outpatient, which was 37 days, and also 37 days for therapeutic community. So we identified those two areas to be also something that we need to pay attention to see why the wait time is that long and what needs to be done for...in order to show the wait time. Women with dependent children, their wait is much longer than other priority populations,

indicating perhaps we do not have enough services tailoring toward women, especially those women who have children who may have substance use problem. Emergency protective custody admissions have steadily increased over time. For example, between 2011 and 2016, EPC admissions annually declined from 744 to 683, which is one of the positive signs that we observed. It is important to understand that EPC admission is very common. One in ten adult consumers served through Behavioral Health Division, they experience at least one EPC each year. EPC use rate was much higher in Region 1, which is close to 20 percent; Region 4 also 16 percent, meaning 16 percent of the people in Region 4 had at least one EPC. Interestingly, EPC admission rate was much lower in Region 5 and 6. So we have seen some evidence of regional variations pointing out some of the planning is region-specific; other things, other problems we observed are more a statewide problem. Okay. So I have a lot of statistics which I took from the presentation, but since I have limited time I will leave it to you to read the comprehensive report that we presented to use through division. But some of the slides, for example, we are presenting here is about residential service capacity assessment. This is the data to support one of the findings to say, for example, psychiatric residential rehabilitation service may need to be expanded for consumers with mental health problems, because when we examine the data from fiscal year 2015 and 2016 for psychiatric residential rehabilitation we observed above capacity level at the region of 136 percent in fiscal year 2015. Fiscal year 2016, region level capacity was 162 percent. So when we...from capacity data, it clearly shows expansion of residential care for both mental health and substance use may be needed. I would like to change the subject now to special populations. We use this term to discuss about populations which are higher risk of developing mental health issues and also substance issues. There are many different population groups that deserve our attention, but because of the limited time we were allowed to spend on the needs assessment we decided to focus on persons with intellectual developmental disabilities, criminal justice population, veterans, and homeless populations, but we need to emphasize the need to look at the data and assess how we are serving other vulnerable populations such as LGBT communities, transitional aged youth who may fall into the gap between their coming out of the system and going into the adult (inaudible). That's the area we do not have the good data to assess but we know anecdotally that services are probably lacking and need more attention in the future. But, unfortunately, we could not spend time to study that particular population. Persons with intellectual developmental disabilities: According to the state data, 10 percent of children with developmental disability do have some type of behavioral health issue, and 50

percent of adults served in community-based programs administered by Division of Developmental Health do have diagnosis of mental health or substance use disorder. Nationally, it's been a problem in terms of developing/offering tailored programs for persons with developmental disability and that is something that I did not receive the data to say how Nebraska is doing. Probably need to investigate further. National statistics show 50 to 60 percent of inmates have mental health and substance use disorders. I will not spend a long time today in...for the presentation, but I need to point out there are many initiatives and efforts around addressing the needs of the criminal justice population. Collaboration between Behavioral Health Division and the justice system and other partners have been ongoing. Veterans: We have 137,000 vets living in Nebraska, many of them living under poverty. About 20 percent of them are estimated to have PTSD. A small but substantial proportion of female vets may be exposed to military sexual trauma, which is a new area that we are paying more attention to. Also, substance use problem is a huge issue in this population. Ten percent of homeless adults are vets. Although the situation is getting better for vets in terms of their access to housing, this is another area we need to pay attention to provide more support for them to find housing and be able to sustain. Now I'd like to get your attention to behavioral health's work force issue. It has been known, again nationally, in Nebraska, there is a severe shortage of psychiatrists and other behavioral health providers. Seventy-nine counties in Nebraska are recognized as shortage area for psychiatrists and other mental health providers. When I say mental health providers, those work force include psychologists, nurses who are specializing in psychiatry, PAs, other more mid-level mental health professionals, counselors specializing in mental health problems and so on, so forth. But overall, we do have severe shortage, especially psychiatrists. Prescribers are lacking. Okay. So only 12 counties in Nebraska have psychiatrists and people who do have mental illness, they need to be assessed for medication. Medication management is a very important part of their treatment. So the fact that we are lacking psychiatrists and prescribers is a huge issue and it's an ongoing issue nationally. Okay. Of course, rural areas probably experience the most impact from the shortage of psychiatrists, but we do observe shortage or the access issues in some areas in urban communities, especially socially depressed areas. So shortage of mental health professional is not only the problem in rural communities but certain areas in urban counties as well. Throughout this project, we heard clearly from consumers about their desire to more fully participate in decision making and to function as a professional peer support specialist, and that's one area the Division of Behavioral Health has been working on. But we

recommend the training and educational opportunity to be expanded so consumers who are interested in becoming and being certified to serve as a peer support specialist have opportunity to do so. And this was expressed so strongly in the focus group study we conducted. Community-support workers, which comprise of perhaps about 70 percent of behavioral health's work force, so psychiatrists and prescribers are very important but small proportion of work force. And we have mid-level individuals who provide therapies and other services. But when you look at the bottom of the pyramid, we cannot forget the role and importance of individuals who are not licensed but provide day-to-day care to consumers with behavioral healthcare. Retention is very difficult. Turnover rate is very high. Burnout is very high. That is a problem across the board for any professional. But we did observe some evidence from the literature that perhaps we need to pay some attention to this part of the work force. We conducted three statewide surveys to engage consumers, stakeholders, and general public audience who are interested in the issues of behavioral and substance use problem. Also, we conducted a number of focus group sessions throughout Nebraska. We did make every effort to reach out to every region in order to get input from all the main major types of stakeholders and consumers. But this was not a random sample, so when we interpret the data we need to remember this was a convenient sample survey. So we need to be careful about the interpretation. Nevertheless, close to 300 consumers participated in the consumer survey. Over 1,000 stakeholders participated in stakeholder survey. And also, close to 250 individuals from the general public participated in the survey to provide very detailed information, which you will find in the report. According to the survey, 40 to 60 percent of consumers reported they could get therapy, medication management, or substance use disease treatment within two weeks. Two weeks is often used as an indicator to whether the access to care is adequate or not. So the flip side of thinking about the statistics is actually about 50 percent consumers are not getting an appointment within two weeks. But again, this is a convenient sample survey. I'd like to get your attention that it's not representative but this is a piece of the information that is important to reveal. Twenty percent of stakeholders, which include providers, public health officials, law enforcement, their perception was it is very difficult to get serious mental illness treatment in Nebraska. Twenty percent of stakeholders participated in the survey reported their consumers can easily get SMI treatment, so meaning 80 percent of them are reporting it is very difficult. They also pointed out challenging situation for consumers to access medication they need. Interesting, the general public's perception was such that access to serious mental illness and substance use treatment service is not adequate in

Nebraska. Only 10 percent of the general public respondents thought state has adequate level of service. However, we also need to point out, in general, in Nebraska and nationwide, awareness of mental illness is still very low. So this the perception still that they believe mental illness is an important issue, but when it comes to how to access the care, general public knowledge is very low. Adults with serious mental illness, including schizophrenia, their life span is about ten years shorter than people without serious mental illness. This is mainly due to medical conditions they suffer from: cardiovascular disease, diabetes, obesity rate is very high, smoking rate is very high. So in order for us to improve the quality of life for individuals with mental illness, we cannot forget the medical issue is something that we need to pay attention to. According to the survey, most of the respondents/consumers reported they do see a medical care provider, a doctor, at least once a year. However, people who have chronic disease, even though they're in contact with medical care provider, they are not consulting with the doctors to manage chronic disease. And also, only half of the smokers that is consumers have talked to doctor about smoking cessation. So that's another areas that we would recommend, you know, to see some improvement. Okay. There are so many recommendations we directly received from consumers and stakeholders, so I'd like to pay attention to some major areas that came repeatedly across different stakeholder group and the region. Okay. Many people participating in the focus group agreed Nebraska has a culture of collaboration and partnership, and consumers did show appreciation for the efforts that are made by providers and public health officials. However, they strongly expressed the desire to see more formal collaboration across agencies and systems, especially recommending formal agreement to share information across the systems which they believe would improve coordination and efficiency of care. For example, people who are going through EPC emergency response system, they get hospitalized. And when they are ready to be discharged, there has to be the follow-up care. Many individuals expressed post-care is really lacking, navigation is lacking, and often consumers are left to take care of the appointment, take care of themselves in other situation they find themselves after the discharge. So if the information sharing is more fluid and live, then agency may be able to find appropriate service more quickly and then be able to find out which consumers need service right away. So that's one theme that came out throughout the focus group is read a recommendation of information sharing. People do understand confidential and very private information about consumers that we are dealing with, but there needs to be some way to overcome the issue. So providers and agency which need information about consumers are able to follow the consumers over time to make sure they're getting appropriate

service in a timely manner. Consumers reported even when officers are very compassionate and helpful, involvement of law enforcement is such a traumatic experience. In fact, some consumers reported that because of that experience sometimes they're hesitant to seek care. They recommended 24/7 crisis line should be expanded or to be better known. Consumers report 24/7 crisis line is very helpful for deescalation of crisis situation. Also, providers and stakeholders recommended drop-in and respite centers to be established, especially in rural areas. These are the places consumers and their families can go instead of they were to go for the hospitalization. So here a lot of themes that we heard in the focus group and survey is intermediate level of care, what we can do between inpatient and outpatient. And providers pointed out it's not just inpatient and outpatient. If we do not have very good infrastructure and support system between, then we will continue to see people going back to the hospital. And that's something seems to be really lacking in our state. But if we can develop the places where consumers can go when they start experiencing symptoms and worry that would trigger the crisis situation, there has be the place they can go and feel safety, feel safe for themselves and others and maybe the short-term observation. That all is all they need. So I mentioned about need for intermediate care and maintenance and spoke about the importance of peer support. A few other issues that came up--transportation and housing. It was pointed out transportation to go see the provider is really lacking in the rural areas. Public transportation system is not adequate and often not appropriate for individuals who are experiencing crisis. And a current need, the transportation service we provide to the consumers, it requires maybe one day or two days ahead of time the appointment. But imagine people experiencing crisis. They do not have the time to, you know, advance appointment. So there has to be something more available and tailored toward the individuals who may experience a crisis situation. They need to be transported. They need to get to the care. That system is not established well yet. Housing shortage, especially in the rural area, has been pointed out. Shelters often do not exist in the rural areas and, in general, housing option is very minimum in the rural areas. Now I'd like to start closing this presentation for summarizing some main findings and confirming some of the recommendations I already discussed and some new ones. Shortage of psychiatrists is a problem, especially for individuals who are experiencing serious mental illness. Although integrated care and telemedicine may be alternatives and we do recommend expansion of those approaches, integrated care and telemedicine, we need to urgently address the issue of prescriber shortage. So while we encourage effort to increase psychiatrist work force, we would like to see other options to increase the pool of prescribers.

