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Introduction

The Behavioral Health Support Foundation Steering Committee asked Gallup to conduct research analyzing the current behavioral health system in Region 6, highlighting issues related to care continuity and coordination and to prepare a report detailing findings and recommendations.

Stakeholder interviews were conducted in-person with leaders from health systems, hospitals, social service agencies, and with other interested parties. Interviews took place between May and November, 2009. The following is a list of participants who were interviewed:

- Sheree Keely, VP of Behavioral Health, Alegent Behavioral Health Services
- Steve Spelic, Government and Outreach Strategist, Alegent Behavioral Health Services
- LaDonna Novak, Inpatient Adult Care Manager, Alegent Behavioral Health Services
- Tammy Talacko, Manager, ED Psych Nurse, Alegent Behavioral Health Services
- Mike Anderson, Interim Executive Director, Lasting Hope
- Robin Conyers, Nursing Director, Lasting Hope
- Jean Sassatelli, Sr. Director for Behavioral Health, Catholic Charities
- Mike Phillips, Catholic Charities
- Dr. Nick Battafarano, Catholic Charities
- Carole Boye, CEO, Community Alliance
- Aileen Brady, Community Alliance
- Sherry Glasnapp, Douglas County Community Mental Health Center
- Dr. Sid Kauzlarich, Douglas Community Mental Health Center
- John Sheehan, Douglas County Community Mental Health Center
- Carolyn Thiele, Vice President, Nebraska Professional Service, Heartland Family Services
- Barbara Jessing, Clinical Director, Heartland Family Services
- Karen Foxx, Latino Center of the Midlands
- William Harris, Latino Center of the Midlands
- Ruth Heinrichs, President and CEO, Lutheran Family Services
- Marti Wilson, Lutheran Family Services
- Amy Richardson, Lutheran Family Services
- Barry Walker, Nebraska Urban Indian Health Coalition
- Eleanor Devlin, Executive Director, NOVA
- Suzanne Nord, Clinical Director, NOVA
- Patti Jurjevich, Regional Program Administrator, Region 6 Behavioral Healthcare
- Taren Petersen, Region 6 Behavioral Healthcare
- Katie Hruska, Region 6 Behavioral Healthcare
- Mary Davis, Executive Director, Santa Monica House
• Linda Burkle, Director of Social Services, Salvation Army
• Jessica Jones, Clinical Director, Salvation Army
• Kelly Sixel, Program Administrator, TeleCare Mental Health Services of Nebraska
• Janice O’Callaghan, Friendship Program
• Beth Dankert Babb, Program Director, Friendship Program
• Donald Kleine, County Attorney, Douglas County Attorney’s Office
• Brenda Beadle, Chief Deputy County Attorney, Douglas County Attorney’s Office
• Dr. Susan Boust, UNMC
• Dr. Steve Wengel, UNMC
• Dr. Dan Wilson, Creighton Psychiatry
• Rhonda Hawks, Behavioral Health Support Foundation
• Ken Stinson, Behavioral Health Support Foundation
• Dr. Thomas Svolos, Division Director, Creighton University Medical Center Division of Psychoanalysis
• Dr. Kathleen Grant, Director of Substance Abuse Treatment, Veterans Affairs Hospital
• Dr. Matt Egbert, UNMC
• Cathy Jesus, Creighton University Medical Center
• Jonah Deppe, Executive Director, NAMI
• Kathleen McAllister, Board Member, New Hope Life Center for Women
Summary of Issues

In speaking with providers and interested parties throughout Region 6, it is apparent that there is a lack of alignment between and across state and local governments, care providers (including hospitals, regional centers, primary care providers, etc.), and community support agencies. This lack of alignment ultimately has led to a system that does not put the patient and the patient’s family at the center of care. It requires the patient to adjust to the needs and circumstances of the system, rather than having the system adjust and adapt to the needs of the patient.

There are several key factors that are contributing to the current state:

1. **This is not an outcomes-driven system.** There is a great desire for collaboration across the network, but with HIPAA and other restrictions, it is difficult to collaborate effectively. So treatment remains very tactical in nature, with the goal being to treat the symptoms of the patient on that particular day. Beyond that, there are no agreed-upon metrics for success, – and therefore, no direct incentive for providers to get patients out of the system.

2. **In the absence of a system, providers will create their own.** This applies to assessments (e.g., the unique assessment at NOVA, the different applications of ASAM criteria at Nebraska Urban Indian Health Coalition and Catholic Charities) and referrals. An infrastructure has developed for the different workarounds, limiting the sense of urgency for change.

3. **Patient education alone cannot solve the problem.** There is a sense that if patients were more educated about their options, they could better navigate across the system. But many activities, including involuntary/EPC admissions and transfers, are outside of their direct control. Education about alternative sites for urgent care and assessments would be helpful in keeping some patients out of the ER. But in the end, the issue is less about helping people navigate the system as it is about keeping people out of the system (or helping them stay out).

4. **Collaboration between providers is limited primarily to committees and task forces.** A lot of activities and reforms have come out of the committees and task forces, particularly the Co-Occurring Task Force and Clinical Review Team. Providers would like to see more day-to-day collaboration across facilities. But they are almost resigned to the fact that day-to-day collaboration is unlikely, if not impossible, largely due to the restrictions placed on information sharing by HIPAA.

5. **Given that, there is limited coordination of care.** There are challenges that exist with patients moving from one provider to the next. These include difficulties with information sharing and limited collaboration between providers regarding past patients and their current and future care plans.
   
   a. **It is difficult to know where to go for information.** Care providers and agencies often have limited information on the patient and there are times when providers do not fully understand where the patient has been and who has cared for him or her in the past. Providers, therefore, have to rely heavily on the patients to fill in the gaps. This reliance on patients is a concern because the patients may not know or remember all the important information providers need, or they may offer incomplete or misleading information to the provider to get the care or support they want. Many providers simply choose to start from scratch.

   b. **The process of obtaining records is extremely cumbersome.** Providers have to rely on their fellow providers to track down patient records and have them faxed or mailed, which is very time consuming. These efforts leave little time for collaborating about the patient and what should be done to effectively care for him or her. The manner in which records are kept is also inconsistent, leaving providers with doubts about the information they collect.

   c. **Consistency of care is another concern.** Community providers all follow some sort of care plan with their patients. But when patients move from provider to provider, there is no way to ensure
continuity and coordination between plans. There is no way to track whether the plan is modified and adjusted as they achieve milestones and goals or as they relapse and interact with new providers. There is no organization or person responsible for making decisions on care for a patient and assuring that care and follow-up are received. (Region 6 fills this role for some patients, but not fully.)

d. The primary physician may or may not be involved. Concerns were also raised about the lack of communication that takes place between physicians regarding patients and that primary care physicians are not sufficiently involved in the management of behavioral health-related issues. Many feel that this is the ideal level where disorders should be identified and where care should be coordinated as patients move through the system.

6. Each provider tends to know the other providers, but not necessarily the depth and breadth of their offerings. There is a general familiarity with the different providers in the system. There are also some natural alliances between partners (e.g., Immanuel to LFS for urgent care and to Lasting Hope or Mercy for long-term care, Latino Center of the Midland to Campus of Hope or NOVA for intensive outpatient or inpatient services). But it’s not clear that everyone is fully aware of the different services being offered at each facility, particularly services being offered by second-tier providers. Nor are providers necessarily sharing best practices with each other.

7. The system is still catching up to the realities of co-occurring illnesses. Not all providers are capable of caring for patients with co-occurring disorders. Without these capabilities, patients are often misdiagnosed and provided care that is ineffective over time. It is common for patients to be referred to multiple facilities before landing in a place that is able to take them in.

   a. Even where care is offered, it is not necessarily balanced. Patients with co-occurring disorders need to be cared for in a comprehensive manner. Yet the sense is that 90% of the focus is on mental illness and only 10% on substance abuse and addiction.

   b. This is largely a funding issue. The state reimburses mental healthcare separately from substance abuse care. This structure creates limitations for providers. Despite this structure, many organizations are working to train more people to become capable of caring for co-occurring disorders simultaneously. Another concern is having multiple payers for the same patient, which can throw a wrench into the care process.

8. There are other “outside” factors at play. Even if there was greater collaboration, many of the factors leading to repeat visits are societal rather than clinical in nature (e.g., homelessness, availability of meds, lack of transportation). These issues are often compounded by the wait times involved in securing assessments or treatment. It is not uncommon for patients to have to wait up to six weeks or more to get into a program. This creates major gaps in care that can derail progress that a patient has made or lead him or her to a state of crisis.

9. Wait times are often traced back to capacity and funding. Limited capacity is frequently mentioned as a cause of these excessive wait times. There is a notion that there are not enough beds or capacity within programs to support the number of people who need care. Funding was mentioned as another cause. Some believe that this may stem from a negative stigma that exists in the general public about behavioral health conditions and those who suffer from them.

10. It is not just the number of beds, but how they are used. Many have concerns regarding patients getting lost in the current behavioral health system. Part of this can be traced back to the shortage that exists for residential services. This shortage is due in part to the number of actual residential programs that exist relative to the number of individuals in need, but it is also due to the lack of diversity in services relative to specific patient needs and the often stringent requirements for patients to qualify for residential services.
a. Many feel that the sheer number of residential services is a big concern. As mentioned, there are long wait times for residential programs. When patients do not have a place to go they may try to rely on hospitals or perhaps homeless shelters, which do not provide a constructive environment for patients. Patients’ reliance on hospitals for a place to stay creates inefficiencies in the system, backups in emergency departments, and fills beds that would be better used by other patients. Probability for success increases if patients stay in a residence that provides a supportive and positive environment that encourages recovery and has limited negative temptations.

b. There are also not enough levels of housing to account for the diversity in stages of recovery that patients find themselves in. Individuals suffering from behavioral health issues can be in varying ranges of recovery while in a residential program. It is not healthy for people who are further along in recovery, but still vulnerable, to be surrounded by people who are struggling to recover. For example, if someone has a mental health disorder and is recovering from substance abuse but is surrounded by people who are still struggling not to relapse and whose temptations are high, this can create an unhealthy environment.

c. Requirements for patients to qualify for residential services were also raised as an issue. People with certain disorders and conditions have a hard time getting into residential programs when it would be beneficial for them. Examples of these patients include people with developmental disabilities and sex offenders. Others were concerned with requirements that were necessary to maintain housing, an example being that in some cases, patients need to have some level of community support to qualify for certain residential programs. This circumstance leads patients to hold onto their community support longer than they need to maintain the housing vouchers.

11. Even where effective care is provided, there isn’t enough support for patients once they are discharged. The sense is that some patients are released before they are ready to be discharged. Staffing restrictions then limit follow-up or check-in activities. Additionally, the system is not currently equipped to flag high-end users. (However, Region 6 can track repeat visitors to County and Immanuel, as they fund both facilities.)

a. Alarmingly, follow-up from providers after a patient has been discharged is not common. Most organizations do not have a formal process in place to check in with patients after a certain period of time, which many feel has a negative impact on outcomes. Some organizations follow up informally and help the patient as much as possible before the patient is discharged but have limited interaction after the patient leaves their care.

b. Providers do not have much incentive to follow up with their patients. Follow-up takes a lot of time and effort and is expensive to execute appropriately given that most providers are typically under staffed. Providers are not accountable to following up with patients after discharge to help assure they are adjusting well in society. At the same time, providers stated that they are not reimbursed for efforts related to follow-up, so it becomes difficult to assign resources to this practice.

c. Yet follow-up is vital. Organizations consistently expressed that to consider a patient’s visit to be successful, the patient needs to have a place to go after discharge, needs to have transportation, needs access to medications, and needs to follow his or her care plan. Many patients navigate these tasks on their own. Programs like community support and peer support are growing in popularity and many feel they have had a positive impact on patients. Although additional support services are becoming available, more are still needed due to the high demand of these services. More patients need access to support that they could rely on over an extended period of time and that can follow them through the system as they use different providers.
Recommendations for Change

Most of these issues have been heard or discussed before. The challenge remains how to do anything considering HIPAA regulations and in light of the enormous funding that would be needed to build additional capacity or services into the system and provide additional support to follow up with patients.

Ultimately, change can occur at one of three levels: tactical, transitional, or transformational. Recommendations for each level are provided on the following pages.

Tactical Changes

Tactical changes focus largely on education and communication. They are a logical first step for this effort because they can be initiated in the near term with minimal investment and can be driven from the outside in. They won’t change the system, per se, but they would begin to alleviate some of the problems referenced in this section. More importantly, tactical changes provide the necessary momentum for future change efforts. Initial recommendations here include the following:

1. **Quantify demand across the network.** We still don’t know how many consumers typically pass through the system at any given time. Nor can we necessarily break that number down by the nature/extent of illness or by demographic group. In theory, Magellan was supposed to provide access to those data, but that isn’t happening (or at least it wasn’t as of June 2009). That is either because the system can’t produce the necessary information or because Magellan has been unwilling or unable to do so. Without those data, it remains difficult to propose and prioritize recommendations and initiatives, and, more importantly, to assess the value of different recommendations relative to cost. An initial step here would be to check in with Magellan to better understand what is and isn’t available.

2. **Increase clarity about point of entry.** Despite recent efforts, law enforcement and doctors are still channeling too many consumers through the emergency department for initial assessments and “crisis care.” This seems to be where the education issue is manifesting itself — not with consumers (who may or may not be in control of their own situation), but with these ancillary providers. As a result, consumers continue to enter the system at the point where costs are highest. And more consumers may be entering or re-entering than necessary (as opportunities to divert a crisis are not fully exploited). A starting point would be to check in with law enforcement to see why the previous education initiative didn’t have the desired effect (or at least a sustained effect), and then consider a broader effort to inventory and promote providers of urgent care. This would initially be focused on ancillary providers, but ultimately extended to consumers and their families as well.

3. **Create a provider portal to offer greater transparency across providers.** As mentioned, providers aren’t always fully aware of the breadth of each other’s services. And even when they have that awareness, they have no way to track the availability of services. So referring a consumer to another facility requires a series of phone calls to different providers to check on capacity and to gauge how suitable the service might be given the mix of patients at the receiving facility. An expertise has since developed concerning this referral process so that it now even seems normal or desirable to those involved. Certainly the existence of such a portal could raise HIPAA red flags, so the information shared would be extremely limited at first (number of available services, red/yellow/green coding about suitability). But the portal could ultimately become a test case for communication across providers. It could be used to catalog the available services at each facility. Chat rooms could be created to answer questions or share best practices. It could also house a master calendar for assessments and therapists that are part of the network — with a first alert system to advise providers of changes or openings in the schedule.
Transitional Changes

Transitional changes are more significant than tactical changes, and they speak more directly to the nature of care provided in Region 6. But they are still largely grounded in the status quo. In some cases, best practice examples of these changes already exist with the region.

Recommendations are offered here in four areas: communication and collaboration, co-occurring disorders, residential services, and follow-on support. Some of the recommendations are aspirational in nature — meaning they are worthy of additional discussion and analysis but can’t necessarily be implemented without intervening changes to the system.

Communication and Collaboration

Existing Best Practices:

- **Clinical Review Team.** Clinical Review Team meetings organized by Region 6 are very popular. Participating in these meetings has been a great way for organizations to collaborate and share best practices. Many believe that these efforts should be expanded to include more patients and more organizations. Specifically, providers feel that more participation from hospitals, physicians, and law enforcement would improve the productivity of these meetings and improve coordination within the system.

- **ACT Teams.** ACT Teams are composed of licensed mental health professionals, nurses, substance abuse and rehabilitation professionals, peer support workers, and a psychiatrist, all of who share responsibility for the individuals the team serves. This team works to coordinate flexible care in a comprehensive manner. ACT Teams will provide care for patients in their homes or at locations across the community on a 24-hour basis, 7 days a week. This team's responsibilities also address issues related to follow-up and support.

