Nebraska's Regional Behavioral Health Authorities

Behavioral Health is essential to overall health.

Prevention Works

Treatment is Effective

People do Recover

Regional Behavioral Health Authorities

- Six Regional Behavioral Health Authorities (RBHAs) first created in 1974 through the Nebraska Comprehensive Community Mental Health Services Act with revised responsibilities and authority in 2004 under the Nebraska Behavioral Health Services Act which reaffirmed the roles and responsibilities of the RBHAs to reflect the evolution of the publicly funded behavioral health system in Nebraska.

- Governed by a Regional Governing Board consisting of elected officials (Commissioners or Supervisors) from counties served.

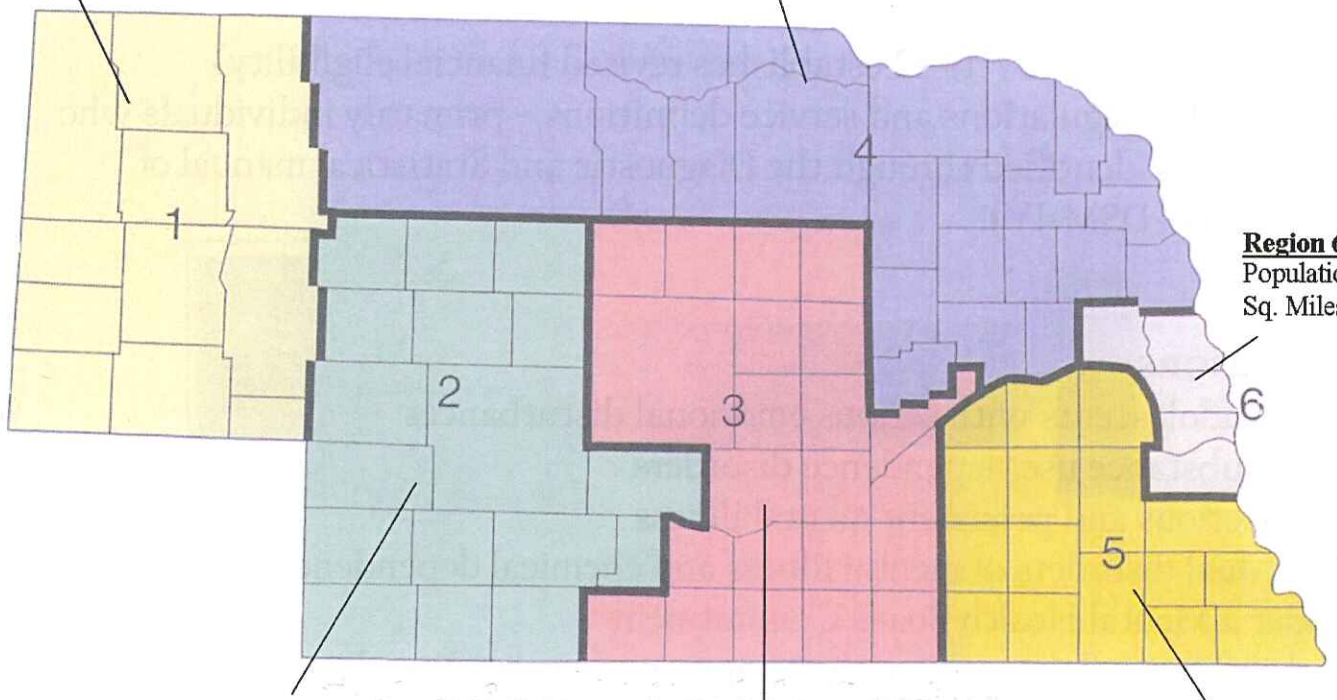
- To accomplish the intent of the Act the following Nebraska Behavioral Health System partners are responsible for the delivery of services:
  - Department of Health and Human Services, Division of Behavioral Health
  - 6 Regional Behavioral Health Authorities
  - The Lincoln Regional Center

- Regional System provides for:
  - Local participation and autonomy in the development and delivery of needed services
  - Counties and the State come together to share resources to meet local needs

Nebraska Behavioral Health Regions

Region 1
Population: 90,410
Sq. Miles: 14,116

Region 4
Population: 216,388
Sq. Miles: 21,000



Region 6
Population: 671,287
Sq. Miles: 2,036

Region 2
Population: 102,311
Sq. Miles: 15,171

Region 3
Population: 223,143
Sq. Miles: 14,972

Region 5
Population: 413,557
Sq. Miles: 9,308

- Each Regional Behavioral Health Authority contracts with a network of behavioral health providers (and also provides services based on statutory requirements).