For example, APRNs and a physicians assistant who could prescribe, they may be trained, certified. And maybe additional training for primary care providers in the rural area could alleviate some of the shortage burden issues in the rural areas. So we need to start thinking about alternatives while we keep focusing on still the rural psychiatrist development. Emergency response system: We recognize from the data, situation has been going into the right direction, some positive direction. But we do recognize this is one area that needs close monitoring and attention, and to keep an eye on how this positive trend would continue. We talked about residential care service. We feel that is an area that needs some expansion, especially for substance use treatment and especially for women with dependent child who needs to wait sometimes over one month to get substance use care. Okay. In terms of education of the general public, we do recommend a continuation of mental health first aid for the general public but with specific focus on individuals who do work with young people, so school officials, teachers and coaches and parents, to raise their awareness about mental illness; how do we spot some signs of depression, prevent suicide. Those are very important. We recommend expanding and strengthening co-occurring services and trauma-informed care. Division of Behavioral Health and providers in regions have been making efforts, but those are two areas that need continuing efforts. SBIRT, which is called screening, brief intervention, referral and treatment, this is one approach that we can use in the primary care to screen and treat individuals with substance use. Since we have such a high binge drinking rate, there needs to be some efforts being made to screen at-risk population, especially young adults, and get them treated before things get worse and see the death rate among the middle-age to continue to rise. We need to have the preventative effort for that. Finally, we recommend comprehensive assessment to be repeated within three to five years to make sure these areas of gaps that we identified from the needs assessment to be monitored and then making sure there's some progresses. We do recommend the Division of Behavioral Health and regions continue to use this new information system called Centralized Data System and billing system to make sure they're using the data and establishing performance measures, which should be examined quarterly basis, okay, for the process assessment, but each year, at the end of the year, to see that each region and division is making progress. So comprehensive examination to be within three to five years, but the annual examination of some major areas that we pointed out need to be done and reported. That should really help not only the division but make things really objective and transparent. And we really appreciated the efforts of Behavioral Health Division and their partners to provide the data. But we agreed, data

quality is some time a problem and more complete data need to be collected and assessed. So this is the conclusion of my presentation. If you have any questions, I'm happy to answer what I can answer. [LR413]

SENATOR BOLZ: Very good. Thank you for the very thorough presentation and the hard work that you've put into the gaps and needs assessment, Dr. Watanabe-Galloway. I'll open it up to the task force members for questions. Go ahead, Senator Crawford. [LR413]

SENATOR CRAWFORD: Thank you, Senator Bolz, and thank you for this assessment. I appreciate that. One part that I found particularly helpful was your overview of the residential service capacity assessment. [LR413]

SHINOBU WATANABE-GALLOWAY: Uh-huh. Yes. [LR413]

SENATOR CRAWFORD: And I notice in the executive summary there was some...an issue raised of some limited capacity data. I wonder if you'd just talk a bit about the other capacity data you were able to collect and what we might expect to see in the report and what are areas where you were attempting to collect capacity data but you weren't able to draw conclusions in the report. [LR413]

SHINOBU WATANABE-GALLOWAY: So this is...this was a working and collaborative process between us and division to examine the data. We did receive capacity data on residential care as well as outpatient care. But after examining the data because we know how to spot some problems when some data points look unusual. And so we asked the division to further look into the data quality and they determined residential data to be most comprehensive and complete. Centralized Data System began implementation in June 2016, and this is now one of the main sources of data division can use. Because it takes some time for the system to mature, usually, you know, a couple of months or half months, this is from my experience working with other system, data system, we need, really understanding the data, how people are entering the data. So providers enter the data into Centralized Data System. We do recommend a quality improvement for the data entry and in how quickly providers actually enter the data. It seems like some of the data issue was due to the fact people were not consistently entering the data or they

misunderstood what type of data or information to be entered. So we recognized some problems with outpatient data so we were not able to fully assess the capacity of outpatient care this time, and that needs to be done. [LR413]

SENATOR CRAWFORD: So the...what you're hearing from the focus groups is the consistent urgent needs and emergency care, and especially intermediate care. [LR413]

SHINOBU WATANABE-GALLOWAY: Uh-huh. [LR413]

SENATOR CRAWFORD: But you don't have some assessment of capacity in intermediate care that's available with the data that you've gathered. [LR413]

SHINOBU WATANABE-GALLOWAY: We did not specifically ask for intermediate care. What we asked for was to give us just any capacity data. So we did not ask for intermediate care. So that's a question that you perhaps need to ask division. I don't have the accurate answer for that, but that's something that needs to be done. We did not examine the data. We did not receive and examine the data on intermediate care. [LR413]

SENATOR CRAWFORD: Okay. Okay. And so in terms of looking at the...you say the capacity outcomes there that you have say we need to address problems associated with the emergency response system... [LR413]

SHINOBU WATANABE-GALLOWAY: Uh-huh. [LR413]

SENATOR CRAWFORD: ...and the use of...substance use disorders and co-occurring disorders. [LR413]

SHINOBU WATANABE-GALLOWAY: Uh-huh. [LR413]

SENATOR CRAWFORD: So can you just speak a bit about what that capacity data was that you used in making that statement? [LR413]

SHINOBU WATANABE-GALLOWAY: Yes. So where we did not have data directly from the division, we had to rely on the focus group and survey. [LR413]

SENATOR CRAWFORD: Okay. [LR413]

SHINOBU WATANABE-GALLOWAY: That is where we need to be careful. This is not the representative survey data, but it showed something about what people are experiencing from the survey data. So the way we would interpret is among those people who completed the survey, that was their experience. So the wait time for substance use and some of the services were rated as very minimum. So that's the conclusion we made from the survey data. Yeah. So that does speak about the data needs. [LR413]

SENATOR CRAWFORD: And on that point I'll just ask your sense when you're talking about substance abuse treatment for our youth. You said only 11 percent receive treatment for drug use disorder and only 7 percent for alcohol dependence... [LR413]

SHINOBU WATANABE-GALLOWAY: Uh-huh. Uh-huh. [LR413]

SENATOR CRAWFORD: ...where we have such a huge binge drinking problem. Do you have a sense from your data analysis whether those very low treatment levels are a lack of capacity or a not seeking care issue or some other kind of access issue? [LR413]

SHINOBU WATANABE-GALLOWAY: Just to clarify before I answer that question, those statistics came from population-based data. So we feel those are pretty good estimates of treatment use. It's not from our survey but it was done by SAMHSA. I have knowledge from literature review from other states, but I do not have direct knowledge to answer your question to what is causing that problem in state of Nebraska. [LR413]

SENATOR CRAWFORD: Okay. Would you mind sharing what the literature says in general? [LR413]

SHINOBU WATANABE-GALLOWAY: The literature speaks about our general lack of awareness about mental health impact in substance use disorder in general population. And although there are some genetic causes we understand about mental illness, mental illness in substance use problem can happen to anybody. So from that perspective, we all need to be educated to understand what mental health issue is in substance use problem, just like we have awareness around cancer, heart disease, and diabetes. We know so much more about those medical issues. So what a lot of researchers and public health officials are saying is public campaign to raise awareness so people do understand and feel mental health issues is as important as medical chronic issues. So that's the first step, to raise awareness so we know the sign. So a lot of time people who are experiencing problems and family members did not recognize the signs of mental illness. If they do not recognize the signs of mental illness, they do not seek care. So that's one. Number two, it's such a stigma that is also shared with mental illness. We heard from consumers and family members. People are being labeled as, you know, just mentally ill individuals instead of being treated as a whole person who has mental illness and substance abuse. Literature shows that a lot of people worried about impact of receiving diagnosis from the insurance perspective and job, getting the job: What if somebody find out I have mental illness or getting treatment for substance use? So a lot of people are reluctant to seek the care. Once they recognize there is a care, there is a reluctancy because of the stigma; then access, where to get access. So from our survey, general public is not knowing where to go for the treatment. And consumers, once they're in the system, they know where to get. So it's really the mix of a lot of different reasons, from the literature again. This is not a study from Nebraska but what we know. [LR413]

SENATOR CRAWFORD: Thank you. [LR413]

SENATOR BOLZ: Go ahead. Go ahead, Senator Scheer. [LR413]

SENATOR SCHEER: Thank you, Senator Bolz. In reference to the serious and persistent mental illness, you're talking about adding additional prescribers as far as for the medication. The areas that I'm familiar with, that would be part of the problem, but a larger problem than that would be that one of compliance and of the management,you know, compliance and management by

nursing staff to make sure that those that are receiving those are taking them on a normal basis and a continuous basis to become therapeutic. [LR413]

SHINOBU WATANABE-GALLOWAY: Uh-huh. Uh-huh. [LR413]

SENATOR SCHEER: I don't see anything in your report that speaks to that at all. And personally, more disheartening is that I know that the state has started discontinuing that service as well. So if we're really serious about trying to improve the mental health of people, trying to keep them on target and the services available to make sure that they are compliant with their medication, certainly is a lot cheaper than putting people into facilities for when...the recidivism basis. So that's a concern of mine and you didn't speak to that, so I'm curious. [LR413]

SHINOBU WATANABE-GALLOWAY: I did not speak that during the presentation partly because the report is 300 pages. [LR413]

SENATOR SCHEER: Fair enough. [LR413]

SHINOBU WATANABE-GALLOWAY: So we wrote about the issue of whether people are getting case management is one, you know, way of making sure people are getting the medication. People are discharged with enough medication before they get to the outpatient appointment. Bridge care is one, you know, method that's been used in some communities. But we did not, you are correct, we did not specifically examine the issue in this report. We mentioned about importance of access to medication and...but we did not examine the issue in particular. And I do recognize that's important. [LR413]

SENATOR SCHEER: I guess to me that's as big a picture to me as the availability of the prescription. Because if you get a prescription but you're not taking the medication,... [LR413]

SHINOBU WATANABE-GALLOWAY: Uh-huh. [LR413]

SENATOR SCHEER: ...what good did it do to have access to the drugs? So I, you know, we've, one, from a state perspective, if we've paid for those pharmaceuticals and somebody is not taking

them, then we've wasted the money for those drugs. And then, because of the lack of compliance, then they will revert back and probably have to be hospitalized for a period of time, which is the most expensive form of treatment that we have, so. [LR413]

SHINOBU WATANABE-GALLOWAY: I acknowledge that, but I still must say that access to psychiatrists and prescriber is essential as part of the comprehensive assessment to say... [LR413]

SENATOR SCHEER: Oh, don't misinterpret. [LR413]

SHINOBU WATANABE-GALLOWAY: Yeah. Uh-huh. [LR413]

SENATOR SCHEER: I'm not trying to imply that we have way too many of those. We don't have any and I know from experience how difficult it is to recruit and maintain a psychologist, so...a psychiatrist. So I'm not trying to minimize that at all. Mine is, best case scenario, we get the psychiatrist. But if we don't have people that are helping those individuals maintain their compliance to those prescriptions,... [LR413]