Additional Recommendations:

1. **Evolve the role and perception of Region 6.** Some recommended transforming Region 6 into the “air-traffic controller” for the local behavioral health system. In this role, Region 6 would monitor patient needs and availability/capacity providers have across the region. In this role, Region 6 would direct where people should go to receive care based on their needs, condition, and services available. They would work with providers on funding and reimbursement, structure accountabilities concerning patient outcomes, and assure alignment of goals. Region 6 would also assure that patients are being discharged at the appropriate time, know where the patient is being transferred, approve appropriate facilities for the patient to be transferred to, assure there is follow-up or support in place for the patient post-discharge, help coordinate housing, facilitate communication within the system, coordinate with law enforcement on how to handle patients and where to take them, etc. Lasting Hope and the Nebraska Department of Health and Human Services were also mentioned as organizations well-suited to fulfill this responsibility. Outside organizations could also be used to partner with the state and/or region to coordinate and manage the continuum of care. This partnership could come from existing organizations like Alegent Health, UNMC, or other health systems that have experience managing an integrated network.

2. **Shift more to a community case management model.** Community case management is an effective way to coordinate care and get providers working together more effectively. Region 6 or another central representative could execute this role. New York was mentioned as an example of using community case management effectively. There, providers are able to flag frequent users of the system. For these patients, efforts are made to develop a community wide care plan incorporating more than one agency or provider. This approach helps assure that all providers are on the same page and working toward the same objective. These efforts may be similar to efforts by the Clinical Review Team. The state of
Ohio was also mentioned as an example of a state that effectively coordinates care. There a medical director is responsible for reviewing patients' cases and determining the appropriate level of care and path through the system. The medical director assures that the patient stays appropriately connected to the system.

3. Create a central intake system for all patients who enter the system. This intake system would be responsible for bringing patients into the system, stabilizing them, conducting initial assessments, making initial diagnosis, gathering medical history, updating records, making recommendations on where the patient should be transferred within the system and facilitating the transfer assuring all information is shared and that the patient is accepted in a timely manner. This facility would be responsible for monitoring all patients before, during and after they receive care. Ideally this would cut down on trips to the emergency department and assure that patients stay on track. Expanding Lasting Hope's role in the current system could help fulfill this responsibility.

4. Have behavioral health disorders identified in a primary care setting and see that as the ideal level of care for interventions to begin. Enhanced collaboration between behavioral health providers and primary care physicians and practices should be explored to create alignment among care provided for medical issues and behavioral health disorders. Consideration should be made to have physicians or primary care professionals take on a roll where they are responsible for coordinating care among facilities across the region. In this case they would act as the "air-traffic controller" for the patient, guiding them in where to go and who to see based on what is appropriate relative to their condition and what facilities have capacity to take the patient in a timely manner.

5. Integrate behavioral health professionals into the primary care setting. In an effort to create greater collaboration, primary care providers should look to place behavioral healthcare professionals into clinics and integrate behavioral health evaluations, services, and recommendations into this care setting. This level of collaboration would allow providers to identify disorders early on and to initiate treatment that aligns with medical needs. Consideration should also be made to coordinate care on this level on an ongoing basis. Alegent Health is currently looking into creating an Advanced Medical Home for patients that would provide the patient access to a comprehensive, multi-specialty team that would work to coordinate treatment comprehensively in one location.

6. Implement a central electronic medical record (EMR) in Region 6. This EMR would be a central repository containing all patient records across the region. Each provider would be given access to this system to pull and update patient records. With a central EMR, an administrator would need to be responsible for approving access to the system, assuring that information flow meets regulatory privacy guidelines (HIPPA). One way to assure that permission is granted to facilities to access records is to have those who qualify for Medicaid automatically grant permission to organizations who have access to the EMR in exchange for care. A “voucher model” was mentioned as another way to grant approval for record sharing. In this model, patients grant access to patient records that are housed in a central location by giving providers a password that is specific to the patient.

7. Create more specialization in the region. Some believe that there are currently too many duplicative services that cause confusion for people looking to enter the system. Specializing services would provide added clarity on where patients need to go for certain issues. This would also eliminate confusion when coordinating care between providers and making recommendations on where patients should go. This effort would be particularly helpful for law enforcement who regularly transfer patients to emergency departments. Specialization may make providing specific recommendations on providers easier and simplify the patient’s path through the system.
**Co-Occurring Disorders**

Existing Best Practices:

- **Co-Occurring Task Force.** The Metro Area Continuum of Care for the Homeless started the Co-Occurring Task Force to formally work on transforming the system of services in the Omaha Metro area into one capable of providing integrated, coordinated treatment for people with co-occurring disorders. Many feel that this has had a positive influence on the way these disorders are treated. Expansion of this effort in Region 6 could benefit those with co-occurring substance abuse and mental health disorders.

Additional Recommendations:

1. **Restructure how treatments for those dealing with co-occurring disorders are paid for.** Care providers have limited resources and have a hard time justifying providing care for services that won’t be reimbursed. Payment for co-occurring substance abuse and mental health disorders need to be made together when appropriate. This would remove a major barrier for providers effectively diagnosing and caring for these conditions and could reduce recidivism, which would positively affect system capacity. These steps would also have a positive impact on issues related to the rigid funding structure that exists.

2. **Work with the new administration at the Nebraska Department of Health and Human Services to assure that there is a fluid and comprehensive funding structure in place that mirrors what patients need from a clinical perspective.** This includes payment for care that addresses co-occurring disorders and enables substance abuse and mental health disorders to be addressed simultaneously as mentioned previously.

3. **Create incentives for organizations to train staff to become co-occurring capable.** Many organizations are training their people to be co-occurring capable already, but incentives should be put in place to encourage all organizations that provide care and services for behavioral health patients to become capable of caring for patients with co-occurring disorders. Ideally, incentives would be monetary and would be structured into adjustments mentioned previously. Innovative approaches to prevention, assessment, and treatment can be found on SAMHSA’s Co-Occurring Center for Excellence Web site, [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

**Residential Services**

Existing Best Practices:

- **Salvation Army.** Increasing transitional residential services would help increase care continuity and prevent patients from getting lost in the system. These services could be similar to what the Salvation Army currently provides. Transitional residential placements would provide patients with a temporary living arrangement and give them access to case managers who could help them transfer to more appropriate permanent housing.

Additional Recommendations:

1. **Explore intermediate or step-down residential services.** These services would provide patients with an environment that is more appropriate relative to their current condition. This would also place them in an environment where they are surrounded by people whose conditions are similar to their own. This type of housing would be structured so that the patient can cascade up or down based on where he or she is in his or her recovery and what his or her condition is. If a patient is recovering from substance abuse and makes progress with his or her recovery, he or she would step down through different levels of housing with less supervision and live with others in a similar stage of recovery. If the patient relapses, he or she would go back to the appropriate level based on the severity of the relapse. This
would prevent a patient who relapses from being completely removed from a residential program and allow him or her to gradually recover in a healthy environment.

2. **Expand services for specific patient segments.** Providers feel there is limited room for new patients to enter the system based on capacity that is available. Effort should be made to explore/research which services have the greatest need, what services have available capacity, what are wait times for services and determine what wait times are appropriate for each service. Any changes made should then be prioritized based on these findings. Additionally this research effort should look for inefficiencies that exist within the system that can be addressed which would free up capacity for providers. Services mentioned during interviews that could be expanded or created include expanding service for sex offenders; creating outpatient services for treating co-occurring disorders; expanding services for geriatric patients; creating secured, locked facilities for substance abuse treatment; expanding services for inpatient and residential treatment for chemical dependency; etc.

3. **Help to reduce the stigma of behavioral health disorders (as a means of securing additional funding).** Additional residential services are needed in Region 6. Much of this comes down to sheer capacity. There are more people who need housing than there are services available. Funding is clearly a major factor with this problem. Some feel that this is attributable to the negative stigma that surrounds behavioral health. Efforts to increase community awareness on the scope of challenges that those with behavioral health disorders face and the number of people and families affected could influence action and may result in additional dollars being designated to this problem. Increased awareness could come through social marketing campaigns focused on educating the general public about the number of people who live with behavioral health disorders, how to identify behavioral health disorders, and highlight stories of people who successfully live with behavioral health disorders. Creating partnerships with other health providers, schools, or businesses to educate them on behavioral health is another option to help create awareness.

**Lack of Follow-Through and Support**

**Existing Best Practices:**

- **Alegent Health’s Nurse Navigator Program.** This program uses a certified nurse who helps patients with entry in to and out of the health system and who acts as a single point of contact for patients and families. The nurse navigator assists with scheduling tests and consultations, collaborates with members of the medical team, and helps patients understand their diagnosis and care plan.

- **VA’s 90-Day Aftercare Program and Friendship Program’s 90-Day Follow-Up Calls.** The VA expressed that they assign patients a counselor who follows the patient from the moment he or she enters into the system to discharge. This person is then responsible for following up with the patient post-discharge. Each patient is then placed in their 90-Day Aftercare program, which is designed to help patients with scheduling appointments, arranging transportation, and assuring the patients have access to their medications. Friendship Program also has set a standard that they will follow up with their patients over the phone 90 days after they complete treatment.

**Additional Recommendations:**

1. **Introduce a central patient support system.** A crucial success factor for patients is the level of support they have from family members or caregivers, particularly as they transition between organizations. Patients need to be monitored more closely and they need to work with a consistent person over a long period of time. Working with a consistent person will encourage a close relationship and high level of familiarity. Familiarity is important for understanding the patient and how to work with him or her as he or she experiences ups and downs and receives care from providers across Region 6. Support from this central system could come from a social worker, a past patient or peer, a caregiver, or a volunteer, but the key is to have a consistent person who can advocate for the patient and check in with him or her on a regular basis. Individuals providing support would be responsible for helping patients over time...
to arrange follow-up appointments, assure they have access to their medications and that they are taking their medication, arrange transportation, support them in crisis situations, and help them with day-to-day tasks. Interactions like this are shown to help improve outcomes, prevent relapses that lead to readmissions, prevent unnecessary visits to the emergency department, and help with adherence to care plans and medications. More consistent support over time would also reduce the number of frequent fliers in the system and free up capacity.

2. **Establish standards for following up with patients within a certain time frame and incentivize providers based on compliance.** Data should be used to determine which patients providers are following up with and what percentage of patients providers follow up with. These data should be transparent and available to the public along with other key performance indicators including providers’ re-admission rates, data related to patient outcomes, care quality, patient/customer satisfaction, etc. This information could help track how effective follow-up efforts are. Data collected should be benchmarked at the organizational level so that the public can make comparisons between organizations. If the general public had the capability to compare each organization’s outcomes data side by side, it could be used to determine preferences between organizations. This level of transparency would incentivize care providers to be more accountable for follow-up and to take extra steps to assure that patients are adjusting well post-discharge, adhering to their care plans, and taking medications. These data could also be used to provide extra reimbursement for high performers and less reimbursement for low performers, creating a pay-for-performance system.

3. **Creating mobile support units.** These units would have the capability to access patients wherever they are and could help patients get their medications, remind them of appointments, assure that they make their appointments, and follow through on their care. Ideally these mobile units could help assist patients regardless of who they received care or treatment from.

4. **Put additional incentives in place for providers to thoroughly follow up with their patients to assure adherence to their care plans.** Disincentives could also be considered for not following follow-up care standards. More detailed research may be needed to make a case for the affect that follow-up care has on outcomes and how these incentives would lower costs over the long run for the state and Region 6 due to a decrease in readmissions and “frequent fliers” in the system. These incentives should be considered on some level for all patients and an individual approach should taken to determine what level of follow up is appropriate for each patient.

**Transformational Changes**

Transformational changes upend the status quo, and are therefore more difficult to come by. Change of this magnitude is often the product of great vision and leadership. One such change occurred recently with the opening of Lasting Hope, which added capacity and a more immediate source of urgent care into the region. It is unlikely that we’ll see that level of change again in the near term — at least not without substantial influx of funding or calls for change at the state level.

A long-term vision needs to be created by the state of Nebraska for the behavioral health system and goals and objectives made at the state level need to be in alignment with those of community providers. These goals and objectives should be focused on what is best for patients. Currently, glaring gaps in care and inefficiencies exist within the behavioral health system. Some of these gaps exist due to the fact that the current system is not an outcomes driven system.

One consideration for change is to modify the way in which providers are incentivized, which currently seems to be heavily based on the number of patients providers care for, and change this structure to one that provides incentives based on outcomes and quality. Shifting incentives is one step toward creating more alignment on goals and objectives. For this change to take place universal outcome measures would need to be decided upon and organizations would need to assure that they have the capability to track those outcomes.
and report them to NE DHHS and/or Region 6. Outcomes should include but not be limited to clinical outcomes, quality measures and patient/family feedback. Reimbursements and incentives would then be linked to performance on these measures. Shifting system-wide objectives to focus more on outcomes would incentivize providers to become more efficient in areas like information sharing, collaboration with other providers and assuring appropriate follow up with their patients in order to obtain desired positive outcomes.
Questions for Representatives From Hospitals and Community-Based Providers

Summary of Services Provided:

Define the nature of care your facility provides.

Alegent Behavioral Health Services

Overview:

- Alegent Behavioral Health Services has 190 acute beds in Nebraska and Iowa. They have services for adults, geriatrics, and pediatrics, including partial hospitalization services, outpatient clinics, psychiatric emergency services, chemical dependency/addiction therapy, and residential programs for children. They also provide community education and community support services.

Entry Points:

- Most patients are seen in their outpatient clinics
- Emergency departments at Alegent Health facilities

Providers That Refer to Them:

- Primary care physicians
- Therapists
- Other acute care providers
- Community services
- Law enforcement
- Social Services if the patient needs medical attention

Providers They Refer to:

- Lasting Hope
- Immanuel
- Community services

Exit Strategy:

- For outpatients a follow-up appointment is made with the patient’s primary care doctor.
- For patients seen in an acute care setting, partial hospitalization, or coming out of their residential program, they analyze what the patient’s support situation is like and determine if they should refer him or her to a community service.

Lasting Hope Recovery Center (a service of Alegent Health)

Overview:

- Lasting Hope Recovery Center is a service of Alegent Health and a community resource center providing acute care for those in crisis. They provide 24-hour clinical care and chronic behavioral health crisis management and stabilization. Lasting Hope provides law enforcement, a psychiatric home base
for people experiencing a crisis because of a mental illness, families access to support, and patients experiencing mental illness and co-occurring substance abuse disorders high-quality care. Lasting Hope most commonly treats people with major depression, bipolar disorder, schizoaffective disorder, and co-occurring substance abuse disorders. Lasting Hope has 64 private patient rooms including 32 immediate crisis beds requiring a week or less of treatment and 32 beds for those requiring three to four weeks of inpatient care before transitioning to outpatient programs.

Entry Points:
- Patients present themselves or are brought in by a loved one
- Brought in by law enforcement

Providers That Refer to Them:
- Community services
- Alegent Health
- Area hospitals
- Law enforcement

Providers They Refer to:
- Hospitals if the patient has a medical need
- Community services

Exit Strategy:
- Upon discharge, a physician directs next steps that can include a referral to another agency.
- Lasting Hope has a new discharge process that includes a discharge planner who begins the discharge process upon admission. The planner provides the patient with discharge instructions, information on medications, access to Lasting Hope’s crisis line, transportation (if needed), information on the agency he or she is referring the patient to, a safety plan for the patient, and a support group. The planner also asks the patients about their satisfaction with their stay.

Catholic Charities

Overview:
- Catholic Charities provides multiple services for people suffering from mental illness and substance abuse. Services for addiction and substance abuse include intensive outpatient treatment, assessment, and a continuum of residential treatment services at Omaha Campus for Hope. They provide psychiatric evaluations and medication management, outpatient and residential programs, domestic violence services, counseling for adopting parents and pregnant women, adolescent behavioral health, and programs that focus on co-occurring disorders, including their community-support program where support is provided in the patient’s home. The city’s only voluntary detox program is also available, and they recently started a peer support program.

Entry Points:
- Most patients enter from other community services
- Some patients come from the court system or are referred by probation officers
- Patients receive a standard chemical evaluation upon entry
Providers That Refer to Them:
- Community services
- Court system
- Probation officers

Providers They Refer to:
- Oxford House System
- Community services

Exit Strategy:
- Catholic Charities looks to assure that their patients can better manage their condition before they discharge them. They use American Society of Addiction Medicine (ASAM) criteria to assess needs or the patient. Prior to the patients leaving, they attempt to get them connected with services they are referring them to.

Heartland Family Services
Overview:
- Heartland Family Services is a nonprofit, non-sectarian social work and counseling agency that serves adults and pediatrics, primarily in an outpatient setting. They also have a residential treatment center that conducts clinical evaluations for juveniles. Heartland Family Services has programs that focus on treatment for addiction, therapy for mental health, child abuse, domestic violence, early childhood development, juvenile delinquency, neighborhood enrichment, and poverty and homelessness.