- Eligibility
  - Financial (LB871 effective 7-18-12 establishes revised financial eligibility)
  - Clinical (defined in regulations and service definitions – primarily individuals who have a diagnosis as identified through the Diagnostic and Statistical manual of Mental Disorders--DSM-IV)

- Service Populations
  - Children and adolescents with serious emotional disturbances
  - Adults with substance use/dependence disorders
  - Adults with serious and persistent mental illness
  - Adults with dual disorders of mental illness and chemical dependency
  - Adults under a Mental Health Board Commitment
  - Adults and children/adolescents with major mental health disorders
  - And adults and children/adolescents with substance abuse problems

REGIONAL BEHAVIORAL HEALTH AUTHORITIES' ROLES AND RESPONSIBILITIES

Provider Network Development and Management

- Determine standards for network providers.
- Monitor provider enrollment.
  Develop annual regional plan of expenditures.
- Contract or provide technical assistance to community teams and family support networks.
- In addition to the Network services, Regions provide services to address specific populations and fill gaps in the service array.

Program Development and Management

- Assess the current service delivery and identify gaps.
- Plan to ensure a balanced, integrated service system.
- Develop strategies to effectively meet needs, fill gaps, overcome barriers and determine effective use of resources.
- Coordinate services for youth, prevention and the emergency system.

Evaluation and Quality Management

- Ensure the effective utilization of resources.
- Ensure quality services and improvements as necessary.
- Track outcomes and performance standards in our network providers.
- Support and fund utilization of evidence-based practices.

Fiscal Management and Accountability

- Develop and manage contracts with network providers
- Maintain accountability for the public funds it administers.
- Conduct annual fiscal and programmatic reviews of contract providers.
- Serve as a fiscal agent for related grants as needed.

Advocacy

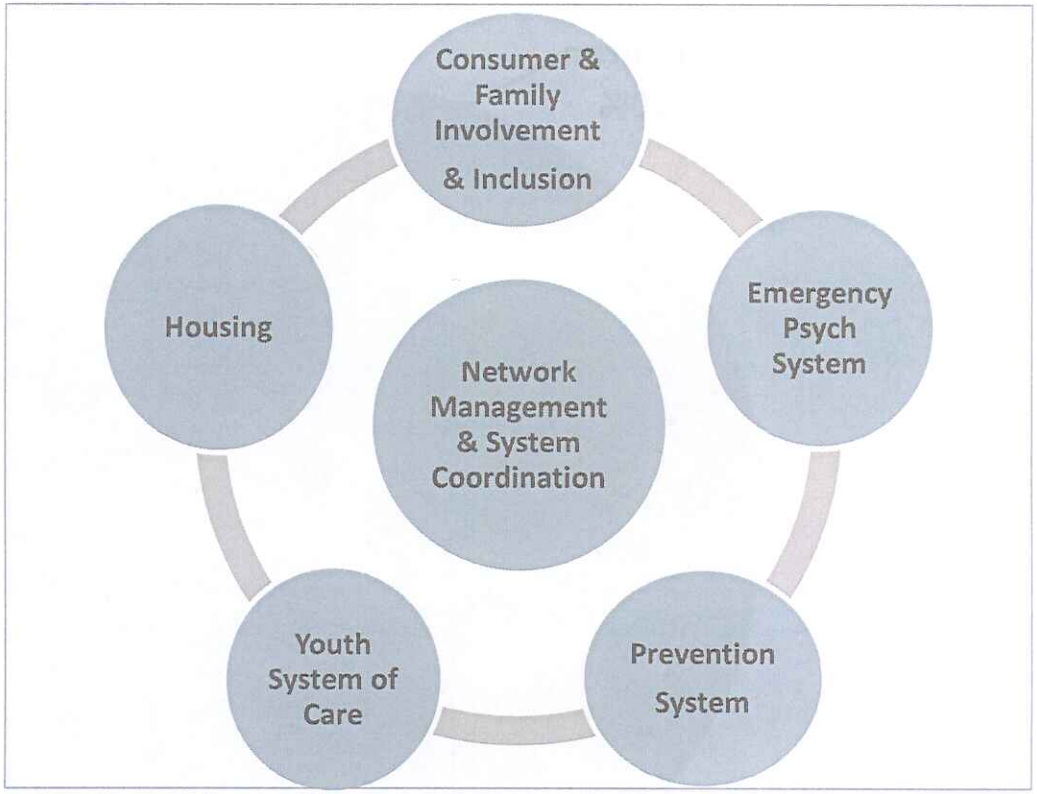
- Advocate for children, adults and families who experience behavioral health problems.
- Advocate for system improvements.