SHINOBU WATANABE-GALLOWAY: Yes. Uh-huh. [LR413]

SENATOR SCHEER: ...the fact that we have psychiatrist or another mental health provider does that person no good in the end run, because if they don't take the medication to a therapeutic level, it's for naught. [LR413]

SHINOBU WATANABE-GALLOWAY: I do (inaudible). [LR413]

SENATOR SCHEER: The housing, you know, you've talked about housing in the rural areas, and I don't know that you are an expert in that or if you folks looked into it. I'm from an rural area so I'm somewhat familiar with it. And we continue to try to get additional housing, but those federal funds are almost nonexistent. I mean it is very, very difficult. So I'm just...any thoughts on how to go about providing that in the more rural areas, because you have lower numbers, which then, you know, increases the cost on a per unit basis. [LR413]

SHINOBU WATANABE-GALLOWAY: So I will only speak about the data we collected and will not speculate things that I'm not familiar with. We looked at housing data, overall housing data from the state. And also housing data, housing supports data is specifically designed to serve people with mental illness, so that's very specialized. [LR413]

SENATOR SCHEER: Uh-huh. Correct. [LR413]

SHINOBU WATANABE-GALLOWAY: And I think that's what you are speaking about, those resources. [LR413]

SENATOR SCHEER: Uh-huh. Correct. [LR413]

SHINOBU WATANABE-GALLOWAY: We did not do an assessment to say whether the current level of housing support, you know, the money, the funding, is adequate or not. What we know from the focus group is that the rural residents tend to report there is an issue. There are limited options. So I suppose that I do not have a direct answer to your question. [LR413]

SENATOR SCHEER: You've looked, you found the problem. They haven't explored solutions, let's put it that way. Would that be a fair assessment? [LR413]

SHINOBU WATANABE-GALLOWAY: That is. So our recommendation is to understand better exactly how to go about expanding the service in a rural area. That is correct. [LR413]

SENATOR SCHEER: And in regards to the EPC, did you look at the availability of beds throughout the state, and especially more rural areas and probably, I would suspect, in your metropolitan areas as well, how short we might be in that capacity? [LR413]

SHINOBU WATANABE-GALLOWAY: Yes. So the residential care, the beds (inaudible). [LR413]

SENATOR SCHEER: Not residential. The EPC portion, hospitalization. When you have put somebody in protective care, usually it's in more of a protective facility, not necessarily residential. [LR413]

SHINOBU WATANABE-GALLOWAY: When we look at the penetration rate of how hospitals have been used in Nebraska compared to other states, there is some indication that we may need more beds in this state. But it's not clear completely because Nebraska's data only cover division supported programs. So we do not have the Medicaid data, so I do not have a complete answer to address your question. [LR413]

SENATOR SCHEER: And if I...one last question. Did any of your study--because I didn't see it so I'm not saying it's there and I just missed it--look at any type of comparison levels of reimbursement for services via Nebraska versus surrounding states or national exposures? [LR413]

SHINOBU WATANABE-GALLOWAY: No, we did not. [LR413]

SENATOR SCHEER: Okay. [LR413]

SHINOBU WATANABE-GALLOWAY: That was out of scope. [LR413]

SENATOR SCHEER: Out of scope. [LR413]

SHINOBU WATANABE-GALLOWAY: Yes. Uh-huh. [LR413]

SENATOR SCHEER: Okay. Thank you. Thank you, Senator. [LR413]

SENATOR BOLZ: Go ahead, Senator Howard, and then Senator McCollister. [LR413]

SENATOR McCOLLISTER: Thank you for your testimony. [LR413]

SENATOR HOWARD: Oh, that's all right. [LR413]

SENATOR McCOLLISTER: Oh, did I...Sara, are you next? [LR413]

SENATOR HOWARD: No. Get after it. [LR413]

SENATOR McCOLLISTER: Okay. You identified that there's a severe shortage of mental health, behavioral health work force in Nebraska. How are some states dealing with that, those shortages, that we might learn from? [LR413]

SHINOBU WATANABE-GALLOWAY: Shortage, one approach is to expand integrated care, is to train primary care providers to better work with population with mental illness. So bringing mental health into primary care and training the primary care providers to work at a more higher level to treat individuals. I outlined, we outline in the report some examples of integrated care done through VA, has a model program. They have been very successfully expanding access in rural areas through integrated care and telemedicine. I know VA system is different from state, but approach and methods they use may be something that we can look at. So North Carolina is another example. They have been very aggressively expanding telemedicine and integrated care and they have observed a huge improvement in cost saving and outcomes in the individual. So we do have several states' example, and some of them are a public behavioral health system. So I think we have, you know, we could look into some other states' examples. [LR413]

SENATOR McCOLLISTER: Thank you. [LR413]

SENATOR BOLZ: Senator Howard. [LR413]

SENATOR HOWARD: That actually dovetails very nicely. I wanted to see if, in your assessment, you had a broad understanding of Nebraska's utilization of integrated care, and then if you had any suggestions for how to incentivize utilization of the SBIRT model in an integrated care setting or a primary care setting. [LR413]

SHINOBU WATANABE-GALLOWAY: I've been involved with some assessment of SBIRT in Omaha area. We discovered, not surprisingly, reimbursement is an issue and maybe part of the solution, meaning providers need to be able to bill for the services they provide. So the Medicaid

recognizing some of these services as billable services is one...not incentive, it's a need. They need to get paid. So places that are doing...implementing SBIRT more experimentally how this works so...but we need to have the business model that works in order to establish the infrastructure. So that's one issue that's been raised in any place that we go and speak about SBIRT. [LR413]

SENATOR HOWARD: Could the same be said about MTM as well? [LR413]

SHINOBU WATANABE-GALLOWAY: And tell me a little bit. [LR413]

SENATOR HOWARD: For medication therapy management, could the same be said that it needs to be a billable in order to incentivize its utilization? [LR413]

SHINOBU WATANABE-GALLOWAY: That may not be the only answer but certainly it could encourage providers in the system to start looking into that service. [LR413]

SENATOR HOWARD: Thank you. [LR413]

SENATOR BOLZ: Very good. Well, I very much appreciate your hard work. The committee members just received the copy of your report this morning, so I know they'll spend more time reviewing your recommendations. And we will continue to be in contact with you. So thank you for your efforts. Final questions? Okay. Thank you very much, Doctor. And with that, we'll invite up Deputy Platte County Attorney Elizabeth Lay. I think I saw her earlier today. [LR413]

ELIZABETH LAY: Hi. [LR413]

SENATOR BOLZ: Thanks for joining us. [LR413]

ELIZABETH LAY: Good afternoon. My name is Elizabeth Lay, it's E-l-i-z-a-b-e-t-h L-a-y, and I'm a deputy county attorney from Platte County, Nebraska. That's the Columbus area. And I was here approximately a year ago to give the same type of testimony in a different hearing, and I'm here today to pretty much give you the same story that I gave last year because nothing has really

changed. I came here last year and I was talking about how we needed emergency...something in the emergency system to cover the people who were violent and dangerous because we don't have anything right now that covers those...that particular portion of the clientele that we serve. And we still don't. We're still having problems, a lot of problems finding placement for these people who are violent and combative that private hospitals don't want to take. And then, on the flip side of that, you have this felony assault of a healthcare worker rule so they get molded back into the criminal system again and again and again. It's just this vicious cycle that continues on and on and on, and there's no way to stop it without having a place to get them to. And so from the roundtable discussions that I had with Senator Bolz and Senator Seiler, one of the things that we talked about were these emergency crisis beds in the Lincoln Regional Center, which right now to get into the Lincoln Regional Center you have to have a commitment and so...a mental health board commitment. And so one thing that is still severely lacking is this ability to find that a person needs this type of treatment and then get them to the proper treatment protocol, which would be Lincoln Regional Center if an inpatient, a private inpatient hospitalization isn't...is not an alternative or it isn't going to happen at that point. And we still don't have that ability. So now we're having to find these creative ways to get around that, and that means people being sent to D&E for evals. Or, you know, obviously they committed a crime, and we know that there's some other things going on and we want to make sure that we're doing the fairest possible thing for this person. We want to make sure that we're treating the primary cause of the problem. Whether it be, you know, criminal in nature or mental in nature, it's very important to distinguish those two things and treat the cause of the problem. And to do that, we're having to find all of these weird and creative loopholes in the system to try to figure out how do we get this person served in the best way. And the emergency protective...the custody part of it comes into that because we can't take a person into emergency protective custody if we don't have a place to put them. So those people are being underserved. And then one of the other things that has not changed is that we don't have resources for people. We don't have community resources. In the last year in Columbus alone, we lost our dual diagnosis facility. Our day program, Rainbow Center, has completely had to cut services for lack of...for lack of funding and for a bunch of other reasons. So we're losing services in our community faster than we're gaining services in our community. And that's a problem, that's a big problem with outpatient. Another big problem with resources is at the highest level, which is Lincoln Regional Center, we only have one secure psych-res facility in the state of Nebraska. It's a private facility and they can't take everyone that needs to go to

them and coming out of the Lincoln Regional Center. So then what happens is people who are in the Lincoln Regional Center, who have done well under that structure there and under the protocol that they had in place there, are just immediately put back out into the community with no structure, with no aftercare like you were talking about earlier, because there is a gap there between hospitalization and aftercare. And the cycle continues over and over again. Just within the last year I've had an example of that with a person who has been in the Lincoln Regional Center for a large majority of his life. He keeps continuing to get put back out into the community, because nowhere else will take him, and then he gets into the community for about a month and he doesn't take his medications, he doesn't go to his appointments. And then we're back in the same place again and he's back at the Lincoln Regional Center, and it's just this cycle that perpetuates. And so we don't have a good structure of step-down treatment at the state level. And I'm not talking about reinstitutionalization by any means. I'm just talking about a clear path for success for people coming out of the Lincoln Regional Center to not be in a completely structured and kind of a hand-holding environment to nothing, to just, here, have fun, good luck making your appointment next month, because those are the two levels that we have. Those are the two levels that we have. We have completely administered healthcare in the Lincoln Regional Center, and we have, good luck, you're on your own. Those are the two levels because, as the doctor just mentioned, everything else has this incredible wait list. And so these community resources are severely lacking. We have a severe lack of long-term residential. We have a problem there because there is no...there's no placement for long-term chronic and custodial care. There's not that piece of the puzzle. So even if a person needs continued care, Medicaid gets to come in and say, we're not going to pay for custodial care or chronic care and so you need to just get them out as quickly as possible. And so once they...their acuity level decreases, they're forced back out into the community for lack of payment. And so all of these things are a problem and it all kind of accumulates into this one ball of problems, which is we have this private-based mental healthcare system that can accept or deny a person at any given time, whatever criteria they want to use, and because of that I have a hard time finding resources for people. I know the region has a hard time sometimes trying to find resources for people. They certainly get frustrated with the same things, with the long-term care and the people coming out of the Lincoln Regional Center, because it's not just that they land on my desk again. They land on their desk again as well. And so we have to have a better system to take care of these people and to set them up for success, or I'm going to be here next year, too, and the year after that and the year

after that, because it's not problem that's going away. Obviously, it's a problem that's chronic. Mental health is a treatable...it, in general, is treatable, but most often it's not curable. And so these are things that we have to fix. We have to fix them at the state level because the community-based resources, with work force being an issue like it is, the community-based resources are not able to...we're just not able to handle the load right now. And we're certainly not able to handle a person that's coming straight out of Lincoln Regional Center back into our communities with no aftercare, or the aftercare that's set up isn't appropriate for a person that's at that level of care to come just straight back into independent care. And so I'm happy to answer any questions that you may have. [LR413]