Entry Points:
- Most patients come from the court system
- Central intake team conducts a prescreening assessment

Providers That Refer to Them:
- Most referrals come through the court system

Providers They Refer to:
- Community services

Exit Strategy:
- Patients are discharged if there is a mutual agreement that predetermined goals have been met.

Community Alliance
Overview:
- Community Alliance’s sole focus is on adults with mental illness. They encourage adults to work toward their own recovery. Community Alliance has a variety of services that individuals ebb and flow through including day rehabilitation services, residential rehabilitation, work source vocational services to assist individuals in finding a job, community support services, homeless services, community housing, family education, and Assertive Community Treatment (ACT) which offers a coordinated team approach to
meeting the needs of adults with mental illness. ACT combines a full range of treatment, rehabilitation, and support services to help individuals succeed in society and keep them out of hospitals.

Entry Points:
- Most enter through an onsite central evaluation system where evaluations are made to determine appropriate care
- Homeless outreach — they go to shelters to provide basic needs to patients

Providers That Refer to Them:
- Area hospitals
- Community services
- Clinical Review Team

Providers They Refer to:
- Community services

Exit Strategy:
- The care team will work with the patient to develop a plan for how he or she will monitor and maintain a healthy lifestyle as he or she moves on to another level of care.

Latino Center of the Midlands

Overview:
- Latino Center of the Midlands is a social service agency providing cultural transition, education, social, and health services to the Latino population in Nebraska. They offer outpatient treatment services to individuals diagnosed as having substance abuse disorders or a substance dependence disorder. These services include group treatment and individual treatment, low-risk offenders group therapy, adult alcohol education classes, and alcohol/drug assessments and evaluations for adults. They are also setting up peer support positions to check in with people after completion of their programs. Latino Center of the Midlands also offers services for adult education, family-based services, and education and student support.

Entry Points:
- Patients frequently come to them as a part of their probation, typically for DUI
- Written assessments are done with the patient initially, oral assessments are conducted later (there is usually a wait for these)
- Most patients are referred to other organizations for outpatient services

Providers That Refer to Them:
- Law enforcement

Providers They Refer to:
- Campus for Hope
- NOVA
- Refer patients who need mental health assessments
Exit Strategy:
- A clear strategy was not provided during interviews.

Santa Monica House
Overview:
- Santa Monica House offers a residential program including individual and group counseling, 12-step meetings, life skills training, and relapse prevention for women dealing with substance abuse. Santa Monica works to help women cope with daily stresses without dependence on drugs or alcohol. They focus on treating addiction, but also work with issues related to co-dependence. Santa Monica’s Halfway House program is a 6- to 12-month program and their Intermediate Residential program is a 12- to 24-month program. Santa Monica House offers these programs to women aged 19 and older.

Entry Points:
- About 70% come through the court system
- Other patients come from Alcoholics Anonymous or other area service providers

Providers That Refer to Them:
- Area hospitals
- Community services
- Court system

Providers They Refer to:
- Community services

Exit Strategy:
- A counselor conducts a review with the patient to see that the patient has achieved goals that she has set concerning treatment and to assure that necessities are arranged including housing, transportation, and employment.

Salvation Army
Overview:
- Salvation Army offers behavioral health services, services for the homeless, senior services, and child development services. Most of the care they provide is support for individuals as opposed to treatment. Behavioral health services include community support, emergency community support, intensive community services, psychiatric respite, adult rehabilitation for addiction, transitional residential support, and long-term residential support. They are the only provider of emergency community support in Omaha. Individuals do not need a clinical diagnosis to qualify for these programs.

Entry Points:
- Most often patients come from area hospitals
- Homeless shelters

Providers That Refer to Them:
- Area hospitals
Behavioral Health Support Foundation Report

- Homeless shelters
- Community services

Providers They Refer to:
- Community services

Exit Strategy:
- Discharge begins day one for the patient as the Salvation Army looks at various life domains and tries to remove any barriers that get in the way of the patient making a smooth transition into society. They also provide information on additional services they recommend to help with this transition and to avoid having the patient go to shelters.

**TeleCare Mental Health Services of Nebraska**

Overview:
- TeleCare provides a secured residential facility for those dealing with mental health disorders. They treat those with severe mental illness, most come from regional centers. TeleCare views their care as a step down from inpatient care that stabilizes patients and gets them closer to home.

Entry Points:
- Most of their patients are hospitalized many times before they come to TeleCare
- Many patients come directly from regional centers or area hospitals

Providers That Refer to Them:
- Regional centers
- Area hospitals

Providers They Refer to:
- Community services

Exit Strategy:
- When they see a person stabilize, their objective is to move the patient to a lower level of care. They want to see that the patient has met treatment goals, has adjusted to medications, has access to resources for support, and can function outside a secured setting. They then get the patient ready to transfer to another provider.

**Friendship Program**

Overview:
- Friendship Program is a nonprofit agency committed to creating a supportive environment to assist elderly and disabled individuals remain independent in the community. Friendship Program offers adult day services, community-based rehabilitation services, community support services, and case management.

Entry Points:
- Set up an intake appointment to conduct assessment and collect information on medical history
Most patients come directly from Lasting Hope or area hospitals

Providers That Refer to Them:
- Lasting Hope
- Area hospitals
- Community services

Providers They Refer to:
- Community services

Exit Strategy:
- Ultimately patients decide when they are ready to be discharged, and then a discharge summary is provided which outlines services the patient can use in the community.

**Lutheran Family Services**

Overview:
- Lutheran Family Services is a statewide, multi-service human care agency. LFS’ services range from prevention services to intensive treatment. LFS’ three broad service areas include behavioral health, adoption and services for children, and community services. Behavioral health services include mental health counseling, sexual abuse/incest treatment, substance abuse treatment, gambling addiction treatment, community support, urgent care services, and specialized counseling for children, adolescents, adults, and families.

Entry Points:
- Primary care or family practice physicians send patients directly to LFS
- Patients are provided information on LFS from the court system or law enforcement
- Initial connections are made with patients via phone and an interview is conducted to determine what services are appropriate

Providers That Refer to Them:
- Law enforcement
- Medical clinics
- Community services

Providers They Refer to:
- Community services

Exit Strategy:
- If the patient meets the goals that have been outlined, LFS feels comfortable discharging him or her. A lot of emphasis is put on helping the patient develop natural support with family, friends or peers, outside their care and discussing how the patient can meet his or her basic needs in life.
NOVA

Overview:

- NOVA provides behavioral health services for individuals with substance abuse disorders and mental health issues. They also provide foster care placement for infants, children, and adolescents as well as in-home safety services. NOVA has inpatient and outpatient services for mental health and substance abuse disorders. Services include adolescent treatment group home services, adolescent intensive outpatient services, adult residential services, and outpatient services. Residential services include a long-term Therapeutic Community program serving people diagnosed with personality disorders and substance abuse disorders and a Short-Term Residential program that serves individuals diagnosed with co-occurring severe mental illness with substance dependence. The typical length of stay for the Therapeutic Community program is 4 to 6 months and the typical length of stay for the Short-Term Residential program is approximately 30 days.
- Referrals for the Therapeutic Community program are made from multiple sources including self-referral, family members, hospitals, clergy, law enforcement, probation, physicians, etc. Referrals for the Short-Term Residential program are made through the Region 6 Clinical Review Team.

Entry Points:

- Intake team conducts assessments, processes paperwork, and explains programs. ASAM criteria helps with placement
- Most patients come to them from jail; others come from hospitals, state wards, area hospitals, and other community services

Providers That Refer to Them:

- Hospitals
- Law enforcement
- State wards
- Hospitals
- Clinical Review Team
- Community services

Providers They Refer to:

- Community services

Exit Strategy:

- They take an individual approach to discharge as they work with patients to create their own continuing care plan and recommend follow-up services specific to individual needs. They work with the patient to develop a care plan appropriate to his or her needs and circumstances.

Douglas County Community Mental Health Center

Overview:

- Douglas County Community Mental Health Center offers inpatient and outpatient care to adults over 19 years of age who are residents of Douglas County and/or the Region 6 area and are uninsured. Inpatient services consist of two secure inpatient units, one is a 22-bed unit providing patients with 24-hour observation and therapeutic management, and the other is an 8-bed psychiatric intensive care unit
providing a higher level of observation and treatment for patients who are experiencing a more severe level of crisis. Douglas County’s psychiatric outpatient program provides psychiatric care to adults on an outpatient basis by a treatment team consisting of psychiatrists, psychologists, nurses, licensed mental health practitioners, and case managers. Their partial hospitalization program provides short-term treatment for people in an acute phase of mental illness. This program provides a structured environment to people who have been discharged from an inpatient unit and also for outpatients who require stabilization and management. Their Mental Health Diversion program is an intensive management service provided to individuals with serious mental illness who are in the criminal justice system.

Entry Points:
- Law enforcement/emergency protective custody
- Board of Mental Health Petition
- Many patients are ordered to go to Douglas County due to the Board of Mental Health petition or as an alternative to jail

Providers That Refer to Them:
- Law enforcement

Providers They Refer to:
- Community services

Exit Strategy:
- A hearing is held with the Board of Mental Health Petition, and if approved, a patient is discharged. Voluntary patients can put in a request to be discharged at any time.

Nebraska Medical Center

Overview:
- Nebraska Medical Center is the hospital partner for the University of Nebraska Medical Center. They educate medical students and clinicians and provide acute medical care.

Entry Points:
- Emergency Department
- Law enforcement

Providers That Refer to Them:
- Physicians
- Medical facilities
- Community services
Providers They Refer to:
- Community services
- Medical facilities

Exit Strategy:
- Discharge plans are created that are specific to patients’ needs. Patients are also given recommendations on services available in the community that can support them.

**Creighton University Medical Center**

Overview:
- Creighton University Medical Center in partnership with their primary teaching hospital, Saint Joseph Hospital, is an acute care medical center and trauma center. They also provide medical education and research. All behavioral health patients come through their emergency department; they provide treatment for people with medical needs.

Entry Points:
- Emergency department; care team conducts evaluations of the individual on-site
- Law enforcement

Providers That Refer to Them:
- Community services
- Medical facilities

Providers They Refer to:
- Community services
- Shelters

Exit Strategy:
- Once the patient receives medical clearance from his or her doctor, nurses and social workers help the patient to find a facility or service that can support him or her when appropriate. The hospital frequently arranges transportation for the patient to the referred facility or service.

**Veterans Affairs (VA) Hospital**

Overview:
- VA Nebraska-Western Iowa Health Care System serves veterans in Nebraska, western Iowa, and portions of Kansas and Missouri. The Omaha facility is an outpatient facility and also a large outpatient clinic for primary and specialty care. Services in their Mental Health and Behavioral Science Program include their Mental Health Clinic, Recovery Center, Substance Use Disorder Program, Mental Health Intensive Care Management Program, Post Traumatic Stress Disorder Clinic, and Psychology. VA has multiple levels of care for substance abuse. Level 1 requires a lower level of outpatient care, nine hours or less. Level 2 is a high-intensity outpatient program. Level 3 provides residential care, and level 4 is inpatient care that provides 24-hour nursing care.

Entry Points:
Patients come through the VA emergency department or are referred by other services and organizations
Upon admittance patients are assigned a councilor to orient them to their services

Providers That Refer to Them:
- Mental health facilities
- VA physicians
- VA emergency departments
- Acute care hospitals
- Other VA facilities
- Homeless shelters
- Law enforcement

Providers They Refer to:
- Community services

Exit Strategy:
- Counselor works with the patient to create a care plan and to orient him or her to the VA's 90-Day Aftercare program to help him or her arrange appointments, get medications, and to assist with transportation needs.

Nebraska Urban Indian Health Coalition
Overview:
- Nebraska Urban Indian Health Coalition is a nonprofit agency dedicated to improving healthcare for all urban Indians in the community. Urban Indians do not live on reservations, and therefore, are generally not entitled to the health benefits their tribes offer. NUIHC offers inpatient and outpatient behavioral health services for substance abuse disorders. Their Intertribal Treatment Center for substance abuse program provides inpatient, co-ed substance abuse treatment for Native Americans in the Aberdeen Indian Health Services Area, which includes South Dakota, North Dakota, Nebraska, and Iowa. The residential period is on a 45-day cycle and the wait is usually 6 to 10 weeks. The Behavioral Health Program is the outpatient component; the target population includes Native Americans and others residing in the Omaha Metropolitan area including Dodge, Cass, Sarpy, Washington, and Douglas counties.

Entry Points:
- Incoming patients are put through an assessment to determine what treatment is recommended
- Law enforcement will bring patients to them

Providers That Refer to Them:
- Law enforcement
- Hospitals

Providers They Refer to:
Community services

Hospitals

Exit Strategy:

- Next steps are established for patients depending on their needs and they are referred to other providers when necessary. Urban Indian Health Coalition does all they can to assure a smooth transfer, which at times includes transporting patients to other providers to assure the patient arrives. There are times that patients are referred to other providers after they go through their assessment because Urban Indian Health Coalition does not provide services the patient needs or because they do not have the capacity to take them.

Discussion about Patient Entry

Under what circumstances does a patient typically arrive at your facility?

There are many entry points for an individual into the behavioral health system. The way an individual enters the system and the reasons for him or her being introduced into the system are as varied and diverse as the number of patients in the system. Often patients are referred to providers by other providers, hospitals, community services, homeless shelters, physicians, psychiatrists, therapists, by the court system, or by word of mouth. Other times police will bring patients in, patients will present themselves, or a loved one will bring them in. Most providers see patients who voluntarily come to them and some see patients who come to them on an involuntary basis. The challenge is not to get them into the system but to get them to the right type of care at the right time.

Many times when a patient comes to a facility the level of service he or she needs is not available at that particular facility or that facility does not have the capacity to help the patient at that exact time. Capacity was mentioned numerous times as a serious barrier to providing effective care and support. Another challenge for providers and patients is that often when patients arrive at an agency or provider, they have no prior knowledge of or history on the patient. This information is crucial in determining what level of care is appropriate. Not having immediate access to this information extends the amount of time and resources to get the individual into the right care and increases the likelihood that he or she may not get the right type of care. With past treatment plans or history, a facility would be able to determine how to handle an individual.

How do they know to come to you?

Agencies in Region 6 are currently using many strategies to create awareness. Some efforts include traditional methods of promotion, other methods are less traditional and more creative, but nearly every organization interviewed stressed that they rely on word of mouth to some degree to create awareness; some rely on word of mouth exclusively. These efforts are supplemented by nearly every organization by a Web site that provides information regarding their organization, the services they provide, and where they can be found.

Many organizations interviewed, including Alegent Health, Lasting Hope, Heartland Family Services, Lutheran Family Services, and Catholic Charities, mentioned that they advertise or have marketing strategies to help people get to know them. These strategies include TV and radio advertisements, use of billboards, and print ads.

There are also other unique methods of creating awareness and building partnerships outside of traditional marketing efforts. Lasting Hope conducts trainings on various topics with other providers, which creates awareness of their services to peer organizations. Lutheran Family Services has similar efforts in place where
they work with other services to educate them on their services and they conduct trainings with law enforcement to educate them on how to work with someone dealing with a mental health issue or substance abuse and to help them understand the work that Lutheran Family Services does to help these people. Alegent Health has a very comprehensive marketing strategy that includes advertisements and participation in health fairs, but they also have less traditional efforts in place. They have done media pieces with local news agencies that showcase providers and conduct other targeted marketing with clinics they have created partnerships with.

Catholic Charities is an example of an organization that has realized that many people in the general public are not aware of all of the services that fall under their umbrella, which has created a desire to develop a more sophisticated approach to branding. Santa Monica is also looking into marketing their service to create awareness of their existing services and to promote the expansion of their services.

Other organizations like TeleCare have no marketing efforts in place and have no plans to develop a marketing strategy because they already have more patients than they can handle.

Word of mouth is a major source of awareness. There are many referrals that happen between providers and that come from the court system, law enforcement, hospitals, shelters, Clinical Review Team (CRT), insurers, and Medicaid to name a few. Another source of referrals takes place between the recovering community and patients speaking with other patients on their preferences. There is an understanding in the behavioral health community that patients do have some understanding about different facilities and know what services they like.