SENATOR BOLZ: Well, first, thank you for coming back. [LR413]

ELIZABETH LAY: Sure. [LR413]

SENATOR BOLZ: Thanks for your dedication to this work. Committee members? Go ahead, Senator Crawford. [LR413]

SENATOR CRAWFORD: Thank you, Senator Bolz. And thank you for your testimony and I appreciate your persistence as well. I wonder if in your work with your peers from other states or professional workshops, if you have heard of state models that you've heard from your peers are effective in other states, if you have any insights from those discussions that you'd like to share. [LR413]

ELIZABETH LAY: You know, I don't. I can't speak to that because I haven't really spoken with anyone outside of the state on anything that works. I know that we're dealing...you know, mental health in general is a nationwide issue. I think every state is affected, though they may be affected differently. I just can't attest to anything that might be successful outside of this state. [LR413]

SENATOR CRAWFORD: Thank you. [LR413]

SENATOR BOLZ: Go ahead, Senator Seiler. [LR413]

SENATOR SEILER: Thank you. On...have you seen any numbers on that concept that I talked about a year ago with you concerning an emergency EPC cell type of program bending into a longer term, middle care, and then eventually into the residential homes? Have you seen any numbers on the EPCs per year in Nebraska? [LR413]

ELIZABETH LAY: Do I know how many people are EPCed... [LR413]

SENATOR SEILER: Right. [LR413]

ELIZABETH LAY: ...each year in Nebraska? You know, I can't say that I know exactly how many people are EPCed every year in Nebraska. I know that in Platte County alone we have anywhere from 150 to 175 people who are EPCed every year, and that's in Platte County alone. [LR413]

SENATOR SEILER: Wow. Okay. What I'm looking for is if the proposal...how many beds would we need to be able to handle that short term. Granted, they're only going to probably be there ten days or less... [LR413]

ELIZABETH LAY: Right. [LR413]

SENATOR SEILER: ...in that cell part. But the intermediate part, how many numbers of beds would we need to solve that problem? [LR413]

ELIZABETH LAY: For long-term residential you mean or for psych... [LR413]

SENATOR SEILER: Well, not long term but... [LR413]

ELIZABETH LAY: ...or psychiatric? So which part are you talking? [LR413]

SENATOR SEILER: Programming. Programming to get them back... [LR413]

ELIZABETH LAY: Into the community? [LR413]

SENATOR SEILER: ...into the community, into the residential communities. [LR413]

ELIZABETH LAY: You know, I would think that...I don't know exactly how many beds Sarpy Recovery Center has, but I would think that another facility that same size would take care of the overflow. That's not that I just...I don't have the answer to that question. It's...I know that it's a needed facility because I see the effect of not having it in my everyday job or in my job that I do every day. So I see that the effect of not having that particular piece puzzle, I see that that effect is there, and that if I can utilize that particular facility in Platte County then I know that other counties can utilize that facility as well, not to mention that I hear from people that work with our region that that's something that's severely lacking in the state as a whole is that piece of the puzzle to reintegrate people back out into the community. I think using a model like Sarpy Recovery Center wouldn't be a bad idea just because it's there and we know that it works. It's just that they are privately...they're private and so they can refuse to take people, though they try really hard. The wait list can also be extremely long as well. So I think utilizing that model wouldn't be a bad place to start. [LR413]

SENATOR SEILER: And the last time we talked, we were talking about what do you do when you can't place them because you got to put them in jail to protect themselves but they can't be a mental health patient if they're in jail. [LR413]

ELIZABETH LAY: Right. [LR413]

SENATOR SEILER: How many of your...would you estimate that went back into the prison system from your county? [LR413]

ELIZABETH LAY: In the last year? [LR413]

SENATOR SEILER: Yeah, just the last year. [LR413]

ELIZABETH LAY: We've probably had, since I was here last year, we've...I've probably seen three or four people who I've had to kind of go around the system on, and that, for Platte County, is actually a big deal. But that doesn't take into account how many people we couldn't get into a

hospital because the hospital was full or because they were combative or because there was a medical issue or because there was something that the private hospital couldn't take. Those people usually spend the night in our emergency room because if there isn't a crime...if there's not a crime that's taken place, obviously we can't use jail as... [LR413]

SENATOR SEILER: Right. [LR413]

ELIZABETH LAY: ...an alternative. Under normal circumstances, we're talking about violent, combative people. When we're truly afraid, public safety is a concern. Those people have already committed a crime and they've probably already been taken to jail. And then at that point we kind of try to assess and figure out where do we go from here. We know we don't need them in our jail. So what do we do from here? And I would say at any given time, you know, over the last year there was probably three or four of those people that we had to move, maybe more, to D&E to try to get evals or wait on something to occur so that we could move them into a more appropriate placement. [LR413]

SENATOR SEILER: See, the way our D&E is piling up, I'm believing that more and more good county attorneys are in the same position you are. [LR413]

ELIZABETH LAY: Uh-huh. [LR413]

SENATOR SEILER: ...and their alternative is being forced... [LR413]

ELIZABETH LAY: Right. [LR413]

SENATOR SEILER: ...to send them down for evaluations, which then plugs up the hole where you got to pass through to get into the prison system... [LR413]

ELIZABETH LAY: Right. [LR413]

SENATOR SEILER: ...and it just backs everything up. [LR413]

ELIZABETH LAY: It does. It does. And I know that I'm not the only one. [LR413]

SENATOR SEILER: I think we were close to 300 percent in the Diagnostic Center last year. [LR413]

ELIZABETH LAY: Uh-huh. [LR413]

SENATOR SEILER: And if we're doing a lot of the county work, then that's backing up the real criminals that need to be passed through to the system. [LR413]

ELIZABETH LAY: Right. [LR413]

SENATOR SEILER: And so if we could cut that off with the program that you just described,... [LR413]

ELIZABETH LAY: Uh-huh. [LR413]

SENATOR SEILER: ...emergency protective care facility that's lock-down and with the alternative then to get them over, we would solve that other problem that we've got hanging over our head of 160 percent occupancy in prisons. [LR413]

ELIZABETH LAY: Right. D&E is not...that's not what we set out, to send people to D&E so that we can treat whatever it is that's the problem. But when you get a police report in and you see someone who has, you know, 10 or 11 or 12 pages of these petty crimes of disturbing the peace, trespassing, unlawful acts, things that you know you read the police report and you say to yourself, wow, this person has a serious history of mental illness that no one else has taken any interest in whatsoever, and we're going to and we're going to figure it out and we're going to try to see what we can do. There's no private hospital that's going to take that person when they were standing outside of, you know, whatever gas station trying to assault people and yelling obscenities at the top of their lungs. No hospital is going to take them. We don't want a hospital to take that person because that person is going to go to the hospital, they're going to assault someone, and then you're not going to be talking about D&E. Then you're talking about a felony

conviction for someone who shouldn't have been there in the first place, because we needed a better place for them from the start. It's not fair to hospitals to ask them to take those people. It's not fair to their staff. It's the state's responsibility, just like the state's responsibility is the prison system. It's our responsibility to take care of those people and to figure out where do they best fit into this picture. And that's what we're trying to do on our end, but where they fit into this picture isn't there. There's a big hole in the picture where they should fit in. And so we have to go to the next best thing, which is, while they've committed this crime and they're on our jail, D&E is a safe place where we can hold them. And we know that D&E will evaluate them or we can ask them to or we can pay them to or whatever it might be that we have to do to get it done. We can hold them there until we can figure it out. And then once we figure it out, we can move them, you know, to a more appropriate placement for their mental health needs. That's not the best way, certainly not the most cost-effective way, and it's not the most...you know, if you're talking about the overcrowding in the prisons, this is certainly not doing anything to help that. But you have to do what you have to do to do the right thing. And so that's what we're trying to do, is we're trying to find ways to do it. [LR413]

SENATOR SEILER: What you're saying is the law is forcing you into the situation you're talking about versus an alternative method for the mentally ill person. [LR413]

ELIZABETH LAY: Right. Right. The law forces me into figuring it out. My oath as a public official and public safety being my number one concern, you know, makes me feel like I have to do something to keep this person safe, not only from themselves but from the public and the public safe from them. And so we do whatever we can do within the confines of the statutes, what the statutes will allow us to do to make sure that we're treating them in the best way that we can possibly treat them and get them to a place ultimately that they should be, and that place may be the Lincoln Regional Center. And in that situation it usually is, because they're violent and combative and that's where they're going to go anyway. That's where they should start. That's where they're going to go anyway. That's where they should start, period. [LR413]

SENATOR SEILER: And that was the proposal we talked about the last time. [LR413]

ELIZABETH LAY: Right. Right. They need to be...and I say the Lincoln Regional Center because right now that is the only state-sponsored mental health facility that we have. But any state-sponsored mental health facility that would take care of that person, that's where they should go. That's what we need. We need that hole to be filled where that crisis is. And it happens a lot. I mean if it's happening four, five, six, seven times in Platte County, you know, I'm imagining it's happening across the other counties as well. [LR413]

SENATOR SEILER: Go ahead. [LR413]

SENATOR BOLZ: We can certainly get some of the information that the committee members are interested in regarding statistics and best practices, but I think the added value that you have, Ms. Lay, is being someone who's really on the front lines. And maybe for those who weren't here in the special investigative committee, maybe you could walk us through just one brief case study, an example of someone that you've worked with that you think is exemplative of the circumstances that you're describing. [LR413]

ELIZABETH LAY: Okay, sure. I have...the case that I walked through last October was a case regarding a young man who he had been in the system for quite a while. He had been let out of the Lincoln Regional Center into his own independent apartment. He immediately started to deteriorate, and then he brought himself back to our attention again because he was involved in a criminal act. I got the reports and I reviewed the reports and there were some things in the reports that made me a little concerned about his mental health. And so we were trying to...we tried to get him into the Lincoln Regional Center. At that particular time...and I will say that it's been a lot easier to get my...the people that I need into the Lincoln Regional Center after I gave that testimony, that's the truth. But at that particular time, it took me almost three months to find him and secure him a bed at the Lincoln Regional Center. And because of his past history with the hospitals in our regions, no private hospital would take him. He was also violent and homicidal. And so no private hospital would take him, being as he was as homicidal as he was at that time. And he was so completely unstable, no private hospital would take him. And we had him in jail on a criminal charge and so, a felony criminal charge, and so we kept him there hoping that we would be getting this bed available at Lincoln Regional Center. And three months later, finally, a bed became available and we were able to move him to that particular facility

after he had his Mental Health Board hearing in front of the Mental Health Board. Now after that happened, he was in the Lincoln Regional Center and he was there for a while and the Lincoln Regional Center just...you know, he needed to go to a private care facility. When he was ready to be discharged from the Lincoln Regional Center, he really needed to go into that private, secure residential type of facility, that locked-down facility, so that he would still have some structure, not be completely on his own. But that facility, the only one that we have in the state, refused to take him and they refused to take him over and over again because they were aware of his behaviors in the past and they didn't think that it was safe. They thought he was too dangerous for their particular facility. Because they are licensed differently than a state hospital would be licensed or a state facility would be licensed, they have to be more careful about who they can take in to their facility. And so we...the Lincoln Regional Center wanted to move him into that type of a facility but they couldn't because he was declined. And then even if that particular facility would have taken him, Medicaid was saying, no, he can't be...we're not going to pay for that level of care, he's too dangerous for that level of care; the only level of care that we'll pay for is independent living. So they were saying he was too dangerous for that level of care, but they would pay and they needed to try to push him out into independent living. And so I conveyed my intent to object to that because I thought that that was the most ridiculous thing that I had ever heard. And Lincoln...during that time that we were trying to put that stuff together, he had some more issues at Lincoln Regional Center. So his discharge plan was moved back some, and so we had some time to try to figure out what else to do. They kept him at that point and they are still trying to kind of rectify those things, but it's not happening yet. And at this point, there is no place for that particular individual to go, like a person like that; there is no place for them to go. And so because there's no place for them to go, what we're left with is you can't leave them in the Lincoln Regional Center because there's no place else for them to go. The law clearly states that once they are dischargeable, you have to do the least restrictive treatment available. And if they are not acute enough to be in the Lincoln Regional Center, they can't stay there. They can't. They shouldn't. We shouldn't be leaving them there. We shouldn't be leaving them there. And I know that it happens, but that's not the way it should be happening. We should be discharging them to the least restrictive means available. If those means aren't there, that means independent living. You have no other option. So the state, by having these gaps in the system, you're basically saying, okay, those gaps are there, we're not going to do anything about it. So this person who is really dangerous, who has had 30 days of nondangerous behavior in the Lincoln Regional

Center--and that's our criteria now, apparently, so we're going to push them out--nowhere will take them. Medicaid won't pay for anything else. We're just going to put them in this apartment and, I'm sorry, neighbors, I really hope that you're safe. That's the model we have right now. I don't know that that's okay in any universe, but it's certainly not okay in mine. But that's what we're forced to deal with. And that's what we're forced to deal with on these cases. I just had another case not just a few weeks ago with this same type of situation. No private hospitals would take the person. We had to put that person in D&E for safekeeping. We had them evaluated. They were found to be mentally ill and dangerous and we were able to get them into Lincoln Regional Center. We had to go through jail. We had to. We had to do it that way because we didn't have a hospital setting to put them in. And so luckily they were compliant because if...it's because they're not EPCed. I can't EPC them and hold them in jail, so you just have to hope that the patient is compliant and that they want to do this avenue instead of going to jail because, if they don't, then our hands would be completely tied. You just have one more mentally ill person sitting in your prisons. And there's nothing I can do about it; even though I try hard every day not to do that, my hands are tied. [LR413]

SENATOR BOLZ: I appreciate that case example because I think they're helpful. I think Senator Scheer had a question. [LR413]

SENATOR SCHEER: Thank you. Real quickly, you made comment that you do about 150 EPCs in Platte County. Are any of those repeat or are they...at least I'm assuming they would be. [LR413]

ELIZABETH LAY: Absolutely. Absolutely, some of them are the seventh, the eighth, the ninth, the tenth, the 15th. And the ones that we see, the ones that we truly see repeat over and over again, I think, are a lot of the substance dependency ones, the ones where we have substance issues. Those are the ones that we're more likely to see repeat over and over again. That's a difficult task to take on. But the services that we have I don't think are adequate. A lot of...sometimes when the wait lists get really long, and they do, they're not always really long, but when you're talking about on average a one-month wait for outpatient treatment or for residential treatment, that means that at some point in time it's more than a month and some points in time it's less than a month. So there are times when it can be two months or three months that you

have to wait. And the patient is in the hospital waiting, you know, because they're supposed to be going to residential treatment, which means they really shouldn't be out on their own, managing their own care. And when the wait list is three months long, no private hospital is going to take that person in for three months. They just can't. They're not getting paid for that. You can't expect them to do that. So what they do is they discharge that person back out into the community. And then you see them, you know, come to our attention again, sometimes really badly with wrecks because DUIs when they were supposed to be in treatment but they couldn't get into treatment, sometimes just through more EPCs. We have people who are discharged from the hospital to await treatment and are EPCed the same night because the type of treatment that they need isn't available to them. They're just discharged onto their own care and obviously that's not appropriate because that's why they got EPCed to begin with. And so there are issues with a cycle. I mean we do...our behavioral health system, these gaps in our systems perpetuate this cycle of repeat, repeat, repeat, until finally it clicks and someone is able to actually get into the system in the way that they need to get into it and then we're able to move them through the system in a way that's more geared toward success. [LR413]

SENATOR SCHEER: I would just make note of one thing. What we've been talking about are people that have, because of a lack of medication normally, have created some type of crime and it's that difficult to get treatment. The other half of the story that we really haven't talked about is the lack of care for those that are not in the criminal area. Now she has a hard time getting them into Lincoln with those pretenses. Somebody that has a loved one that is in need of those type of services absolutely has no way in the world to get those type of services for their loved one, at all. And so I think, as bad as this sounds, we also have to look at the other half of the story of those people that have not committed crimes that have mental health problems and need those services desperately and they are absolutely not available because they're not there and what is there is filled with exactly what she's talked about. [LR413]

ELIZABETH LAY: And if I may just for a moment speak to that point, after my testimony last year, I went back to my office and I started doing the same thing that I do every day: just doing my job. And I would say I got between...within the few months after it, there were some articles in the paper. I got between 10 and 15 calls from individuals all over the state who wanted to know more about the system in general, wanted to know more about what they could do with

their mother, their son, their daughter who had mental health issues. And the state, we don't get involved until something...you know, until someone is so dangerous that they're going to kill themselves or they're going to harm someone else or be harmed indirectly somehow. And, you know, I spoke with these people and I talked to them a little bit about our system and my part in the system. And I tried to, you know, help them move towards resources that could help them. But my...the saddest part for me was I had to say, well, have we risen to the level of, you know, have we risen to the level of are they harming themselves, are they holding a gun to their head, are they trying to hold a gun to someone else's head? Oh, no, no, it's not to that point yet, but I know it's going to get there if I don't do something else. And, you know, I have to say, are they willing to go to treatment? Yeah, they're willing to. Okay, well, the wait list is about four to eight months long, sorry about that. I can't get my people in, much less someone who doesn't have a commitment. We're talking, when I would call--and this place isn't even in Columbus now--so when I would call dual diagnosis treatment facility, do they have a commitment? No. Okay, the wait list is two months long. Oh, well, that's not so bad. Two weeks later, do they have a commitment? No. Oh, the wait list is four months long. And so I heard from those people. You know, I heard from 10 to 15 people who just saw a name in the paper and didn't know who to call otherwise. They had no idea who to call, but they were so concerned for the well-being of their loved one that they just picked a name out in the paper and thought, I'm going to give it a shot in the dark, because I don't know where else to go. So obviously that's an issue, obviously it's an issue, it's out there and it's an issue. [LR413]

SENATOR SCHEER: Thank you. [LR413]

SENATOR BOLZ: Well put. Thank you, Ms. Lay. [LR413]

ELIZABETH LAY: Thank you. [LR413]

SENATOR SEILER: Thank you very much. [LR413]

SENATOR McCOLLISTER: See you next year. [LR413]

ELIZABETH LAY: I hope not. Let's get this fixed. [LR413]

SENATOR BOLZ: I'd like to invite up former Senator Annette Dubas who is now the executive director of the Nebraska Association of Behavioral Health Organizations. Nice to see you again. [LR413]

ANNETTE DUBAS: Nice to see you, too, Senator Bolz. Good afternoon, members of the LR413 task force. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations. I want to thank your committee for your commitment to this very important issue. And hopefully when we are...everything is all said and done, we will have some direction and a course to chart and head us in the right direction anyway. We certainly appreciate this opportunity to speak to you and have participated in the round-table discussion which Senator Bolz called. And our focus, the round table that I was a part of, focused on Medicaid, fiscal issues impacting behavioral health, and provider rates. I have told senators in the past, we will always come and talk to you about provider rates. Provider rates are that foundational topic. Without adequate rates, you can't build capacity; and without capacity, you impact access. So provider rates are always going to be front and center because those are the building blocks for everything else that we talked about earlier and that you will talk about later today. We did a survey in 2014, and I think you've all had a chance to see that, where we just looked at how far behind rates have fallen just in regards to inflation. That's just a snapshot of really where rates are at and where they need to go. We've also heard the figures batted around a little bit about how underresourced behavioral health is. You know, we've heard everywhere from $25-50 million. But how do we get a better grasp of those dollars and where we're underresourced? How do we evaluate the system? So through that discussion it became clear that it is really time to approach rate setting in a much more purposeful and structured manner. We need to know where those service gaps lie. How much are we truly underresourced? You know, is it $25 million? Is it $50 million? Is it somewhere in between? Is it not even in that range? I mean it's easy to talk about those numbers, but when we're making a decision those need to be much better defined. How many people are not receiving services? Why aren't they? If they're not receiving services, what does that mean to our overall systems, child welfare, Corrections, you know, Probation, just across the board? So from this point forward, we recognize as an association, and I think that's what came out of the round table, is the importance of data to support when we're talking about provider rates, services, and all of those other things that are connected with behavioral health. There are currently some