At the VA, most patients are referred from within the VA system. This could be from a primary care physician, an emergency department physician, or other VA facilities and hospitals. They also get referrals from outside organizations including homeless shelters, the criminal justice system, hospitals, etc. Generally speaking, there is a lack of awareness about services that are available in the region from primary care physicians, and this has some concerned. It is believed that if behavioral health issues were addressed at this level of care to begin with and that if behavioral health providers had a closer relationship with primary care physician, the patient would be better off because of it. There is also a feeling that the negative stigma that surrounds behavioral health exists with some family practice physicians. This stigma may exist because of a lack of awareness.

Although there are many efforts in place focused on educating law enforcement, agency staff and medical professionals know what types of services are available for those suffering from behavioral health disorders, but issues still exist with connecting the patient to the right provider or agency at the right time. Many agencies feel that the CRT has begun to fill much of that knowledge gap, but their reach is still limited. There is still not enough collaboration among different agencies to understand where the patient needs to go next and what agency/facility has capacity.

What makes them come here as opposed to some other facility?

There are various reasons behind why patients go to various facilities and use different services. Some of these reasons involve voluntary decisions by the patient, while others are involuntary. Selection on facility over another also involves consideration about the type of service provided, availability of service, personal preference, location, aesthetics, references, and payment options, among others.

The location of the organization plays a role in why people come to one facility over another. Many organizations are located in lower-income neighborhoods or near downtown Omaha where many of their patients live. Having a close proximity to their patients is advantageous since many do not have convenient access to transportation.
According to Lasting Hope, proximity was the primary reason why patients initially came to them, but now their facility is updated and aesthetically pleasing, which attracts a wider range of people creating greater awareness and more loyal patients. The facility was designed with the patient in mind, and the working culture there reinforces that the patient should be at the center of everything they do. Santa Monica also attributes a warm and comfortable environment as a reason why they attract patients. They pride themselves on creating a welcoming environment that feels like home for their patients.

Often times the level of service offered an organization offers and the availability of services plays a role in why people choose one organization over another. Alegent Health’s name recognition helps them attract patients, but they feel that having physicians on-site at each of their outpatient facilities helps to differentiate their services because not all services in the region have physicians on-site.

Santa Monica feels their comprehensive approach to service attracts patients to them because they do more than just provide treatment, all recovery issues that might make a patient relapse are addressed, including fundamental things they need to survive such as shelter, work, money, etc.

The Salvation Army views itself as “the safety net to the safety net.” Although they are routinely working over capacity, they do their best to serve the underprivileged and the underserved, separating them from others and attracting people to their organization.

TeleCare’s secured setting attracts patients who need a higher level of care and a locked, secured setting when they are struggling to maintain their symptoms. The choice for patients to choose their services is an easy one since their services are so unique in communities of Omaha and Bellevue.

Although uniqueness of service does attract patients to certain services, the capacity which these services can handle becomes a major deciding factor for patients. Most organizations who were interviewed cited that they routinely have waiting lists for their services, particularly those who provide some sort of residence for their patients and patients. Heartland Family Services mentioned moments when people came to them because other organizations could not take them because they are full. They take in as many people as they can, but capacity is a concern for them as well.

Recommendations from physicians, therapists, or other care providers also have a tremendous influence on patients deciding where to receive care. For example, Nebraska Medical Center cited patients visiting them based on recommendations from physicians, these referrals also take within the VA system. Friendship Program cited the close relationships that they have built with other agencies and clinics as a means to attract people. Other sources of referrals and recommendations come from homeless shelters, law enforcement, the court system, and other hospitals to name a few.

Insurance and affordability play a role in this decision-making process too. Many times the individual’s insurance or lack of insurance determines where he or she goes. Organizations like Lutheran Family Services are willing to take patients without insurance, but there are times when patients end up relying on local emergency departments for their care because they cannot afford to go elsewhere. This situation puts a strain on the system and has negative implications for patient outcomes. Heartland Family Services cited their sliding fee payment system that makes their services more affordable for lower-income patients and hence more attractive.

**Are there some cases when coming to your organization is not the right decision (for the patient or for you)?**
When a patient comes to an organization with a condition that the organization does not provide services for, often that organization will refer the patient to another organization. Although this happens frequently, reasons behind these decisions are varied throughout the region.

There are occasions when patients are put through a pre-assessment over the phone or receive assessment in person from a medical care provider. Based on the results of the assessment, the medical facility will recommend the patient to a support service they deem to be appropriate. There are occasions when the support service turns the patient away because they do not provide the appropriate level of care or they do not have the capability of caring for that patient given his or her condition. Although they may have the services to care for the patient, the results of the assessments will lead them to make a decision that this patient is not right for them. For example, some support services may be able to deal with a patient with schizophrenia, but they cannot care for a patient with schizophrenia and a drug addiction, so the support services will refer them to another organization. Multiple transfers and referrals reduce the likelihood that the patient will succeed in recovery.

Many organizations do not have the capability to handle acute medical situations, so if a patient comes to them with an injury, such as broken bones, if they are pregnant, or need if they need emergency medical services, then they need to go to a hospital. Most providers and services have standards on how medically stable a patient needs to be to take that person. If a patient is intoxicated, the organization may require that the patient leave and come back when he or she is sober. Campus for Hope is one of the few providers who will detox a patient; law enforcement will also do this or put the person in emergency protective custody if necessary. At times, patients also come to providers in violent states and need to be dealt with by law enforcement or sent to the Lincoln Regional Center. Many organizations will not take violent patients and will only take people who can benefit from treatment and who want to be willing participants in the care process. A concern was mentioned that there are times when law enforcement does not take appropriate action with patients. One example is that law enforcement will place intoxicated patient with suicidal tendencies in emergency protective custody at times when really they should put them in a detox center.

Creighton University Medical Center, Nebraska Medical Center and Alegent will take patients who need medical assistance. Creighton University Medical Center mentioned that they do receive patients who come to them who do not need medical attention but do not know where else to go. For these people, Creighton University Medical Center’s refers them to another service that can treat their mental illness.

Capacity is another consideration when making these decisions. It is not uncommon for agencies to have to turn patients away because they do not have room for them. The way things are now, providers simply cannot care for everyone in need.

Describe the admittance/entry process. Do you receive referrals or transfers from other providers? If so, which ones?

Most organizations interviewed have a central intake team, an assessment team, clinical director, or designated individuals responsible for evaluations and assessments for new patients as they enter their organization and help to make a decision on what care is appropriate if they should admit them. Assessments and information collected include mental health assessments, bio-psycho-social assessments, chemical evaluations, analysis of the patient’s level of risk, medical history, past treatments, past mental health history, family history, medications, social history, discussion about the patient’s current support system, the patient’s cognitive ability, etc. As organizations collect this information, they rely on two different sources, the patient and past providers. Often times providers rely heavily on patients for accurate information about their medical history, which is concerning for many. Providers consistently feel as if patients are not always great historians and it is difficult to gauge what to believe. Those organizations interviewed also consistently stated that they contact past providers to obtain any information they have on the patient which could help them formulate an
effective care plan. Information is commonly shared via fax or mail, and providers rely on other providers taking
time to retrieve these documents and send them. This process can take a long time considering how many
requests various providers receive for patient history. This lengthy process can then delay care to the patient.
When information is finally collected, it is used to determine what services are appropriate for the patient,
whether he or she should be seen at another facility, or if he or she should utilize a different service. If the
patient is appropriate for that service, the organization will use the information collected to begin formulating a
care plan. Many organizations emphasize the importance of developing the care plan in a collaborative way
with the patient as a decision maker. Many adhere to Substance Abuse and Mental Health Services
Administration (SAMHSA) and American Society of Addiction Medicine (ASAM) criteria during the time of
assessment and rely on this as a foundation for reassessing patients throughout their care.

Alegent Health’s admitting process includes identifying of what the patient’s issue is upon arrival, looking into
his or her family and medical history, and then developing a care plan. Alegent also has to check the patient for
contraband, which can be a complicated process because they do not want to traumatize or humiliate the
patient. On the inpatient side, Alegent has to assess and stabilize any symptoms the patient is showing. If a
patient comes to them through the emergency department, they have to accept that patient, but agencies do
not have to accept patients for inpatient care. Upon discharge from the emergency department, a patient will
go to Immanuel if there is a bed available. If not, Alegent will call other facilities in the region for available beds.
First calls usually go to Lasting Hope or Immanuel Medical Center, or sometimes a patient will have a
preference on where he or she would like to go. At discharge they also refer patients to outpatient providers
and community support. In an attempt to avoid having patients rely on the emergency department, Alegent will
do crisis intervention and de-escalation over the phone. Alegent has an intense registration process because
of Joint Commission. Since Lasting Hope has opened, some of the burden on Alegent’s emergency
department has lifted.

Lutheran Family Services is unique in that they are a community service that has an urgent care program that
takes people with emergency needs. Referrals to this program largely come from medical clinics and law
enforcement. LFS is also looking at creating a central intake system for incoming patients. Currently they
gather information from their patients over the phone to help them identify what services are appropriate for
them, how they will pay for it, etc. They do have the ability to connect patients to a provider directly over the
phone if there are any emergency needs that can be handled in this way.

At Lasting Hope all patients go through a mental health assessment that includes looking at their risk level.
Lasting Hope also looks at medical history, medications patients are taking, social history, their support
system, their cognitive ability, past mental health history, family history, and they put patients through a
physical assessment that includes blood work. After they have all of this information, a psychiatrist makes a
call on the best course of action for the patient, which can include admitting them to the facility. If they are not
medically stable, then Lasting Hope may send them to Bergen Mercy.

Most organizations also rely on other organizations for past medical records. This process is inefficient at times
because of the reliance on others to physically transfer or fax the record. The common thought is that people
are busy and they do not always have time to search for records and send them.

A concern that was brought up by Catholic Charities is that they need to conduct a standard chemical
evaluation with their patients every six months. This evaluation is needed for patients receiving care that the
state covers. In their opinion, this evaluation is not effective or necessary because the individuals taking this
assessment are suffering from chronic conditions.

Referrals are common, and many organizations rely on them to attract patients. Those referrals come from
many places, including hospitals, other community providers, homeless shelters, law enforcement, Douglas
County Community Mental Health Center, and Alegent. The VA refers patients internally to other services and
providers that fall under the VA umbrella. CRT is also another source for referrals for services and helps providers effectively organize appropriate next steps in a patient’s care. Capacity becomes an issue with referrals; it is common for patients to be referred to other services only to be told that there is a wait. These wait times can last months, and that has negative implications for care continuity. Urban Indian Health Coalition said they see waits anywhere from 6 to 12 weeks for their residential services and intensive outpatient services. Lutheran Family Services tries to minimize this negative effect by connecting a patient with a provider immediately over the phone to help him or her with any emergency situation and to avoid having the patient fall onto a waiting list.

**What information/education do you provide to the patient and the patient’s support network?**

When it comes to information and education that is provided to patients and their families, many organizations in Region 6 take a similar approach. Almost all educate patients on their diagnosis, provide an orientation to substance abuse and mental health, and continue to educate patients on this throughout the care process. Some organizations specifically stated that they put an emphasis on going over the patient’s care plan and assuring that the patient’s support network understands it and has confidence in it. Many use a recovery model that emphasizes having the patient as a primary decision maker in crafting that plan and setting goals and milestones within it. Most individuals and organizations interviewed either stated that this is not a major emphasis early on in the care process, or seemed a little caught off guard by the question and really needed to think about it.

Organizations also expressed that they educate patients on services they provide or other services other care providers offer that may be beneficial for patients and work to get them connected with the right people. Other information provided includes patients’ bill of rights, safety information, and regulatory information. Joint Commission and other accrediting bodies require that organizations provide this type of information to patients.

Santa Monica described a unique practice they use that involves inviting the patient’s family to their home and educating the family about addiction and how to deal with it. Santa Monica discusses with the family the difference between supporting and enabling the patient suffering from addiction and encourages support while under Santa Monica’s care. It is clear that Santa Monica sees support from others as a key success factor for the patient.

**Does the nature of this information play a deciding role in whether you admit the patient? (In other words, is it possible that, based on information provided, the facility refers the patient to another facility, assuming that it’s not an emergency?)**

For many organizations, the information they receive from the patient regarding his or her current condition plays a bigger role in decisions they make on the patient’s behalf than information they give to the patient. Commonly results of evaluations and assessments are reviewed and considered with the patient’s background and how his or her care is going to be paid for, and then decisions are made based on what is best for the patient.

The decision is never cut and dry, Alegent Health expressed the importance of asking good questions and having good conversations with the patient and his or her support network so Alegent has a clear understanding of what the patient needs. When a patient goes so far as to contact Alegent for help, that usually means he or she really needs help. Alegent realizes that most patients wait to reach out for help when they should be seeking that help much sooner. Providers need to be aware of this when working with the patient and considering the most appropriate course of action for him or her.

For Santa Monica, although many of their patients have a dual diagnosis, most have a less severe mental health issue. If a patient’s mental health condition is severe, Santa Monica refers them to Campus for Hope.
and the Stephen Center. Santa Monica also refers patients to other facilities such as Lasting Hope if the patient is in a crisis situation. Santa Monica’s patients usually come back to them after they are stable and ready to participate in their care.

TeleCare looks for how willing a patient is to participate in care and if his or her symptoms are in a place where they can work with them. If not in this place, TeleCare will turn the patient away. For instance, if a patient cannot speak or communicate or is aggressive, suicidal, or psychotic, TeleCare will not admit him or her. A patient in this condition does not work well in TeleCare’s therapeutic care environment.

For Lasting Hope, the patient’s present condition and medical history are the main deciding factors in determining whether to admit him or her. For example, Lasting Hope looks at whether the patient is suicidal and, if so, how realistic his or her threat is (some patients know what they need to say to get admitted). If Lasting Hope determines that they are not the right provider for the patient, a physician will usually make a referral to another provider.

Is that different for repeat visitors?

For those organizations that do regularly get repeat visitors, providers have more of an understanding of those patients’ history. This information is commonly incorporated and can play a role in deciding the appropriate course of action. The care process can be a revolving door; there are times when patients will make rounds between providers because they are looking for a place to stay. Providers look for this and make decisions accordingly. In many ways it is important not to rely too much on a patient’s history because his or her condition may be much different than it was before. For this reason it is important to reevaluate and reassess the patient. Some facilities do not see a high number of repeat visitors, but if they do, the process is similar.

How familiar are you with the patient’s case history at the outset of treatment?

Generally speaking, the subject of accessing a patient’s case history is a source of frustration for providers, although some seemed to be content with the status quo. Most organizations interviewed described the inefficiency of sharing information between providers and the inconsistency of the information they get concerning their patients. Inefficiencies arise out of the time it takes to collect and share records. Inconsistencies arise from relying on the quality of other organizations’ record keeping and on patients reciting their case history accurately, informing them of other providers they have seen, when they have seen them, and why they saw them.

The level of familiarity with case history depends on the patient and the information that caregivers are able to get on admission. Providers often rely heavily on what patients tell them about their past. Typically patients are not great historians, especially if they come to an organization alone. Patients also shop around for agencies and providers — if they get frustrated with one, they might move onto another, but they do not always tell the provider about all the places they have been. A consistent challenge providers face is determining whether to trust what patients tell them.

Most providers also collect medical records and historic information on diagnosis and treatments the patient has had from other providers or from a referring service. Exchanging information usually entails contacting past providers via phone and requesting to have a patient’s record sent to them via fax or mail. This is a time-intensive effort and can delay care for a patient. Depth and quality of information does vary at times because the care a patient receives is spread out between many providers. Many providers across the region expressed frustration with this process because it is time consuming. There were a smaller number who seemed to have no problem with the way information is shared now. Another way of obtaining medical records and patient case history is through CRT meetings, which many feel are productive and hope this effort continues to expand and improve.
The level of familiarity with a patient’s case history is an area that multiple organizations feel they need improve. Alegent Health mentioned that they have an electronic medical record, but they still need to get a lot of information from patients, and the quality of this information varies. Some organizations expressed the need for a central electronic medical record that all providers in the region could access. This record would provide medical history, current and past medications, safety plans, care plans, and strategies that have or have not worked for the patient in the past. With a record like this in a central location, multiple providers could update and access it on a regular basis, thereby increasing the efficiency of accessing patient records. Because the VA has access to all patient records within the VA system, no matter where a patient has been treated, the issues of accessing a patient’s history seem to be less of a concern for them. Others felt that a central electronic medical record could never happen because of HIPPA regulations and the need for patients to provide permission to release their medical history.