initial steps underway. DBH is conducting a cost modeling study. They've completed their first phase and, because of that first phase, we saw a proposed increase for increase for, specifically, med management and halfway houses, because those rates were so far behind where the Medicaid rates where we're talking 30 and 70 percent, respectively. So there was a recognition because of that cost modeling study that those rates needed to be bumped up for providers to even continue providing those types of services. There are two additional phases where DBH is looking at other services that they support. That should be completed by fiscal year '18. So we recognize this as a short-term step. And I will tell you that my members who participated in that cost modeling study felt that it was a very comprehensive, very well-developed study. They thought it was asking the right kinds of questions to get the information that is really relevant. So, you know, we'd like to thank the division for their work in that area. So we will continue to support their efforts as they continue this short-term step. But that's only going to help us look at what's immediately going on. We really need a longer range plan, a more comprehensive review of the rates. And that could be achieved through something, some type of rebasing process or procedure where essentially we just wipe the rate board clear, we just take everything off the board, and then we rebuild those rates from the ground up by looking at all of the individual services and determine where are those actual needs in those services and what are those actual costs. My initial understanding is this probably hasn't been done in quite some time. And so where did our rate structure come from that we are currently operating under? What was that based on? Can't really get a very definitive answer there. And so instead of just coming in and saying, hey, we'd like you to give us another rate increase, we really think a methodology of some type that really is accurate and pointed at what we're trying to achieve, who we're trying to serve, and what it actually costs to serve those consumers. So I think this would give all stakeholders involved, whether it's the Legislature, whether it's DHHS, whether it's our providers, our consumer community, it would give everybody a very clear picture. And I think this is a huge step in creating stability in the system, which is something that we don't have a lot of right now. So again, if you're looking at how do you fill that service gap, we need to have, you know, what the district county attorney just talked about. If you don't have stability in the service, in the system, you're not going to be able to address those other needs. It's been mentioned in the initial report, as well as other testifiers today, the importance of data and how do we collect that data. And I know we have this centralized data system now. I know through the managed care organizations they collect a lot of data. That data is submitted to Medicaid. I

think we have a lot of entities out there who are collecting data, but it's not in a manner at this point in time, and maybe that's where we're going with the centralized data system, but it's just not a cohesive system. I think, as mentioned earlier, you know, do the providers really know how to use the system and are they putting in the right information? So the importance of creating a more cohesive data collection system I think is critical, especially to the work that you do as you're trying to figure out where you put those very finite resources. That data can answer so many questions; it can support accountability and oversight, which is key to what you do; those cost-benefit analyses trying to determine where are the resources; where are we underresourced; are we overresourced in any areas; how do we help create the capacity where it is truly needed? So I believe that there were three main takeaways from our round-table discussion. Number one is for the short term, that we continue that cost model survey work that DBH is doing, but again stressing that's DBH, that's not the entire system, that's not looking at, as was mentioned earlier, Medicaid and how they're involved. But that is an important component, so continue that cost model survey work, and then look at a comprehensive, long-range review of the rates. How do we develop some type of consistent rate methodology? Whether it's rebasing, whatever approach we want to call, that is going to be very important. Something that hasn't been talked about very much but will certainly become more of a topic of discussion is parity. Under ACA, mental health parity is required. And we know that rates for behavioral health versus rates for physical health are not on the same playing field, but that is a requirement, so mental health parity is going to be an important part of what you as policymakers will be looking at and establishing those rates. And then third, the data collection and how essential that is and how do we create that cohesive system. You know, I have members who run the gamut from the largest to the smallest and technology we know can be their friend, but it also can be very intimidating. How do we help all of our members understand the importance of collecting data and having the right kind of cohesive system in place? Determining what we need to know and where the resources are and what's going on in the regions and DBH versus what's going on in Medicaid, just in general creating that cohesive system. We know as we move into the managed care system that we'll go live January 1, 2017. Heritage Health, that's an integrated system; that's behavioral health, physical health, and pharmacy. That will be very data driven; that will be very focused on moving towards value-based purchasing and contracts. That will be driven by data and the work that providers are doing and the outcomes that they are achieving and how they're serving their consumers. So again, we've got a lot of entities out there who are doing a lot of data collection.

But is it really getting gelled together and is it getting distributed to the people that it needs to be distributed to? Number one, as providers, how are we doing in serving our consumers? For you as policymakers, how is that fitting into your determinations for how you fund the system? So again, those three main things came out of our work: the cost model study; development of some type of rate methodology through rebasing or some other procedure; and then the importance of a real cohesive data collection system. So again, we appreciated Senator Bolz and the work that she did with the small groups and the work that you're doing as well. And I'd be happy to attempt to answer any questions you may have. [LR413]

SENATOR BOLZ: Go ahead, Senator McCollister. [LR413]

SENATOR McCOLLISTER: Yeah. Thank you, Senator Bolz. Thank you for your testimony, Senator. You've had extensive experience with behavioral health. The attorney in her fine testimony, from Platte County, identified a gap in the service. Could you help us in any way determine how we fill that gap? [LR413]

ANNETTE DUBAS: Well, I think it goes back to the things that I just talked about here, looking...why are those gaps there. Someone mentioned earlier, I think, Senator Howard, you mentioned SBIRT. Well, you know, there's services out there, but if providers aren't going to be compensated for those services, they're going to be provided on a very, very limited, if at all, type basis. So, you know, through DBH there's much more flexibility in funding versus Medicaid because there's so many more regulations that you have to follow. But I think there's multiple things that you have to look at as far as addressing service gap, whether it's through onerous regulations that need revisited--and I know Medicaid is in the process of revisiting a lot of regulations--defining where we are underresourced and how do we make up that underresource, and defining where is the best place we put those resources to address those service gaps. I think the initial work that was done with the service gap study is a step in the right direction. But as the doctor pointed out, there's so many more places you can go with that type of research. And I think it should be ongoing. So can I give you a specific answer to your question? Not specific--I think there's multiple components--but I will always go back to the rates. And if we don't have a strong foundation of rates and knowing where those resources are going and how they're being used, we're not going to be able to do the other things that need to be done. [LR413]

SENATOR McCOLLISTER: Thank you, Senator. [LR413]

SENATOR BOLZ: Senator Scheer. [LR413]

SENATOR SCHEER: Thank you, Senator Bolz. Annette, good seeing you, miss you. [LR413]

ANNETTE DUBAS: Nice to see you too. [LR413]

SENATOR SCHEER: Not trying to re-create the wheel here, I mean, other states obviously do things differently than we do. Are there some things that we're just missing or that could be implemented fairly easily that you're aware of that would help at least stem it from getting worse and hopefully move towards a better result? [LR413]

ANNETTE DUBAS: As an association we also belong to the National Council for Behavioral Health, and as an association exec I have access to a LISTSERV talking to my association counterparts all across the country. And I put this question out to them and I would have to say we are not alone, unfortunately, and there is just a lot of...everybody is out there kind of trying to put the pieces together, just like we are. So I didn't have any one state come forward and say, hey, we've got this great program and it is...you know, it's just working above and beyond our wildest dreams. Everybody is just looking at how do we maximize our resources, how do we set those rates. So I can't give you any one specific example that other states are doing that maybe we could beg, borrow, or steal from. But I was just at an association executive director retreat a couple of weeks ago and this was a topic of discussion. And there are a lot of states trying to put things together, but nobody has found that silver bullet yet, so to speak. [LR413]

SENATOR SCHEER: Thanks. Thank you, Senator. [LR413]

SENATOR BOLZ: Senator Crawford. [LR413]

SENATOR CRAWFORD: Thank you, Senator Bolz, and thank you, Senator Dubas. One of the issues that's raised in the executive summary and was also raised in the legislative audit was a concern about authorization periods. And I wondered if you would care to comment about that

issue and whether or not from your membership is that an issue both in Medicaid and in DBH services or has that primarily been a Medicaid issue, and any other comment that plays in terms of addressing mental health in the state. [LR413]

ANNETTE DUBAS: I think to various degrees it's across the board. I will tell you right now, as we're still in the implementation stage of Heritage Health, the Division of Medicaid has put together several advisory committees, bringing in providers and other stakeholders, looking at administrative simplification, looking at how do we integrate behavioral health into the system, looking at quality measures. And one of the focuses is how do we create a more user-friendly process? And authorizations is at the top of the list. When my members talked about what is it that we want to talk to, the managed care companies about authorization was definitely at the top of the list. So we are certain that there will be bumps in the road as we move into Heritage Health. We hope that by the work that's being done by these committees and looking at what some of the other states have gone through as far as their managed care, we can avoid some of the more drastic bumps, so to speak. But, you know, just that regulatory environment, you know, talking about getting access to service, that medical necessity, that's a huge issue for my members as well, you know. We don't want people to have to fail up the system, but medical necessity is an important definition that's used by the managed care companies when they're determining whether to authorize services for individuals. So I'm appreciative of the work and the inclusiveness of Medicaid and DBH in bringing all these players to the table. We are very, very involved, our association is very, very involved in these committees, and so we're hoping to have as smooth of a transition as possible. But authorization, like I said, it is at the top of the list. [LR413]

SENATOR CRAWFORD: So have there been conversations on the DBH side about authorization and improvements or changes? [LR413]

ANNETTE DUBAS: They are a part of these conversations. [LR413]

SENATOR CRAWFORD: Okay. [LR413]

ANNETTE DUBAS: DBH--again, I'm very appreciate of the approach--said the Medicaid Division has taken trying to break down some of these silos and walls... [LR413]

SENATOR CRAWFORD: Okay. [LR413]

ANNETTE DUBAS: ...and recognizing that they are often serving the same clients. You know, if you fall off Medicaid, you know, DBH is going to step in and pick you up, vice versa. So there has been a lot of inclusive conversations in talking about how do we make this system a little less clunky, so to speak. And again, I'll go back to the regulations. When we...our members actually went through all of the Medicaid Division regulations that apply to behavioral health and Medicaid said it's their largest, most onerous section of regulations. And so I think just maybe cleaning up a lot of those regulations and streamlining those hopefully will go a long way, service definitions in the process of evaluating those service definitions. So hopefully that will help as well. [LR413]

SENATOR CRAWFORD: Excellent. Thank you. [LR413]

SENATOR BOLZ: There's one issue that we haven't addressed today that I want to make sure we talk about in this hearing. And the UNMC study identified a clear socioeconomic gap here that the population served tends to be minority, low-income, they don't necessarily have an ability to pay. So in addition to rate adjustments, I think insurance plays a role in providing a funding stream and stability for services and a dependable funding stream that could help us build services. And I just wondered if you would have a few comments on availability of and access to insurance, and specifically I think NABHO has been supportive of Medicaid expansion, and was just hoping you could just say a few words about your perspective. [LR413]

ANNETTE DUBAS: We have been supportive of Medicaid expansion and we'll continue to support that for that very reason. There is a large segment of the population that have no access to any kind of financial resources to help them get the services that they need. We constantly harp on behavioral health drives physical health costs. If you can get people behavioral health services early, you will save money down the road in physical health costs, whether it's through diabetes, heart disease, whatever it is. We are...we might not be the largest part of the budget, so

to speak, but we are the largest cost driver. So I can't give you specific numbers as far as the clients that my members serve and how many of those people don't have any type of resources. But we'll tell you that they often talk about the number of people that just can't access services because they don't have the resources to get there. But those are the people we might not be paying for them up-front, but we are definitely paying for them down the road. And again I'll go back to data. If we can collect that data to really support that and really come in and show you X plus Y equals Z, hopefully that gives you a little bit better ability to make those decisions. [LR413]