Competition also creates barriers to collecting information on a patient’s history in that it prevents providers from collaborating in the most effective way. This was not mentioned by most organizations, but some do feel that this is an indirect cause of inefficiencies.

**What is your level of contact with previous doctors or facilities that the patient has received care from?**

There is a high level of contact with some providers but not a lot with others. About half the organizations interviewed felt that they had a high level of contact with other doctors or facilities. For these providers, contacting facilities that a patient has received care from is a routine process. For every patient they contact previous providers or services to find out about medications, medical history, previous hospitalizations and why they were hospitalized, etc. Others felt that their level of contact with previous providers varied, and for 20% to 50% of their patients, they contacted other facilities. Friendship Program stated that they try to have a high level of contact but they need to have more. One factor is they are very dependent on other providers responding to them, which creates challenges because of time constraints. The issue of time constraint was mentioned by nearly a third of the providers interviewed. Most information Friendship Program receives comes straight from the patient. Lutheran Family Services also mentioned the time it takes to track down records as being a barrier to collecting information, but they also added that the process of getting releases for that information signed is a problem at times. For others, their patient’s condition will determine if they need to contact a previous provider. If their patient’s condition is severe, then they will make contact; if it is less severe, they will not.

When contact is made, conversation usually focuses on exchanging records. Many feel there should be more interaction and collaboration, but everyone is stretched too thin. More physician-to-physician contact would help too; NMC sees this as the ideal standard, but it is the least likely communication to actually happen. Some take advantage of CRT meetings and view them as an opportunity to collaborate with other facilities. It was mentioned that these are productive meetings but that hospitals are not well-represented.

**Are there ever steps that the patient or his or her support network could have/should have taken to prevent the visit?**

Most all organizations agree that to prevent a visit, the patient requires a certain amount of ongoing support or human interaction. This interaction helps with adherence to a care plan, can lead to early interventions, and helps to prevent the patient from falling into a crisis state.

Boys Town has a crisis phone line that those suffering from mental illness can use for support. There are also other national hotlines that are designed to provide interaction and support to those in need. These hotlines could help prevent patients from needing to access a service directly. One big component of preventing visits is to get people out of crisis mode and get them in contact (nearly any kind of contact) with people that can
help them before they enter a state of crisis. These interventions could come from a family member, peer, community support service, or a hotline of some sort and should take place as early as possible. Santa Monica also felt that schools also could be potential intervention points for kids and parents. Having patients contact and work consistently with a primary care physician is another way to prevent visits, particularly emergency visits to Lasting Hope or acute care hospitals.

Other efforts that currently exist and can help prevent visits include peer support and community support. Community Alliance feels as if peer support is not used enough. There are patients who have been through the system and they either are helping or could be helping current patients. In Community Alliance’s opinion, more peer-to-peer interaction would reduce the number of frequent flyers. Salvation Army created an emergency community support service for individuals experiencing a mental health crisis, which can help divert patients from going to an emergency room.

Patients adhering to their safety or care plan can also prevent them from needing to visit a provider. Lutheran Family Services feels that if a patient has some sort of peer support and a wellness recovery action plan, and they follow the plan with their support or sponsor, this could help prevent visits or at least help to catch issues early on. If patients have someone supporting them and interacting with them on a regular basis, that would help, but without that interaction, their condition gets so bad they end up needing a lot of help.

Discussion about Patient Exit

What would you consider to be a successful conclusion to a patient’s visit?

When asked to define what a successful conclusion to a patient’s visit would be, nearly every organization mentioned the development of a realistic care plan or action plan for the patient as a major factor for determining success of a patient’s visit and looking for signs that the patient would be able to use the plan after he or she leaves the organization. Other indicators of success were more varied across organizations but included whether the patient was happy with the level of service; whether his or her condition stabilized, especially if it was a crisis situation; whether the organization met the goals outlined during the patient’s care process; did the patient have a place to go after he or she was discharged; did he or she have transportation, access to medications, etc.; was the patient able to function outside a secure and structured setting; etc.

Examples of Successful Conclusions to Patient Visits

Lasting Hope assures that the patient’s acuity is stabilized, formulates an appropriate discharge plan that is sustainable for the patient, gets the patient access to affordable medications, and arranges to have a place for the patient to go, which can be challenging at times because many patients do not have stable living arrangements. Lasting Hope also mentioned that they often need to arrange transportation for patients, noting that they spend a lot of money on taxis.

At Catholic Charities, if the patient can better manage his or her condition then the organization considers that to be a successful conclusion. They like to see the patient manage their addictions better than before so that they can pursue other goals. They also like to see the patient moving in a positive direction and seeing that he or she has reflected on his or her issue or disorder and has made a choice to take care of it.

For Heartland Family Services, success is determined by whether a patient has met the goals that he or she outlined when he or she started his or her care process. If the patient is functioning better and meets or exceeds benchmarks of therapy indicators, then that is successful. Heartland Family Services feels that approximately two out of three patients meet this level of success; if patients have problems with substance abuse that number decreases to one out of two.
Community Alliance works with their patients to develop a “My Action Plan (MAP)” that helps the patient learn how to function on a day-to-day basis. This plan helps the patient identify what makes him or her happy and hopefully leads to maintaining a healthy life going forward. Patients also use a “Wellness Recovery Action Plan (WRAP),” which is designed to help prevent relapses.

Santa Monica defines success as the moment when they feel their patients can live out the skills they teach them. They want their patients to be able to monitor their own behavior, to know they have a sponsor or someone to lean on for support, and want the patient to understand that they are dealing with a chronic disease.

For the VA, a patient needs to meet criteria outlined through performance measures for 90 days after his or her treatment for him or her to be successful. The VA felt that 60% of discharged patients follow through on this. The VA is unique in that they cover all areas of care for their patients. With access to these resources, patients will move through different levels of care within the same system based on the needs they have. Each patient is assigned a counselor at the beginning of treatment and he or she follows the patient through the system.

Describe the discharge process.

The discharge process starts, in many cases, the day the patient enters the facility or program for his or her treatment. The treatment plan, when a person enters the facility, is as specific for that individual as the discharge plan. The purpose of this discharge plan is to continue to mainstream the patient into another step of his or her recovery.

As soon as an individual enters a facility, the medical professionals, facility staff, and other support map out with that individual the goals and objectives he or she wants to achieve by the end of treatment. In cases where individuals may or may not be able to be a part of the conversation, family members may take part in developing this plan. As the individual meets those goals or objectives and moves toward the end of his or her treatment plan, he or she works with the appropriate staff to identify a discharge plan that outlines ongoing support and treatment options. Again, this is an individualized plan based on the patient’s history, availability of needed support, payer source, and commitment from the patient.

An important function of the discharge plan is to identify transportation to doctor’s visits, employment, or to get prescriptions filled. Only a few facilities have a committed person who is in charge of the discharge planning: Lasting Hope (new), VA, and NMC. In most facilities this discharge person is a member of the staff or a medical professional who develops this with the person. The challenge with not having a set discharge person is inconsistencies of planning, not understanding all resources available, and time available to write a plan.

Ongoing support is a vital part of the discharge process. The Salvation Army, along with Catholic Charities and the Friendship Program, outlines and sometimes connects the individual with support from other programs that offer help outside of their facility. They try and remove barriers that get in the individuals’ way and make their transition into society unsuccessful.

There are many factors that affect the discharge process and the ease of transitioning the individual back into society.

- The individual may be ready to exit the current treatment but not ready to go back to his or her original environment: An example might be an individual who needs to maintain sobriety but the home he or she would be going back to is not alcohol or drug free. The facility needs to find either an intermediary living facility or other living arrangements so the individual does not enter an environment that sets him or her back in his or her treatment. Many facilities help individuals look for alternative living arrangements, but there are limited resources. Sometimes the individual does not want to go
somewhere else, and instead he or she wants to go back home. The facility does not have the authority to keep that person from going home after his or her treatment.

- There is limited alignment of resources and the process is slow: Lasting Hope says follow-up care for a patient is slow and transitions are not efficient. Part of the issue is capacity and part is an alignment issue — there is no incentive to speed up the process. Because the discharge plan is an individualized process, the facility may have to contact many different options before the right one is located. Then it takes a long time to get through all the paperwork for approval.

- Transition to ongoing support is not smooth or efficient: The discharge plan may identify options for the individual, but once he or she leaves the facility, he or she is on his or her own. The VA does have an “Aftercare” program that helps improve results of a person staying on his or her plan. Each individual has a councilor assigned to him or her from entry until after exit. This councilor works with him or her on the 90-day Aftercare program that helps the individual enter back into his or her environment.

**What information/education do you provide to the patient or patient’s support network? Do you often refer patients to other facilities or providers after discharge? If so, which ones?**

All of the agencies try to educate patients on what they need to do to continue their improvement and on services and information that is available to them after they leave. As with the discharge process, the type of information shared with an individual depends on the history of the person and the outcome of his or her diagnosis. Many organizations outline the specific services that are available from other agencies and how the patient can get in touch with those agencies. This information includes knowledge about the medication the patient is expected to take and community resources that can help him or her get the medication.

One of the other important pieces of information is housing. Because many people cannot go back to their original environment, many organizations try to locate appropriate housing. For almost all agencies this is the most frustrating piece of the aftercare puzzle. Time and again there are not options available and these organizations do not want to send the patient back to a shelter. Most shelters do not provide an environment that is alcohol and drug free.

Lasting Hope and TeleCare provide a safety or coping plan that outlines how the patient can successfully monitor his or her condition and triggers that he or she should be aware of if he or she is relapsing.

**Is this different for repeat visitors?**

As in the discharge process, the type of information and ongoing support is individualized and based on a person’s current diagnosis. For most agencies the type of information shared is not different if the patients are repeat visitors because it is specific to the person’s diagnosis and what he or she needs based on his or her current visit. Heartland Family Services and Lasting Hope spend time analyzing why a relapse may have happened and how they can tailor their aftercare to help avoid a relapse. These agencies use that past knowledge to adjust how they treat and support a patient in the future.

**What role do you play in the patient’s aftercare?**

The role that providers play in patient’s aftercare varies from organization to organization. Most organizations do not play a large role in a patient’s care after they have been discharged or have standard procedures for following up with patients. Nearly half of the organizations interviewed specifically stated that they do not have a formal process in place for following up with patients. Many organizations work to position their patients the best they can for success before they are discharged, encourage their patients to come back if they are in need of help, and provide them with information on other services they can use to help them when they are in need. To effectively follow up with patients takes a lot of time and effort, and providers expressed that this is
not something that is paid for and is expensive to execute, which is why most do not have a formal follow-up process.

For Lasting Hope, they will do all they can before they discharge patients to position them for success, including getting them medications, arranging appointments with other providers, and providing them with transportation. Many of their patients do not have access to a car or transportation, so Lasting Hope will give their patients a ride to the pharmacy or pay for a cab ride. They also arrange for follow-up appointments for their patients and proactively provide information to those providers on the care the patients received while they were at Lasting Hope, medications they were given, etc., to make the transition process as smooth as possible. Although they do not conduct any follow-up calls, Lasting Hope will get calls from former patients if they are having issues or sometimes they simply want to talk to someone. Their approach to follow-up after a patient has left is informal and they make decisions on what is appropriate for the patient on a case-by-case basis.

Catholic Charities takes a similar approach. They make efforts to connect their patients directly to other community support services or recommend outpatient services. They try to do as much of their follow-up as they can while patients are still there and connect them with the appropriate services and support before they leave, but they do not have a formal process in place. Their feeling is that aftercare is not what it used to be because it is not paid for anymore. Lutheran Family Services also cited a lack of reimbursement as a reason why there is a lack of a formal follow-up process.

Some providers do conduct follow-up phone calls with the patient within a certain time frame. Friendship Program conducts follow-up phone calls with their patients 90 days after they have been discharged to assure patients are following through on their plan and to provide any assistance they can. Alegent Health conducts follow-up phone calls with for their acute care patients within a certain time frame, and if a patient moves to another Alegent facility or service, they will follow up with him or her there. There are times when the patient’s care team will also stay intact if the patient moves from one Alegent service to another, but this is not the norm.

Community Alliance takes a different approach. Patients will use their wide array of services depending on their level of need. The patient and Community Alliance’s team of professionals work to develop a plan for how the patient will monitor and maintain a healthy lifestyle when he or she moves to another level of care. Community Alliance also feels that more leadership development is needed for patients and that the region is not using peer support as much as they should be. The thought is that this type of support would greatly reduce the number of patients who are consistently coming through the system. Other providers have alumni groups that bring past patients or clients together. These groups give patients a social network to lean on for support which helps prevent their condition from regressing.

To what extent are you being contacted by other facilities about previous patients?

Two-thirds of the organizations interviewed said they do not have much contact with other providers regarding previous patients, but if they do, it is only to exchange patient records. It was also mentioned that physicians across facilities do not communicate much, but when they do, it is usually to request and review records. Releases make it difficult to have discussions about patients because of concerns about privacy, and many providers do not have time for these conversations — they barely have time to simply send over a patient record. The CRT provides an opportunity for providers across the region to discuss a patient’s care in a collaborative way, but these discussions involve a limited number of patients. Oftentimes it is easier for organizations to start from the beginning with their patients and get all the information they need straight from them. Providers feel it is important to discuss this information anyway to help them build a relationship with the patient.
Santa Monica feels they need to work on this. They would like to know how their patients are doing and if any of them have relapsed. If they were aware of this, they could catch any relapse triggers early on and perhaps prevent them from happening all together. Santa Monica could also use this information to assess their effectiveness, and then they could make adjustments accordingly to improve their level of care and service.

Is there an efficient process for getting them the information they need about the patient?

Most organizations rely on mailing or faxing patient information and records to other providers, which can be time-consuming. Many expressed frustration with the lack of efficiency that exists with sharing information on patients. The process is redundant, there are a lot of documents that need signed, and the physical transfer takes a lot of time. When you multiply this over as many patients providers see every day, it really adds up and becomes a burden.

There are organizations that either have moved to an electronic medical record or plan on doing so. Heartland Family Services is one of those organizations, but they expressed concerns that their EMR will not speak to other providers’ EMR. This could leave them in a similar situation that they are in now, where they need to print and physically ship, fax, or e-mail a record.

Some feel that having a central location for an electronic medical record could help. This would provide patients with a single record that multiple providers could update and access. The perceived benefit is that this would create added continuity and save time. Others feel that this could never happen because of restrictions related to patient privacy. One idea was mentioned that if a patient is a Medicaid patient, permission is automatically granted to share that patient’s record across the region for them to qualify for that benefit. Others feel that it would not end up saving time because organizations would still need to take the time to update the record.

What percentage of your patients that exit your facility come back? Why?

Most organizations did not have a clear understanding of how many of their patients come back to them. It was clear that this is not a metric that is regularly tracked. Responses to this question varied from “many” patients coming back to less than 50% to less than 5%.

Alegent Health feels that many of their patients come back at some point because they do not follow through on their care plan after they are discharged initially. It is challenging for patients to follow through on these plans because of the nature of their condition. Other patients return because they have developed a relationship with staff members and come back for support or need someone to talk to.

Others feel that patients come back for different reasons. It could be that they need adjustments to their medications or they may have trouble getting into another provider. Some patients come back to Lasting Hope during certain times of the year. It could be on an anniversary or on the day of an event that reminds them of something that puts them in a bad mental state that is difficult to cope with.

Relapse is often an overarching cause of why patients need to return to a provider. For Santa Monica, they feel a major reason for their patients relapsing is because they regain custody of their children. Most of their patients are single parents and getting custody of their children brings added stress and a larger financial burden that can cause relapse of those suffering from substance abuse.

Alegent Health stated that a process should be put in place to address the issue of patients needing to return, but they were not sure what that process would look like. There is a feeling, however, that they need to meet their patients where they are, figuratively speaking. They need to address the different stages of recovery that
patients are in with different stages of care. These stages of care would be more tailored to the patients’ current condition and could help prevent them from needing to come back.