SENATOR BOLZ: Just a brief comment, one of the light bulbs in that conversation with stakeholders on rates and stability and fiscal factors that went on for me was that in order to provide sustainable services, that lack of a sustainable insurance funding stream was really a challenge. And so in terms of long-term planning, in terms of filling gaps and needs, insurance, whether it's Medicaid expansion or Medicaid buy-in or a demonstration program or some other strategy or initiative, I thought that was a really important thing to pull out into this hearing today. [LR413]

ANNETTE DUBAS: That is so true. That stable financial system is...yeah, that's the foundation, that's the foundation of everything. So without that stability, everything you put on top of it, it's just on shaky ground. So again, I appreciate the work that this committee is doing and I hazard a guess you'll come out of this with more questions than answers, but at least the questions are being asked and hopefully we have a good direction of where do we go from here. And my association stands ready to support your efforts and help you in any way that we can to get information to you, provide, you know, the personal types of stories, help you understand what the providers are dealing with and how they can help you answer your questions. [LR413]

SENATOR BOLZ: Thank you. [LR413]

ANNETTE DUBAS: Thank you. [LR413]

SENATOR BOLZ: We have two more testifiers today: Dr. Joe Evans with the Behavioral Health Education network; and then we'll have the Mental Health Coalition (sic--Association) folks come up. So I'll invite you up first, Dr. Evans. [LR413]

JOE EVANS: I'm glad the timer is not on today. [LR413]

SENATOR BOLZ: Well, I would encourage you to be succinct as possible. [LR413]

JOE EVANS: (Exhibit 2) Definitely. My name is Dr. Joe Evans, J-o-e E-v-a-n-s, and I am the associate clinical director for the Behavioral Health Education Center of Nebraska and a professor of pediatrics at the Munroe-Meyer Institute at UNMC. I'm involved with the training of professionals to become behavioral health providers in Nebraska and I want to thank Senator Bolz and the committee members for providing the opportunity to testify today but also to respond to the LR413 Committee's request for behavioral health work force suggestions. As recommended earlier by Senator Bolz, Senator Howard, and Senator Crawford, and in light of our tight budgetary constraints this year, we've explored alternative funding sources from federal, state, and grants, foundations, private donations. And I've also examined some possible realignments to maximize our current state allocations to assist with training and increasing the work force of behavioral health providers in Nebraska. Last Thursday--good news--BHECN was awarded a grant from the federal health services...Health Resources and Services Administration to train master's-level clinical counselors in methods to integrate behavioral healthcare into primary care settings. A collaborative of behavioral health training programs from UNK--University of Nebraska at Kearney--Chadron State, University of Nebraska at Omaha, Wayne State College, the Behavioral Health Education Center and the Munroe-Meyer Institute will participate in this training program designed to provide advanced training in integrated behavioral health, and to support education stipends for master's students in this area. While this is encouraging news, at the same time, unfortunately, the grant is only for one year and only scratches the surface of meeting the needs for expansion of the behavioral health work force in Nebraska, especially in rural and inner-city areas. I'd like to suggest two proposals today designed to help prepare additional behavioral health providers for practice in the state. One proposal refers to the need for additional prescribers, as was noted repeatedly as a need in our state, and the other addresses preparation of therapists to become child/adolescent behavioral

health providers in integrated primary care settings. And one of them doesn't even cost money, so...excuse me, new money (laugh). First proposal is to address the shortage of behavioral health providers in our state. In Nebraska, just to give you some real numbers instead of percentages, we have 156 licensed psychiatrists, 98 psychiatric nurse practitioners, 14 PAs--physician's assistants--who formally work in psychiatric settings. And all these folks are the ones who are trained to prescribe psychotropic meds. There's a maldistribution, however, of these providers: 129 psychiatrists, 78 psychiatric nurses, and 11 PAs practice in the Omaha and Lincoln areas, which means there's only 27 psychiatrists, 20 psychiatric nurse practitioners, and 3 PAs covering the remainder of the state, which is about 70,000 square miles. As noted earlier, only 12 counties actually have a psychiatrist and 6 counties have PAs and 16 have psychiatric nurse practitioners. So we definitely, especially outside of Omaha and Lincoln, are deficient. Access to a psychiatrist, even when I as a professional make a referral, can take anywhere from three to six months to make an appointment, often leading to emergency visits in the emergency room which, again, cost much more money. So what's a proposed solution? A relatively untapped source of mental health prescribers can be found in training programs for the physician's assistant. In Nebraska we were one of the earliest states to actually discover and train and recognize as licensed mental health providers the physician's assistant. We have 941 PAs in the state but only 14 of them are actually working in the area of psychiatric prescribing. PAs are trained to provide healthcare under the supervision of a medical doctor and also are licensed to prescribe medications. Each year the program at UNMC graduates about 50 students and there are other programs in the state now. Two of them are just developing, one at Creighton, one at College of Saint Mary; and there's an established one at Union College. So at this point in time, a psychiatric program of fellowship following PA graduation that would provide specialized training for physician's assistants to work in either inpatient psychiatric hospitals or in outpatient settings would be a potential way of addressing this need, especially due to the fact that combined by these four programs we might have as many as 100 individuals graduating each year. And a percentage of those I think will be interested in the area of psychiatry. So a creation of a one-year graduate fellowship is one of the answers that we're...one of the proposals we're suggesting. And new sources for this type of fellowship would have to come from some new sources of either federal grants or state funds or through adjustments in current educational allocations. The second proposal is integrated behavioral healthcare in primary care and it's using what's called the medical home model. Nationally there is a big movement now towards the

integration of physical and behavioral health and one source which would basically be the primary care physician's office for patients. Nebraska Medicaid has actually embraced this approach and the new Heritage Health approach that they have has contracted with three insurers--that is, Centene, UnitedHealth, and WellCare--with requirements that behavioral health actually be integrated into primary care settings. In Nebraska's rural health work force there are 507 primary care physicians, 222 physician's assistants, and 201 nurse practitioners practicing in areas outside of Omaha and Lincoln. By contrast, as mentioned before, there are only 27 psychiatrists, 61 psychologists, and 20 psychiatric nurse practitioners, 199 independent LMHPs, and 314 LMHPs working in rural areas. This represents only 28 percent of the work force but it's serving 70,000 square miles and 47 percent of our population. So there's clearly a maldistribution there. Nebraska faces significant shortages of behavioral providers. In 88 out of our 93 counties, according to federal guidelines and state guidelines from the office of the State Office of Rural Health indicate that all areas outside 25 miles outside of Omaha and Lincoln are also shortage areas. So by default what ends up happening is primary care physicians, especially in rural areas, family medicine doctors in particular, are often put in a very uncomfortable role of being a behavioral health provider, meeting behavioral health problems that they frankly are not well trained to address and they are concerned about that, and then taking time and resources away from their primary goal or main goal of providing physical healthcare. So a proposed solution is that, first of all, Nebraska is blessed to have 16 actual educational programs in the state providing training that leads to licensure and behavioral health, which sounds kind of out of question in light of the fact that we have so many shortages. Recently all these programs have actually joined forces with BHECN with the goal of maintaining 50 percent of their graduates in Nebraska. We have many situations where individuals are trained here, come from another state, and they come in and get their training and they're gone. We have programs in the state in psychology, in counseling, marriage and family therapy, and social work that offer doctoral and master's-level degrees leading to licensure. These programs, however, need additional resources and supervisory access to train in the area of primary care practice. Currently through our efforts at UNMC we have 21 primary care sites across the state that have faculty or staff that have been trained at UNMC and could be used as training grounds for integrated behavioral healthcare provision. As part of its mission to improve behavioral health, UNMC through BHECN and its Munroe-Meyer Institute programs can assist behavioral health training programs through stipend support for selected students, creation of an intercampus integrated behavioral health training

certificate, collaboration with leaders in the behavioral health programs across the campuses for course work, using distance learning formats, acquiring...arranging required supervision for trainees in primary care practices, placement of graduates into collaborating primary care practices, and basically initially targeting the 57 Nebraska cities in the state that have a population of at least 2,000, which means they usually will have anywhere from three to five physicians to make this an economically possible approach. How do we fund something like this? Well, as noted earlier, BHECN has explored a number of funding options to increase behavioral health work force in the state, including repositioning of current state budget allocations. One potential source of funding for this program may be found in a realignment of funds currently used to...directed at the Children's Mental Health Act which was initiated in 2013, sponsored by Senator Amanda McGill as LB556 last year...excuse me, 2015 it was reauthorized as LB240 for another two years. This program conducts behavioral health screenings. It also has referral and treatment and education for school personnel. The program started with three pilot sites, has expanded to eight primary care sites, and has supported behavioral health screenings for 5,389 children and adolescents in the first 38 months of its data collection that began in 2013. Interestingly, 21 percent of the children screened have potential behavioral health problems, which is right in line with national and other state data. Also interesting was 16 percent of parents indicated that they would like help in terms of working with their children's behavioral issues. Additionally, over 500 teachers, school counselors, special educators, and administrators have received some training in school mental health through the activities of this particular approach. Given that a significant demand for additional diagnostic and treatment services has been now demonstrated through LB556, it now may be prudent to consider realigning funding to support an intercampus training in behavioral health and primary care program. This is a logical progression from screening to diagnosis to treatment in the primary care setting. And UNMC and BHECN have, with our graduate training program, collaborations across the state, and physician partnerships, the capability of providing educational opportunities for behavioral health trainees in integrated care. Additional services and expansion could be realized without additional cost to the state budget. And this approach would then ultimately expand behavioral healthcare for all Nebraska citizens, especially in underserved areas. So in closing I'd like to thank the committee members again for opportunity to respond to your request for proposals. I strongly believe that state-appropriated fellowships, internships, and advanced training for behavioral health providers could be a cost-effective and

expedient way to improve access to behavioral health for Nebraskans, particularly those in rural and inner-city areas of our state. And with that, I'd be happy to take any of your questions. [LR413]

SENATOR BOLZ: Very good. Thank you, Doctor. Our last testifier of the day is Kasey Moyer, who is executive director of the Mental Health Association. So welcome, Kasey. We're glad to have you. Glad you're here, Kasey. [LR413]

KASEY MOYER: Thank you. My name is Kasey Moyer; it's K-a-s-e-y M-o-y-e-r. I am the executive director of the Mental Health Association. We in our focus group talked mostly about reentry housing and peer support. The Mental Health Association of Nebraska is a peer-run organization, so all of us live with mental health, substance use, have been incarcerated, have been in some sort of institution in the past and we believe in recovery and being able to support people who are going through the struggles that we at one time, ourselves, went through, or still periodically go through. We run Honu Home and the Keya House, which is a peer-run respite home. One of them is a five-day stay; one of them is a three-month stay. The one focuses on behavior, the five-day study focuses on behavioral health. So if I am in my apartment and I know things are starting to break down and my mind is starting to go, I don't have to wait until I hit crisis and need law enforcement or need that level of care. I can call and check in and go be surrounded by people and be able to process and create a wellness plan with you. Honu Home is a transition home for people coming out of specifically the Department of Corrections living with behavioral health issues. So they stay longer because they don't have houses to go back home to. So we allow them to stay for three months and again provide them with peer support 24/7. And we also hook them up with an employment specialist, who also is a peer, and a system navigator. Those of us that have been in the system for a very long time can navigate the system really well. And sometimes when you're not doing well yourself, it's really hard to do that. And it's not always noncompliance that makes us not show up for things or whatever the issues are. It's often really hard to do when you're experiencing your own difficulty. So we walk alongside people to assist them in that. Peer support is an evidence-based practice. We also do wellness recovery action plans. I think the best way that you get people to...in recovery is get them to buy into their own wellness. Instead of having people tell you what you need to do all the time, help them develop their own set of skills to be able to figure out what works for them, what doesn't.