**Barring contact from another facility, what steps do you take to monitor a patient’s progress over time?**

Most organizations do not take any formal steps to monitor a patient over time. Some organizations feel that there is no good way to do this. Many organizations feel this way because they care for a population that includes many transient people and there is no way to contact them. Also, agencies do not communicate well with each other; competition plays a role in this. HIPPA makes inquiring about how patients are progressing difficult. Agencies need to be more collaborative and communicate with each other in more of a productive way. Some rely on CRT meetings to monitor patients’ progress, which is beneficial, but many feel more could be done.

Organizations that do have protocols in place to monitor patients over time include Heartland Family Services, Friendship Program, VA, and Santa Monica. Heartland Family Services has an effort in place to quantitatively track patient outcomes over time, but data analysis is an issue for them, so the effectiveness of this program in unclear. Friendship Program uses their 90-day follow-up calls to monitor patients’ progress and to follow up with them. At the VA, each patient is assigned a councilor who follows him or her from entry to exit and is responsible for following up with the patient post-discharge. Each patient also is put into a 90-day Aftercare program that is designed to help him or her schedule follow-up appointments, get medications, and get transportation. Santa Monica has an alumni association that helps them track progress of their patients over time. This association provides a network for patients who Santa Monica has served and gives them some level of support as they progress through their recovery, but it also allows Santa Monica to see the impact they have on patients over time.

**Discussion on Overall System Improvement**

**What steps can be taken to strengthen the “network” of care across the region?**

Opinions regarding steps that can be taken to strengthen the network of care vary among those who were interviewed. Recommendations included step-down residential facilities, more involvement with primary care physicians, enhanced communication between providers, making adjustments to the payer structure, improving how patients with co-occurring disorders are cared for, improving discharge planning, increasing capacity, and following up with patients after discharge.

**More Involvement With Primary Care Physicians**

One recommendation to strengthen the network of care in the region is to increase interaction with patients and their primary care physicians. Physicians need to discuss issues related to mental illness with their patients and initially identify and address any concerns at this level of care. Also, physicians need to work together more and collaborate with each other as their patients move through the system and are provided various levels of care.

Alegent Health is looking at the concept of the advanced medical home that would provide multi-specialty care for patients in one location. This model will help Alegent take an integrated, comprehensive approach to patient care and will influence enhanced collaboration between physicians and improve quality. Catholic Charities also feels that integrating mental health evaluations into primary care and acute medical care will have positive benefits for those suffering from behavioral health disorders. NMC also feels that an integrated system with more physician involvement would be a beneficial. NMC referenced a book titled, *The Integrated Behavioral Health Continuum: Theory and Practice*. This book makes the case for service delivery integration processes. The authors feel these processes offer an organized system of care rooted in a common vision and defined by
processes intended to promote continuity and quality of care, coordination of efforts, efficiencies of operation, and seamless patient movement through an otherwise bewildering array of healthcare services.

**Enhanced Communication/Collaboration**

Enhanced communication and collaboration between providers is needed and could have a positive impact on reducing gaps in care that patients experience and will improve coordination of care. Currently, providers are not always able to get crucial information they need on their patients, which creates gaps in care. Reasons for this that were discussed include alignment between providers, competition, and issues with information flow.

Connecting providers more efficiently is an issue that needs to be addressed. Right now the arrangement is a group of providers, not a system. There is a major need for alignment between providers; standards need to be set and incentives and disincentives need to be addressed, but solid data should be the foundation of how these decisions are made. Lasting Hope recommended a thorough study that analyzes what patients’ needs really are in Region 6 and within the state system and looks to identify how to connect providers most effectively. Community Alliance also feels the behavioral health community must do a better job of understanding how they can support each other. They need to work together not work separately.

Some organizations feel there is a lot of competitiveness within the region, and that at times providers’ primary focus is on how they can grow their service. Although this mentality is needed on some level for organizations to stay in business, it can also prevent collaboration and influence organizations to fight for dollars as opposed to working with each other. It was mentioned that agencies need to work together more effectively for a common cause, which is to get the patient better.

Easier information flow would also lead to a stronger network. Currently there are concerns about providers getting all the necessary information that is needed to make an accurate diagnosis. Throughout this process, organizations stressed the time it takes to gather past patient records and to send those to other facilities. This process creates gaps in providing quality care. A central evaluation process and standards for information collection could help with communication and information sharing. Every facility currently conducts separate evaluation of patients. Many organizations do not always share those evaluations with the next facility the patient moves on to. A central system would help to assure this information gets to those who need it. Additionally, some feel if more standards were put in place regarding what information providers need to collect from patients, this could help reduce gaps in communication. This would be a step toward ensuring all crucial information is collected from the patient so a more accurate diagnosis can be made.

**Adjustments to the Payer Structure**

The current payer structure is a challenge for organizations in Region 6, and many feel that adjustments to this structure would certainly be in the best interest of the patients. Organizations frequently struggle to understand the rationale behind some requirements for patients to qualify for certain elements of care and how funding is structured compared with what is in the best interest of the patients from a clinical standpoint.

Many times payment is refused for a patient because the patient does not fall within a certain care category that the state provides funding for. There is a feeling that exists that the state does not fully understand the ways in which providers care for patients, how they make decisions regarding their patients, and the ramifications involved if the patient does not get the care providers recommend. The system needs to be more flexible and responsive to what patients need. The Salvation Army provided one example of this when they stated that patients need long-term community support to qualify for housing vouchers. Patients need to be able to give up their community support and free up capacity for other patients while not having to fear that their housing vouchers will be taken away.
According to many, care that the state pays for is funded separately regarding issues related to substance abuse and mental illness. Salvation Army stated that this is a problem for them, and that these funding sources need to be combined for them to comprehensively help their patients. This would be better for patients and make it easier for providers to do what is right for them. Multiple concerns were also raised with having multiple payers for the same patient. NOVA stated situations like this throw a wrench into their care process at times.

To have an impact on these issues, NMC thinks the system needs to ask the right questions to evaluate effectiveness. We need to consider several questions: What is the true cost of behavioral healthcare to individuals? What are the readmission rates of individuals? Where are dollars being spent in behavioral healthcare? Have dollars shifted from behavioral healthcare to other areas of healthcare? Answers to these questions can be turned into metrics used to help track effectiveness. Some think there needs to be a single system to make decisions based on answers to these questions. The VA is an example of how this could work. Wherever a patient goes in the VA, the staff is able to access his or her information and medical history. They have all levels of care so that a patient can move through different levels of care without having to be transferred out. The VA also has standards regarding information they gather on patients and what information they provide them at discharge. This helps to assure that each facility would not have to start from scratch with each patient when gathering information on him or her and would eliminate redundancy with patients and families providing the same information and possibly leaving something out.

**Handling of Co-Occurring Disorders**

We need to figure out what to do with people who continually struggle with mental health and substance abuse issues. We need to do more to treat co-occurring disorders in a comprehensive way and under one care plan. As previously stated, reforms have taken place to improve the behavioral health system, but many reforms have predominately focused on mental health issues, with few focused on addiction. This focus should be more equal. For example, LB 40 provided additional dollars for housing, but this money is only for those dealing with mental health issues.

The issue of co-occurring disorders has lead Community Alliance to sponsor a task force with 8 to 10 agencies to address issues related to co-occurring disorders. They also address issues related to capacity, communication between providers, and customer service.

According to some, Nebraska is behind the curve in dealing with co-occurring disorders compared with other states. Agencies need to work together to become more competent treating co-occurring illnesses. They need to assure that their staff members are equipped to handle both issues.

**Step-Down Residential Facilities**

Catholic Charities cited concerns they have with their patients who suffer from co-occurring disorders and their housing situations. They stated that if a patient uses when he or she is in housing, he or she is generally removed from that housing, which is detrimental to his or her condition. This is a tricky issue because Catholic Charities does not want to drop individuals who use, but they cannot have them living with others who are recovering because that is not healthy for them. Catholic Charities’ thought was to structure housing so patients can cascade through the system, up and down, based on where they are in their recovery process. As patients makes progress with their recovery, they could “step down” through different levels of housing with less supervision and live with others who are in a similar stage of recovery. If they experience a relapse, they go back to the appropriate level based on the severity of their condition. This does not exist today.

**Effective Discharge Planning**

At times, discharge planning does not happen effectively. Effective discharge planning is critical to care continuity. Therapists need to refer more patients and refer them sooner to increase chances for success.
Outreach and engagement is important. It is crucial to figure out how to get the individual engaged in wanting to take responsibility for his or her care and assuring that he or she has the resources to do that.

**Capacity**

Capacity is a major issue in Region 6. Too often patients are faced with long wait times as they move from one provider to the next. Many organizations feel that there are not enough beds and not enough capacity to care for people effectively and at the right time.

The VA feels that there is a major need for more residential beds. At times, patients are transferred out of the state due to a lack of beds or support services. More supportive housing would help deal with this issue or taking a step-down approach to housing, as mentioned previously, may have a positive effect. More supportive housing or a step-down approach would provide patients with additional access to services after they leave an organization and provide them with additional support, which can help identify triggers that may lead to relapse. With the capacity that exists now, some patients do not get the support they need or they are released too early to accommodate others.

NOVA feels that the region’s struggles with capacity start with funding. Their thought is that the negative stigma that surrounds mental illness has an impact on the amount of money that is allocated to mental health. An increase in funding would help to address capacity. They also think that having multiple funding sources for a patient can throw a wrench into the care process (Medicaid, Magellan, Child and Family Services, etc.). Magellan is the worst, but Region 6’s system is more user-friendly.

**More Follow-Up With Patients**

Creighton University Medical Center mentioned another opportunity for strengthening the network. They brought up a best practice that the region could look to in Detroit where they have an emergency psych facility where all patients in their system filter through before being admitted to the correct agency or facility. This organization is responsible for monitoring all patients before, during, and after they receive care. This effort helps them cut down on inpatient admissions and helps to assure that patients stay on track through their care process.

Creighton also feels that mobile units that go where the patients are would help strengthen the system. They would have the capability to access patients wherever they are, helping patients get their medications, remind them of appointments, and assure that they make their appointments and follow their care plans. Efforts like this would also help improve patient outcomes and create increased continuity.

**What are the key opportunities from a clinical or administrative perspective?**

Multiple opportunities exist from a clinical and administrative perspective in Region 6. There were more opportunities discussed that could be classified as administrative but there are clearly issues that should be addressed in both categories. Clinical opportunities discussed included more consultation in a primary care setting regarding behavioral health issues, specializing services, adding intermediate care, and increasing competence on how co-occurring disorders are managed. Administrative opportunities include increased capacity and added services to make the continuum of care more comprehensive, assuring that decisions made at the state level align with goals and objectives that providers have for their patients, simplifying standards for approving care, more collaboration between providers in Region 6, more community case management, additional peer support for patients, and improvement to the public transportation system in Omaha.

**Clinical Opportunities**
Organizations interviewed expressed varying recommendations from clinical perspectives. Bringing behavioral health professionals into the primary care setting was one opportunity that was cited that would have a positive clinical influence for patients. Many view this as the ideal level of care where behavioral health issues should be identified and the care journey should start, but this is not the case today. Primary care and behavioral health professionals coordinate very little presently, but doing so could help create added continuity of care.

Specializing services was also mentioned as an opportunity. Specialization would make navigating the system easier for patients and would provide them with a clear understanding of where they need to go for certain issues or circumstances. The perspective of some is that there are many redundant services that make it hard to decide which provider to see for certain issues. Making providers more specialized may reduce this ambiguity, reduce duplication of services, and lead patients to the right provider immediately, reducing the chance that they have to be referred and transferred to other providers to manage their immediate, present condition.

Additional intermediate care could also provide positive benefit for patients. Services today are not structured in a comprehensive way, which has caused a gap between mental healthcare needs and available services. More intermediate care could fill gaps that exist and help to catch issues before they become too severe.

Many patients struggle with co-occurring disorders and providers need to be more competent with treating these patients. This issue was brought up during interviews on many occasions and is consistently viewed as a tremendous opportunity. According to NOVA, many patients with co-occurring disorders are not accurately diagnosed. This misdiagnosis makes their assessments and treatments harder to follow and less effective from a clinical perspective. Misdiagnosis can also lead to an increase in recidivism due to less effective care plans being put in place. Additionally, this puts a strain on overall system capacity. NOVA feels there are a lot of services in the Omaha metro area who need more people with dual credentials for caring for those with co-occurring disorders. Douglas County Community Mental Health Center feels that there has been an increased focus on co-occurring illnesses but that services have not caught up to the scope of the problem despite efforts by the newly created Co-Occurring Task Force organized by Community Alliance. Reasons for why this is an opportunity can be traced back to incentives and how providers are reimbursed. If you are a mental health provider, you cannot bill for substance abuse services, which makes providers reluctant to treat both simultaneously.

**Administrative Opportunities**

Increasing capacity and creating a more comprehensive continuum of care are two opportunities that were mentioned by those organizations who were interviewed. Some providers feel that the current capacity in Region 6 leaves no room for additional patients and there are not enough services to support the existing patient population. There are consistently long wait times for patients at every level of the system and there are many holes that exist in the level of care that patients have access to. Many organizations mentioned how patients are discharged from agencies only to face new challenges associated with availability of care that is recommended as a follow-up; housing, access to medications, and a lack of transportation add to these challenges. Other examples that were cited include the fact that there are not many services for sex offenders; there are no outpatient services for treating co-occurring disorders; services are limited for geriatric patients; there are no secured, locked facilities for substance abuse treatment; and inpatient and residential treatment for chemical dependency is not available (people can be committed for chemical dependence but once they are committed, there is no treatment available to them). Often patients are put into services because they are the only service available or they have room to take a patient. This is not a fluid continuum of care, and this has a negative impact on outcomes for patients.

The state needs to create a long-term vision for the behavioral health system to assure that changes made within the system align with goals providers set and the best interests of patients. Some view the state as
taking a reactionary approach to issues that arise regarding the behavioral health system. This reactionary approach has resulted in frequent changes in guidelines and regulations that make it difficult for providers to keep up with the latest changes. Salvation Army feels that there are times when decisions are made at the state level that are inconsistent with goals they have laid out for their patients and that seem to be solely driven by dollars. These situations create added barriers to providing effective care.

In general, a simplification of standards that are in place for approving care recommended by providers would be greatly beneficial. An example here lies in barriers to providing comprehensive care to patients with co-occurring disorders. Many organizations are spending more to enable themselves to effectively handle these cases, but the current payment structure will only reimburse them for one set of services or the other. This is a major roadblock to patients receiving the most effective care for their current condition and a disincentive for providers to make recommendations that are ultimately in the best interest of the patients they serve.

Another opportunity exists with requirements that patients need to meet to obtain services like housing. For example, according to the Salvation Army, patients are currently required to have some level of community support to qualify for housing. This requirement causes people to hold onto the support they receive through community support longer than they need to so that they can maintain their housing situation. Requirements like this create backups and logjams in the system particularly for community support services in this case.

Additional collaboration and conducting roundtables between providers to share issues that each are running into and to discuss solutions to address these issues is an opportunity that many providers feel exists. These could be additional meetings organized by Region 6 or an expansion of the CRT meetings that already take place. Some see Region 6 as a provider of funding, but not necessarily a driver of collaboration; however, there are varying opinions on the role Region 6 should play to encourage partnerships and collaborations. Some see them as the logical ring leader, while others believe that agencies need to be given the liberty to choose who they partner. However these collaborations are organized, it is believed that to increase effectiveness of collaborations it would be beneficial to influence physicians to participate. Some, however, feel this would be difficult because physicians cannot bill for their time at such collaborations. Representatives from community corrections facilities and law enforcement were also mentioned as desired participants so they could work with patients and prepare them if they are going into or coming out of custody.

More community case management could also benefit patients and get providers working together more effectively, but compliance with releases and HIPPA laws create barriers to this. There was mention of “HIPPA radicals” existing within some agencies. These individuals are hesitant to share information on their patients and fall back on privacy compliance as a justification. It was mentioned that this mentality could be because these agencies view patients as “their patients.” An example of effective community case management can be found in New York. There, providers are able to flag high-end users across the system. For these patients they focus on developing a community-wide care plan, not just an agency plan that helps assure that all providers are on the same page and working toward the same goal with the patients.

Multiple mentions were made of peer support and the benefit that patients receive from this service. Although more agencies are offering peer support, it provides limited consistency with regard to the relationship that develops between the patient and the peer providing support. As it stands, as patients moves from agency to agency, they switch peers because peers are affiliated with specific agencies and do not move with patients after they move on. If peers could work with patients on an ongoing basis, this would help patients navigate the system more effectively, get them the appointments they need, assure they show up for those appointments, and help them to get the intermediate care and support they need to stay on track with their care plan.

The current state of the public transportation system in Omaha is a barrier for patients without transportation and is viewed as an opportunity for improvement. There needs to be a better transfer system for getting
patients from one provider to another and giving them access to transportation so they can get their medications.

Can you cite one thing you’ve been doing to try and work more closely with other facilities?

Overall, most organizations could not describe any deliberate efforts that they have in place to work with other organizations more closely. The feeling was that they either had not thought of it or did not have the time to do so.

Examples of organizations that do have efforts in place include Alegent Health. They have a dedicated position for community outreach that involves working with other facilities. This individual sits on a number of committees and boards and serves as a liaison to other providers and Region 6. They have also introduced a Crisis Intervention Team Training which is a 40-hour course on how to effectively work with people who have a mental health disorder. This course was created for local law enforcement personnel.

Lasting Hope’s discharge planners work to assure that they are providing all necessary and relevant information to providers that the patient maybe going to. They assure that the communication to the provider is effective and that the transition process is smooth. What they want to avoid is the impression that they are simply dumping patients on them. They want to focus on sharing information about the patient and have an explanation of why they are recommending them.

Santa Monica likes to bring other providers on-site to their house. This allows them to interact with them and give them an in-person overview of the services they provide. Santa Monica also conducts educational sessions with the Alcoholics Anonymous community.

Multiple providers cited the CRT as a great way to work with other providers to identify how to appropriately care for individuals dealing with mental health disorders. It is a good opportunity to network with other providers and helps providers understand what other providers or services are available for them to refer their patients to.

Are there other best practice examples the region should look to follow?

Best practices that were discussed during interviews involved a number of diverse issues. The most specific best practices mentioned focused on collaboration between providers and with law enforcement, improving residential stays and support, improving care for those dealing with co-occurring disorders, enhanced community and peer support, improving information sharing, and focusing on patients’ strengths and increasing their accountability.

CIT is a team that works with law enforcement and provides coordination between police and mental health providers. This team looks to assure that people suffering from mental illness get the help that they need from the right people in a timely manner and helps enhance law enforcement’s response toward people with mental illness. This model helps police officers learn to recognize common forms of mental illness and use the most effective means of communicating with people undergoing a crisis. Officers are trained to de-escalate the individuals in crisis and allow them to participate in the decision-making regarding their treatment. The following links provide information pertaining to Crisis Intervention Teams (http://www.thekimfoundation.org/html/edu_training/crisis-intervention.html and http://www.nami.org/Template.cfm?Section=CIT2). Teams like this would create additional focus on using community partnerships.

Best practices were also shared on how to improve residential stays for those suffering from mental illness to help them stay on track in their care process. Establishing intermediate residential stays for patients who are in
between care will provide them with a better chance to stay on course with their care plan. This will provide patients with intermediate support if they have to wait to be seen by a provider they are being referred to. Another thought that expands on this is to provide supportive housing services that offer various levels of service depending on where the patient is in his or her recovery. If a patient suffers from mental health issues and is beginning to recover from addiction, he or she would be placed in housing that can support this and where he or she is surrounded by patients in a similar stage of recovery. As the patient progresses in his or her recovery, he or she moves to different levels of housing where less support is needed and gradually becomes more independent. If the patient regresses and, for instance, starts using again, he or she would go back to the appropriate level of housing based on the severity of the regression. This structure addresses the fact that different patients have different needs with regard to support and their housing situation and would allow patients to step down through various levels of support intensity based on the progress they have made in their recovery.

Concerns were addressed about how those suffering from mental health disorders and substance abuse are cared for. A common perception is that these issues are commonly addressed in silos because of the way funding is structured. Many believe that state funding is too generalized and seems to be moving closer to a medical model, which is cause for concern. There are many restrictions regarding who can make recommendations on services for patients, and recommended services are not allowed to be provided in a comprehensive manner in the current funding structure. Mental health and substance abuse services are paid for separately, but they should be treated together. Friendship Program thinks there needs to be more of a blend between a behavioral health model and a medical model. Pottawattamie County Mental Health/Substance Abuse Network was mentioned as an example of a network looking to find innovative solutions for mental health and chemical addiction prevention and treatment and rehabilitation for children through senior adults in Pottawattamie County. ASAM was also mentioned as a good model for incorporating mental health, substance abuse, and biomedical conditions. The manner in which the state structures funding, however, does not support this and it is not consistent with the care that patients need. A regional co-occurring task force was discussed as an opportunity whose purpose is to make more agencies capable of effectively dealing with patients with co-occurring disorders. Different initiatives such as MACCH, Co-Occurring Task Force, and NAMI are helping bring people together into productive partnerships, but more effort is needed to enable organizations to become more effective at handling co-occurring disorders and to structure funding in a way that removes current barriers to effective care.

Organizations believe that providing more continuous support for patients after they have been discharged drastically improves their chances of sticking to their care plan. One way to use this would be to provide additional community support or peer support for patients. Community support could be enhanced by getting more members of the community involved and having volunteers or paid employees support patients on a regular basis post-discharge. Having a central peer support system is another example. Many services in the region currently provide peer support but those peers only support patients who are currently under that service’s care. When patients leave that service, they leave the peer support behind. Having a consistent peer support a patient over time as he or she moves through the system would help make his or her transition from service to service more seamless and would provide the patient with stability and consistency. Lasting Hope has a coffee shop for patients who are not in the system but who need someone to talk to. This is useful for patients, but there needs to be more emphasis on consistent peer support that can follow the patient as he or she receives care from multiple providers. Community Alliance felt that if a program could be created that involves members of the community (perhaps volunteers) and supports and mentors patients post-discharge, that this would be a positive change for patients. Alegent Health discussed the idea of Community Case Management to help patients follow up with their care, schedule appointments, interpret instructions, and help them navigate the current system. This could help keep patients out of emergency rooms, keep them on track with their care plan, and keep them connected to support. Alegent feels that if a patient is having a hard time finding the right service, their case manager could use their connections to help them access services.
Expanding on the idea of a central peer support system would be to structure services in Nebraska under one system and decision-making body. One interviewee moved to Nebraska from California where they have an entire continuum of healthcare under one roof where services are coordinated. In her opinion, a structure of this nature is ideal. UNMC cited the VA as a best practice because all of their services fall under one system. Wherever patients go in the VA system, providers are able to access their history. The VA has all levels of care, so patients can fluctuate through different levels of care without having to be transferred out, preventing providers from having to start from the beginning when collecting information on patients and preventing patients from having to provide the same information over and over. This structure could improve care continuity and coordination. UNMC referenced the book titled, *The Integrated Behavioral Health Continuum: Theory and Practice*. This book discusses why an integrated healthcare delivery system is needed. Barriers and challenges certainly exist with a centrally controlled system and would need to be analyzed carefully. Alegent Health mentioned a potential alternative to centralizing services. They discussed the Metro Area Continuum of Care for the Homeless (MACCH). MACCH is a collaborative network that coordinates and maximizes resources to prevent and eliminate homelessness. This collaborative could be a model for a similar, expanded effort aimed at coordinating behavioral health services between independent agencies.

Another best practice that was mentioned adds to this idea of continuous support and is focused on using the natural strengths of those dealing with mental health disorders. The common approach to treating an individual with behavioral health disorders is to try to cure or fix a patient’s illness or weakness. By focusing on his or her strengths, this could change how a patient views life and could speed up his or her recovery process. The International Center for Clubhouse Development (ICCD) was mentioned as a potential model for this approach. ICCD’s efforts focus on the fact that people with mental illness can and do lead normal, productive lives. Clubhouses provide members with opportunities to build long-term relationships that, in turn, support them in obtaining employment, education, and housing. These are local community centers that offer people who have mental illness hope and opportunities to achieve their full potential (http://www.iccd.org/index.html).

A similar effort mentioned was the Therapeutic Community (TC) model that gives accountability to patients for their wellness and care outcomes. The primary goal is to foster individual change and positive growth by changing an individual’s lifestyle through a community of concerned people working together to help themselves and each other. TCs offer a holistic approach to treating the whole person, not just the addiction. Members in a TC are not patients, as in an institution, and play a significant role in managing the TC and acting as positive role models for others to emulate (http://www.therapeuticcommunitiesofamerica.org/main/).

Information sharing was mentioned multiple times as being a concern for providers and a barrier to care continuity. South Dakota has an efficient system for information sharing. Information collected on patients is available for other providers to access. Some think that patients receiving care funded by Medicaid should automatically grant permission to share their records across the region. A system like this could create an environment conducive to a central Electronic Medical Record in the region. Urban Indian Health Coalition mentioned another idea to improve information sharing, a “voucher model.” With this model, patients are allowed to access their own information. Patients are given a password that they can take to providers allowing the provider to look up that patient’s records from a central location.

NIATx (www.niatx.net) is a pioneering improvement collaborative that was mentioned as a resource that works with substance abuse and behavioral health organizations across the country. They teach organizations to use a simple process improvement model that they have developed. Their primary objective is to help behavioral health providers improve access to and retention in treatment for all their patients by using this improvement model that aims to reduce wait times, reduce no-shows, increase admissions, and increase continuation in treatment.

U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment’s (SAMHSA/CSAT) approaches to Recovery-Oriented
Systems of Care at the State and Local Level was another best practice that was mentioned. A recent series of case studies published by SAMHSA/CSAT can be found at this link, http://pfr.samhsa.gov/docs/State_and_Local_Levels.pdf.

How much of this is simply an education issue? How can the region (or individual facilities) better educate patients and their families about the services available to them across the network?

A common thought across the region is that most patients do not fully understand what services are available to them and what options they have for support. Patients either go to organizations they are aware of or they go to organizations they are referred to. This does not assure that they have a full understanding of their options. Creating more awareness through advertisements or targeted awareness-building and marketing campaigns would be greatly beneficial to patients. Some feel that if people are bombarded with enough information, the message they are trying to convey about their available services will eventually get through and awareness will increase. For this to be effective, careful consideration must be taken about what messaging is put out to the public and where and how that communication is delivered. In addition, primary care physicians’ general awareness about mental health issues and services available throughout the region is not at the level it should be, and this creates barriers for patients who would benefit from services that are provided.

Santa Monica’s belief is that education is a big issue compared with other existing issues. Their thought is that they need to make clearer to patients what services are available to them. They cited Heartland Family Services marketing efforts as a great example of how to effectively educate the general public on services offered to those in need.

Some organizations believe that the public knows what services are available to them but they do not fully understand how to use them or do not fully understand how that service can help them. Salvation Army’s thought is that more “hand-holding” needs to happen. This could be done through expanded peer support or additional case management. People dealing with mental health issues get overwhelmed and cannot handle simple tasks at times, so they need a more consistent champion or advocate to guide and assist them as they seek the appropriate care.

For some, education about available services needs to be focused not on the general public but on the state. Friendship Program’s feeling was that if the region educated state officials more on what services are available to patients and what various providers are doing to support patients, they would be able to make more educated and effective decisions regarding funding. In addition to this, increasing public awareness about mental health and what it looks like could be an effective preventative step to help detect signs early and continue to remove the stigma that surrounds mental health. This could also provide more impetus for state officials to make adjustments to how mental health services are funded.

Others think that this is not an education issue, but rather that there are services that those who are suffering need from mental health disorders that do not exist. Heartland Family Services used an example of the lack of services for parents with kids, which leads parents to resort to turning their children over to foster care under safe haven laws. Instead of expanding services to provide support for these parents, hotlines are setup for them that they view as being ineffective. Psychiatric services for children in general are limited and have serious capacity issues. NOVA sees more issues with access to services and getting funding from Magellan for certain aspects of care they recommend than education about what services are available. Frequently care that is crucial for patients is denied.

How do you see the overall quality of care improving if there was more of a network approach?
Overall quality would improve greatly if there was more of a network approach across the region. Information is commonly lost when patients move from provider to provider. Communication needs to be more seamless and efficient to assure that gaps in care are limited or eliminated. Lapses in care greatly increase risks and dangers for patients. Providers generally collaborate with each other but there is not an efficient way to communicate and collaborate. Some think that this is attributable to the competitive environment that exists in the region and the battle for patient volume; others feel there are big gaps between hospitals and community providers. Either way there needs to be assurance that handoffs between providers are smooth and effective.

Lasting Hope sees less recidivism as a positive result of an enhanced network approach. Their thought is that an electronic medical record would be greatly beneficial for the region. This resource would increase efficiencies, particularly with information sharing and make patients’ life much easier. They often have to answer many of the same questions over and over and feel like they are starting over each time they visit a new agency or provider. Providers will still need to have dialogue with patients and build relationships with them but an electronic medical record will make that process more efficient and help to assure accurate and safe care.

Balancing access and capacity for substance abuse and mental health will also enhance effectiveness. Some feel that services for those with chemical dependency has dwindled but the capacity for mental health has increased. There needs to be a continuous push to treat those co-occurring illnesses in a balanced and comprehensive way. To effectively treat both comprehensively the current funding silos need to be broken down.

There is also an issue with how incentives are structured. Often patients will need medications, but because they cannot afford them, this limits their ability to recover. Many patients also lack effective means of transportation which they need to get medications or do not have consistent housing. These are basic elements that are crucial to a successful recovery. Wait times are also an issue and can cause gaps in care that limit successful outcomes. Some of these issues could be addressed if providers were incented or disincented based on their patients outcomes and their wellbeing.

More can also be done to address emergency and urgent care needs. Lasting Hope has done a great job of improving the way patients with a crisis situation are cared for but there are still many patients who are seen in emergency rooms, so this issue needs to continue to be addressed.
Questions for Other Interested Parties

What is the nature of your interaction with the behavioral healthcare providers in Region 6?

Dr. Dan Wilson, Creighton University Medical Center
Dr. Wilson works with most psychiatrists in Omaha. His clinic is a provider of ambulatory psychiatric services whose population are mostly Medicaid patients.

Dr. Thomas Svolos, Creighton University Medical Center
Dr. Svolos is a psychiatrist and psycho-analyst who is on the faculty at Creighton University, works as a consultant for UNMC, and is a medical director for a psychiatric clinic who publically and privately insured individuals.

Kathleen McAllister, New Hope Life Center
Kathleen is a mentor for a friend who struggles with behavioral health disorders and is a founder of the New Hope Life Center.

Jonah Deppe, NAMI
Jonah helps to run NAMI, a volunteer, mental health advocacy organization that provides support for patients and education on how to better understand mental illness.

District Attorney’s Office
The DA’s office is responsible for reviewing and acting on the petitions for involuntary commitments into the behavioral health system. They work closely with the Omaha Police Department, prisons, and correctional facilities. Their office also works the Board of Mental Health on all involuntary situations.

Ken Stinson, Behavioral Health Support Foundation
Ken Stinson is an interested party.

Omaha Police Department
They serve and protect the Omaha community and respond to chronic calls.

Patti Jurjevich, Taren Petersen, Katie Hruska, Region 6
Region 6 has responsibility to develop a network of behavioral health providers that it contracts with to provide services. They conduct needs assessments, issue RFPs or RFSs, monitor progress of patients, and offer team assistance. Region 6 helps place patients in regional centers and provides assistance when a community provider has troubles placing someone.

Rhonda Hawks, Behavioral Health Support Foundation
Rhonda Hawks is an interested party.

In thinking about how a patient enters or exits a particular facility, where do the breakdowns occur, and why?

Reasons discussed regarding what breakdowns occur upon a patient entering or exiting a facility and why include a lack of follow-through upon discharge, patients not having a consistent support network to help with
Follow-through and navigation of the system, uncertainty about what organizations are appropriate for care and what capacity is like with those organizations, long wait times, and limited capacity for residential programs. Breakdowns can occur because patients do not have a dedicated person they can rely on to oversee the care they receive and to determine the best path forward through the behavioral health system and the more global healthcare system. The state of Ohio was provided as an example that the state of Nebraska could look to for effectively managing individuals’ care. There they have a medical director who is tasked with reviewing a patient’s case to determine the best path forward for the patient through the system. This was viewed as an effective way to keep patients connected to the system and give them a better chance of success. In Nebraska there is really no one in charge of a care plan and that plan differs agency to agency and facility to facility, which leads to a lack of care continuity. Some believe that more monitoring of patients is needed and it needs to be consistently in place through a regular person. This monitoring could come from a social worker that follows the patient continuously through the system or another dedicated person to provide support on an ongoing basis. This would be a person who can advocate for the patient and check in on them on a regular basis. Not all patients would require this level of support, but there are patients that absolutely need this level of care and support.