And we support them at the houses with those things. We also have a "warm" line. We didn't set out to have a warm line, but when you open a house with a telephone it becomes a warm line. And we...for instance, Keya House received 1,200 phone calls on average monthly. And again, the purpose of the warm line is to give somebody somebody to listen to before it becomes the crisis. Our biggest allies are law enforcement, Probation, Parole, and reentry specialists with the Department of Corrections. We have built very good relationships with them and they...so the hand-off isn't, you know, okay, you are now being released from prison, good luck, see you later. We meet them at the door and again help them get to where they need; even if they're not coming to one of our houses, we walk that with them. We do track data. We do follow-up calls as well. I'll go back to the data thing, but we do follow up, which I think is very important. So when they're with us and they go home, we follow up in a month, two months, and just say, hey, how is it going, is there anything you need, are there other things that you're having struggles with, and often they'll call us and tell us maybe there are some good things. They got job promotions or, you know, they found a new house that they like better. And to have that kind of social integration and feel a part of a community is really important. Like I said, we do track our data, but one of the things...we track the data that the region requires us to track, but we also track quality of life. Do you feel safe in your house? Are you employed? Are you in the job that you like? Do you have $3 in your pocket to go have coffee with somebody? We want to know that their quality of life is improving and we're not just maintaining and that we're growing and that we're recovering. [LR413]

DESTENIE COMMUSO: (Inaudible) some numbers? [LR413]

KASEY MOYER: Yeah, I can give you some numbers. You should probably give the numbers. Is that okay? [LR413]

SENATOR BOLZ: Yeah, just say your name and spell it for us if you would. [LR413]

DESTENIE COMMUSO: My name is Destenie Commuso, D-e-s-t-e-n-i-e C-o-m-m-u-s-o. And currently I'm the reentry coordinator for the Mental Health Association. Previously I was the program coordinator of Keya House for five years. And in the last six and a half years, Keya House has served a total of 590 unduplicated individuals. The people that we worked with or are

working with were going to the hospital 30-plus times a year at $1,200 a day. And the stay is 3 to sometimes 14 days. So if you think about that, that's really high numbers. The cost of Keya House is a little over $200 a day per individual, so it's $1,000 less. Also I think the big difference, too, is we have the time to sit down and actually work with them to find out what their needs are, to process their thoughts they're having, to really come up with a plan, whereas the hospital doctors and nurses don't have the time to sit down with you and really spend that one-on-one time with you. You know, their job is to assess and move on. So I think that's a big difference between Keya and...and then Honu, it's been open since June 15 of last year and it is an up to 90-day stay. And so far we've served 44 individuals coming out of prison. The average stay is about 66 days. And that's also completely free to the individual. The idea of Honu is for them to...I mean we're working with people that have been in for 20, 30 years, so they don't even know what a cell phone is, a microwave, and just anxieties. I know that she's...the doctor said that, you know, 55 percent of individuals in prison have an addiction or a mental health issue. I think that that's a really low number. I think that's the diagnosed ones because if they didn't have a mental health issue going in, they're coming out with one. I mean I have to see it every day. And so the struggle...and I've said this before when I've testified. You know, people do spend their time in prison but their time really actually begins when they walk out those doors. They get all the stigma, they get all the discrimination. It is hard to find an apartment. Housing for people coming out of prison in Nebraska is unreal. I mean I haven't had a charge in 11 years and I can't even get a nice house in a nice neighborhood because of my charges. So the housing is part. And the Parole Board, they really do try and have most individuals transition to a transitional living. We don't have a lot of those. So we're working with people that are from other parts of the state who really want to go home, back to their families and their children, but they can't because there's not somewhere for them to transition to. And I think one of our biggest jobs is to assist them in helping them build a really strong support system. And so it works out really well for the three months that they're with us. But after they finish their parole or their stay with us and they go back to Hastings or York or, you know, these littler places, that support system does not follow them. So I think the idea of putting these types of programs in the rural areas, it will help us help them build their support systems where they're going to actually live and reside and (inaudible). [LR413]

KASEY MOYER: I also wanted to talk about, I believe I heard earlier someone talking about special populations, the LGBT, transitional, vets. We hire peers that have those backgrounds as well so that they are able to connect with somebody and we do see a lot of those populations. And so we try and look at the people that we're serving and the people in that area and identify peers who would engage best with those folks. So I think if you have any questions or... [LR413]

SENATOR BOLZ: Well, thanks very much for sharing. That was excellent information from both of you. Questions? Go ahead, Senator Scheer. [LR413]

SENATOR SCHEER: Are both facilities in Omaha? I'm just not familiar with them. [LR413]

DESTENIE COMMUSO: Lincoln. Lincoln. [LR413]

SENATOR SCHEER: Both in Lincoln? [LR413]

DESTENIE COMMUSO: Um-hum. [LR413]

KASEY MOYER: And they're purposely in a neighborhood and the neighborhood associations actually really support us because we have built relationships with the...it's all about relationships. We built really good relationships with the neighborhood associations and we become participants in that neighborhood. We participate in their garage sales and their whatever it is. We delivered newsletters at the Union College the other day. But it gives us purpose and the people who are at our houses purpose and to feel like a part of a community. And we have heard comments from people who come to our house--well, they get up and go to work every day, or, look, they're walking their dog. And they're doing things and they're seeing people go to the parks and they're seeing activities that when you go back to the same environment that you just came out of, you're seeing the guy trying to sell you, you know, a couple bucks for a cigarette or something but it just...so they're seeing different things and they're wanting something different and it's really neat when you see the light bulb go on and they decide that they want to live like that too. [LR413]

SENATOR BOLZ: I was just going to note that the Division of Behavioral Health did a report relating to housing assistance and one of their recommendations was to build on model initiatives like Keya and Honu and specifically to broaden their geographical reach. [LR413]

SENATOR SCHEER: Just out of curiosity, what would be the gender makeup of your members or clients or whatever? [LR413]

KASEY MOYER: Actually they're both coed. It's kind of...I refer to it as kind of a bed and breakfast. When you come in, you get your key to your room. There's lock boxes in there for their valuables. But they're...it's their room, it's their space. And the houses are based on respect and treating people like adults. We all grew up in systems where we were told when to get up, what time is group time, what time is med time, all those things. And until we learn how to do that for ourselves, we just end up back into the institutions. So the houses are set up that they do those things on their own. We've had people who have never cooked before cook a meal and then they decide they're going to cook the whole house a meal. And it's really neat to watch them grow and learn. And it is that transition from the institution going back into their own homes and being able to do that. But to answer your question, they are both coed. And that, too, is because we have to be able to learn how to deal appropriately with those relationships as well, and they've been restricted from those for a very long time sometimes. [LR413]

DESTENIE COMMUSO: The gender I would say for...after running Keya for five years, we definitely served more females than males, and then it's going to be the same with Honu. But then, only reason that is, too, is because there is less transitional housing for women coming out of Corrections. And the ones that we did have, they shut down, they shut down, they shut down. And so there is definitely I would say a higher need for transitional houses for women coming out of Corrections. I think that the...we're seeing and serving a lot more men at Keya because they've heard that it's different, you know, it's...I think men have a harder time asking for help. They have a harder time sharing their emotions and so...but it's getting...we definitely are serving a lot more men now than we did in the beginning because they know it's different. And then having the male staff, too, that are on the same level makes it easier. [LR413]

KASEY MOYER: One other thing, if it's okay, that I wanted to address that I forgot was that somebody talked earlier about the waiting time to get in to other providers. Often what we will do, we've worked it out here where somebody is waiting to get into treatment that 37 days, we will have them come to the house and just...they don't have to stay there, they can just be around us so that when their time is ready for them to go, they feel more prepared to do that. I see what happens is...but when they're ready to go, they're ready to go. And they end up back using again before they get their bed and then we don't know where to find them because they've already started using again. So what we've been able to do is work really closely with other providers and have them come hang out with us during the day. Sometimes they'll go to respite at The Bridge and then come back to us. But we've worked out nontraditional ways to try and cover those gaps in the system. And we've seen people successfully get from our houses into treatment and not miss that opportunity when their name comes up. [LR413]

SENATOR BOLZ: Did you have...go ahead, Senator Crawford. [LR413]

SENATOR CRAWFORD: Thank you, Senator Bolz. So you had mentioned, Senator Bolz, that this is recognized as a practice you'd like to see in other geographic locations. I just wondered what you see as key keys to helping this model get replicated. Are there things that we can do to help make that a possibility? [LR413]

KASEY MOYER: As always, I suppose the main thing is funding. We have talked with law enforcement in Grand Island, Nebraska City, and other rural areas and they always ask, well, can you do this in our area? And we're not out there. We're funded through Region V right now. And I think, too, the populations, it would be a responsibility on our part to really get to know those communities and reach out and let people know, you know, what we do and who we are. But I think mostly it would be funding. Like I said, we've worked a lot in York with the women there in the prison. And I think there's some natural places where these houses would be really effective to just at least try to see how well they do in the rural areas. [LR413]

SENATOR CRAWFORD: Thank you. [LR413]

SENATOR BOLZ: Great. Thank you very much, both of you. [LR413]

KASEY MOYER: Thank you. Thanks for allowing us to speak. [LR413]

SENATOR BOLZ: Glad to have you. Just as we're wrapping up, I want to note for the record that we've got two written pieces of testimony, one from the Nebraska Commission on Problem Gambling from David Geier, and one from Disability Rights Nebraska from Dianne DeLair. So we thank them for submitting written testimony. We'll make sure everybody has a copy if they don't already. Thanks, everybody who testified and those who listened and to the task force members, for your hard work, and I think we're convened. Thank you. [LR413]