Follow-through is a factor that leads to breakdowns in care. Some think that stricter protocols are needed for follow-through with respect to what individual facilities or agencies are accountable to for following up with their patients. There is a feeling that when a patient leaves a hospital or other provider that someone be responsible for calling on that patient the next day or within a specified time frame. A recovery specialist or a community service provider could make this call. Ideally, this person or another dedicated individual would follow up with that patient over a three-month period of time. This would be greatly beneficial for patients since many struggle with steps they need to take to follow through on their care plans post-discharge. In this situation, the patient’s physician would ideally be suited to determine what level of support the patient needs and in what form. This follow-through could also come in the form of more effective patient hand-offs between providers. Offentimes, patients are discharged before they are ready and there is little or no transfer or hand-off, only discharge. Patients would greatly benefit from effective hand-offs to another provider. Many attribute a high number of frequent fliers to the fact that many people are discharged before they are ready and there is no support for them to access post-discharge. There is a lack of accountability that exists with providers assuring that patients have access to medications they need assuring that they have support before they discharge them.

Breakdowns with entry occur simply because people do not know where to go or there is nowhere for them to go. It is difficult to understand what services organizations provide and how to determine the appropriate place to go when help is needed. Some think this is because there are too many entry points. This makes it difficult to track where and when people enter into and exit the system. This uncertainty can lead to people relying on emergency departments as an entry point to the system, which is not always an appropriate entry point. More of a concerted effort should be made to divert patients away from hospitals. Providers are too quick to say that a patient needs to be admitted to a hospital. Difficulties with entry also occur when there is nowhere for the patient go. The Omaha Police Department takes most cases they run into to the emergency department because there are a limited number of beds available across the region, including Lasting Hope. Many believe that Lasting Hope has helped with these situations, but if someone has substance abuse issues, or is having an episode of depression, etc., there is nowhere for them to go at times.

Wait times and limited availability of residential programs also create breakdowns. Ideally providers in the system would know who is going to be discharged, why they are being discharged, where they are being transferred to or where they are going next, and do they have support or do they require support once they leave. Patients also experience long wait times to enter into residential programs, and there are times that these patients are ultimately left on their own. There are cases when patients with certain disorders and conditions have a hard time getting into a residential treatment program when it would be beneficial for them.
Examples include sex offenders and people with developmental disabilities. Improved access to these programs in a timely fashion would greatly help many.

**How much of this is a clinical or administrative issue vs. an education issue (where patients simply don’t know where to go or what services might be available to them)?**

*Clinical/Administrative*

Some feel that there are plenty of resources in Region 6 but that these resources are not coordinated well. The feeling is that there are many duplicative services that exist and services are ineffective and monotonous for patients due to a lack of follow-through. Providers have a lack of understanding about their patients, which has negative implications on clinical recommendations.

Others question the amount of information that patients get at discharge. There are times when patients may be getting too much information, making it difficult for them to follow through on their care plans. Too much information causes confusion. In addition, concerns exist about whether a patient has a family member or someone to provide support and to be involved in the discharge process and have a place to go.

Some believe that these issues exist in part because there is a lack of formal responsibility and accountability for the patient. No one is in charge of their care from end to end.

*Education*

Concerns exist regarding education but not in the same context as referred to in the question. Some think that more professionals are needed to care for this population and workforce development is a major concern in this case. There is a shortage of people going into psychiatry as a profession and more needs to be done to attract talented people into the profession.

Another issue is that organizations need a better understanding of where their patients are going when they leave their care. This understanding could create awareness about whether their patients are transitioning into environments that are unhealthy for recovery. If this is the case, then facilities need to educate their patients on services they offer that can help them or other services that are available that would be appropriate for them to help them transition back into society smoothly. For this to be effective, however, it is important to understand where the patient can go for support and not have to wait an extraordinary period of time to receive that support. Many times patients have to wait for services, which negatively affects the care process. These wait times are due to a lack of physicians, providers, or limited capacity with support services. Another factor includes whether providers and services will provide care to the patient. These decisions are based on how the care is going to be paid for and what the patient is eligible for. Often patients are limited in this area because many are low-income patients.

**What steps can/should the state or region take regarding those issues?**

The state or region should create a level of responsibility and accountability for one organization or one person to be responsible for making decisions on care for a patient and assuring that follow-up and execution take place with regard to those decisions. Region 6 makes decisions that some view as partial decisions. The system was described at one point as "a symphony with no conductor." There is no focus on integrating services across the region.

Some feel that patients need greater access to care at the right time, which is particularly important when they are in crisis. Treatment group homes are a service which could be provided that would help patients who transition from an acute care setting. Transitional residential placement could also be beneficial. This would be similar to what Salvation Army currently provides their patients. This setting would provide patients with a
temporary place to live and would give them access to a case manager who could help them transfer to more appropriate permanent housing. These options could potentially save the region and the state money in the long run and would be less expensive to run than an acute care hospital, but currently there are not enough places for people in need to turn to.

Some believe there are many people who are suffering from behavioral health disorders that need a long-term program (approximately six months) that would treat multiple issues, including mental health and substance abuse disorders, simultaneously and would provide continuous monitoring for those with severe conditions.

An example was given of a patient who has a Clinical Review Team (CRT), and that this team meets every week to review the patient’s case. This team recommended community support for this patient, which the VA was going to implement, but this never happened. Efforts like this need to be more coordinated, more organized, and need to be followed up on. Opportunities exist for these teams to evaluate and track the severity of the case they are reviewing, determine what level of care will be appropriate and effective, and then monitor this regularly to assure the appropriate steps are taken and that the patient is cared for. This support could come from providers, support services, or from volunteers.

Additional utilization of peer support services could help with these issues. Support of this variety would come from a former patient who would help the current patient through the discharge process, assure that he or she is following the care plan, and work with him or her across providers and support services over a period of time, perhaps six months, or as long as the patient needs the support.

**What steps can/should the individual facilities take?**

Increase Lasting Hope’s influence on decisions to be made regarding patient care, or have a representative from the region at Lasting Hope making decisions on appropriate steps in the care process and facilitating completion of those steps. Some feel this effort would be difficult because there are hidden dis-incentives preventing this from happening. In some ways it is not in an individual facility’s best interest to do this from a business standpoint. Ultimately the state should drive this effort.

Others have concerns about community support staff burning out. Individual facilities need to do more to mentally support their staff, to keep their spirits up, and keep the mission in front of them to help prevent burn out. The behavioral healthcare process is frustrating and can be difficult on those who treat patients. Mention was made that part of the frustration stems from the fact that caregivers rarely if ever see their patients fully “recover” like a staff member in an acute care hospital does due to these conditions being chronic by nature.

Some wish that facilities were more flexible with policies and more willing to adjust their approach based on the needs of the patient. Caregivers need to ask more questions of the patient and of their families and take a hard look at their approach to caring for each patient. Is what they are doing to care for the patient really set out to accomplish what they intended to accomplish and does it meet the needs of the patient. In addition, providing follow-up support from the care team that originally worked with the patient would be helpful too. This would give the patient a familiar team to turn to when he or she is in need.

**How would you define the current “network” of care across the region?**

The current network is a fragmented system. There are many good-hearted people doing diligent work, but there are systematic issues that exist that limit their effectiveness. Some say that the network is not a system. A system is something that works systematically and this does not happen, many parts of the network do not connect.
Some of this fragmentation exists because service providers are competitive and not collaborative. Providers are forced to be competitive because they are all trying to sustain and grow their services and are competing with each other for state and federal dollars. This is not unique to Omaha because many other urban areas face these same challenges. However, providers in rural areas do not struggle with this as much. They seem to collaborate much better. The competitive environment that exists can limit the patient. Competition could prevent a provider from recommending their patient to another service that would be beneficial for the patient in fear that they lose that patient.

**What steps can be taken to improve the “network” of care?**

Strengthening Lasting Hope and providing Region 6 with more decision-making capability regarding patient care and helping to direct how patients flow through the system in a much smoother more comprehensive manner than what they do now would be a big step toward improvement. Some feel the ideal role for Region 6 would be to act as air traffic controller for the local behavioral health system. In this role Region 6 would direct where people should go to receive care based on their need, work with providers on funding and budgets, structure accountability regarding patient outcomes, and assure alignment of mission. Ideally this would lead to a more connected network where providers, community support agencies, and administrative bodies are communicating effectively with each other and assuring high levels of care continuity, coordination, and quality.

To improve the network of care there needs to be a simplification of the entry system so that the general public has a clear idea of where they can go based on their condition. To accomplish this, roles between providers and community support agencies need to be more clearly defined. These changes could be made by using services that already exist but may require lessening the duplication of services to some degree.

**Are there particular models or best practice examples (inside or outside the region) that the region should look to follow?**

Maryland’s behavioral health system was mentioned as a potential best practice. The University of Maryland partners with the state to provide services associated with behavioral health. The university gets funding from the state and they are given the authority to manage the continuum of care. This helps with alignment of services and decision making is clear.

SAMHSA and the National Institute of Mental Health were also mentioned as resources for best practices.

Mood monitoring tools are available for free online and were mentioned as a best practice for patients to use. The tool is simple and can quickly help assess patients’ current mood to build awareness about depression. This resource could also be a beneficial tool for providers to use as well. This resource can be found on the Facing Us Web site ([www.facingus.org](http://www.facingus.org)). This program is sponsored by the Depression and Bipolar Support Alliance (DBSA), which is a leading patient-directed national organization focusing on the most prevalent mental illnesses, depression and bipolar disorder. This organization works to foster an environment of understanding about the impact and management of these life-threatening illnesses by providing up-to-date, scientifically-based tools and information in a language the public can understand.

The Nebraska Association of Behavioral Health Organizations, [www.NABHO.org](http://www.NABHO.org), was referenced as a resource for best practices. This organization exists to actively promote sound, responsive, efficient, and effective substance abuse and mental health services to the people of Nebraska. They serve community behavioral health organizations and are important working partners in the provision of services and the conduct of the overall Nebraska Behavioral Health System.

Others felt that incentives need to be structured to get patients out of the system and to stop the cycle of continuous care. More needs to be done to assure that the end goal is for patients to live an independent life.
CRT was also mentioned as a best practice and expansion of this effort should be considered. In addition, there needs to be more clarity regarding what services community support organizations and healthcare providers provide related to behavioral health, what their strengths are, etc., and this information should be cataloged and shared with the public.

The Omaha Police Department stated that they have put 150 officers through trainings to help them handle situations that involve people with behavioral health disorders. They offer trainings three times per year and they are available to all officers.

Another best practice is to help agencies become capable of handling patients with co-occurring disorders. They have given money to agencies to help with this process. The Co-Occurring Task Force created by Community Alliance has also helped with this process. This effort has created some momentum in increasing the capability of agencies to effectively deal with this patient type, but the state of Nebraska is behind in realizing the significance of this effort.

Region 6 is also working to provide additional support to those who work with people dealing with behavioral health disorders. They are funding new positions for peer specialists who would work with the police department to help answer calls as they come in. These calls would not be crisis calls necessarily, but the idea is that the peer specialist could help divert crisis through the conversation.

Alegent Health’s nurse navigator program was also mentioned as a best practice to help patients with entry into the system and exit out of the system. The navigator program uses a certified nurse who acts as a single point of contact for patients and families. The nurse navigator can assist with scheduling initial tests and consultations. They also collaborate with members of the medical team to ensure information is current and understood by all members of the care team, including physicians. They also help the patient and family members understand the diagnosis and plan for care. Ultimately this person helps guide the patient and family through the healthcare system.

What do you see as the biggest barriers to change across the region (financial, structural, and cultural)?

Structural issues were thought to be the biggest barrier to change across the region by some. When decisions are made regarding care, each entity is not factoring in all elements that need to be considered for the care decision to be effective. Reasons behind this include rivalries among agencies, shortage of care professionals, ineffective collaboration among providers, limited capacity, and access to the right level of care.

Regarding capacity and access to the right levels of care for patients, many times patients will have no permanent residence. Situations like this lead them seek out higher levels of care than they need so they can be admitted into inpatient treatment, or they rely on shelters that are usually located in low-income neighborhoods where drug traffic is high, or they stay in their current environment, which is not a positive environment for them. There are no good options in these circumstances. Some think that 10% to 20% of Lasting Hope’s patients are there because they do not have another place to go. Other services are difficult to get into and intake takes a long period of time. Accessing county services is one example. To get into county services the process can take four to six weeks, at times, to get an intake review and people who do qualify for benefits cannot get them because the process is difficult and cumbersome for them and they do not follow through.

Some see a big void for support for young adults. Support here should be looked at as an early step to prevent issues later in life. The DA’s Office also thinks that people who are in prison today with a mental illness may not be diagnosed early enough, so they end up becoming repeat offenders before receiving the proper support.
Others believe that additional support is needed for patients because so few have it. There seem to be four types of patients in this system: patients that have insurance, get care, get the needed support, and then leave the system; patients with money and insurance but are in denial about their condition and never enter the system; patients that cannot afford medical care, have no insurance, or run out of medical care therefore they access the system through the emergency department; and there are people who are brought into the system from a family member, through police, etc. There is a good number of the total patient population that fall into these buckets that do not get the appropriate amount of support to successfully recover.

Omaha Police Department stated that lower levels of care and support for patients are often missed. Presently there is a great deal of care for those who are severely, chronically ill, but there is not much support for those who need more basic forms of support. They figure that about every third call they make is simply someone who is having a bad day and needs someone to talk to. If these people had someone to turn to before police or emergency caregivers are forced to become involved, the system would run more efficiently. This lack of intermediate support is a structural barrier that can have negative effects on patients.

An example was given of a woman who has run into structural barriers in her experience receiving behavioral healthcare. This woman receives care from the VA system now, but people close to her feel that she has never been fully or accurately diagnosed. There has been no consistency with her providers due to the VA’s heavy reliance on residents. Residents go through rotation so her providers come and go and causing them to have limited familiarity with her. Additionally, the VA has limited the access she has to other community services that could be beneficial to her. The feeling is that this woman’s providers have not always considered the full picture of health when making care decisions. For example, this woman injured her back, which her providers dealt with without considering her mental health issues. In this case, they focused on one condition at a time (her back) without considering the impact that surgery, recovery, or pain medication would have on her mental condition.

Other structural issues include challenges with data collection, inability to flag high-end users in the system, time commitments needed for agencies and providers to participate in committees, and difficulties working with the state. With respect to data collection, challenges exist with getting reports off managed care system, Magellan. For example, Region 6 went years without reports regarding admissions, discharges, demographics of patients, etc. If they did get reports, they would contain errors and be unreliable. Providers now have five specific reports they can get from their system, but they can only get data that pertain to them; they do not have access to other providers’ data. Limitations with flagging high-end users through the system is because Region 6 can find out when patients have been treated at facilities they fund including Immanuel or Douglas County, but for those facilities whose funding comes from the state, they would not know about patients treated there. Generally, limitations mentioned in working with the state were due to the rigid structure of their service deals.

Financial barriers also exist that stand in the way of change, particularly how tax dollars are distributed throughout the state of Nebraska. Some believe that there are too many tax payer dollars that come from eastern Nebraska that are used to support those who live in western Nebraska. The number of counties that exist in sparsely populated areas of the state spread dollars too thin for those in the more densely populated counties. If there were fewer counties, dollars could be spread more evenly, which may help bring more resources to those with behavioral health disorders in Region 6.

Competition between providers is a cultural barrier that exists and all parties need to become more collaborative to address this issue. There needs to be more give and take — dollars cannot be the end all be all. As it stands today, there are a lot of duplicative services in Region 6. This is not necessarily bad, but this could also lead to the absence of services, which would have a negative impact on patients. Restructuring incentives to focus on outcomes rather than volumes could help with these concerns.