System Coordination

Building on Individual, Community & System Strengths

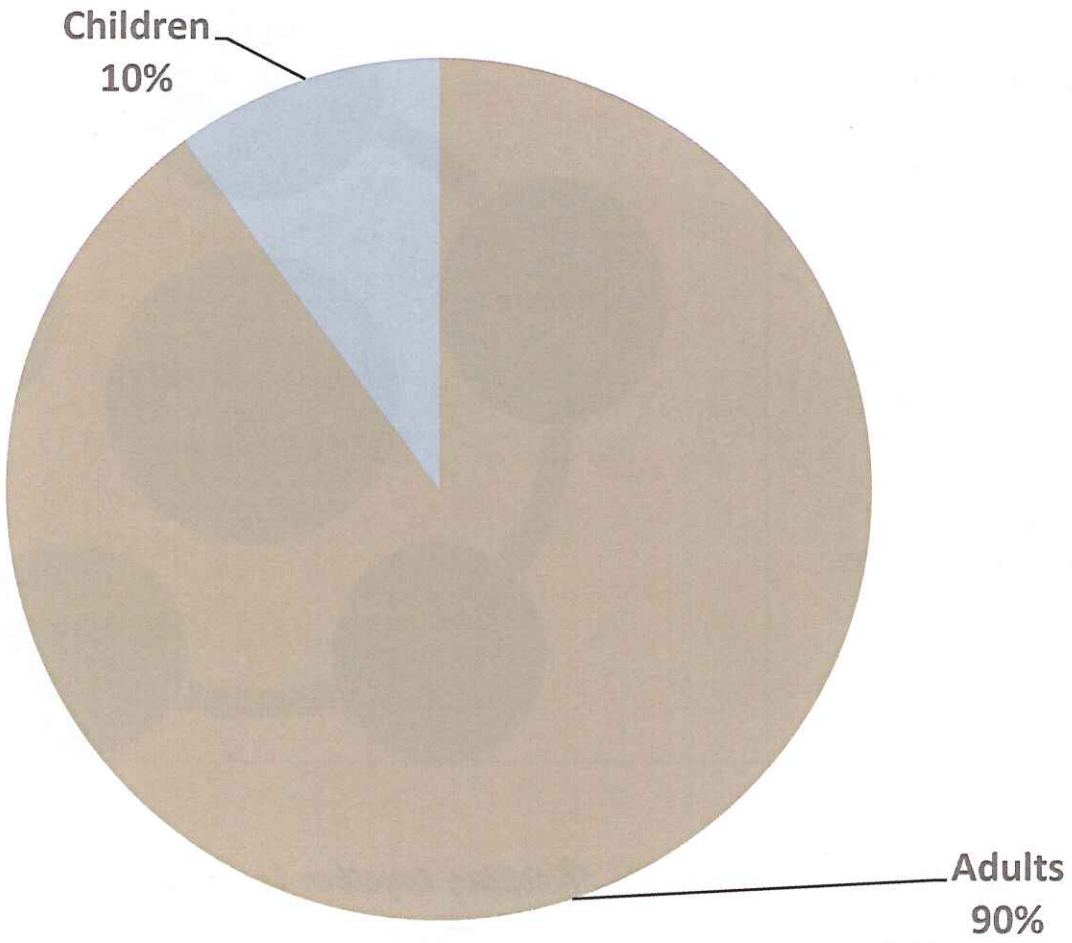
Strategic, strengths-based and Recovery focused process that empowers individuals and communities to achieve positive results.

The Regions work closely with Service providers, community leaders, consumer groups, and representatives of judicial, education, social services, law enforcement, and healthcare providers to create a climate for interagency collaboration and systems integration.



Coming together is a beginning. Keeping together is progress. Working together is success. ~ Henry Ford

Persons Served



Behavioral Health and Child Welfare Collaboration

STEP ONE

- CFS identifies **Transition Age Youth (TAY)** needing ongoing behavioral health services to ensure continuity of care
- CFS fills out TAY Behavioral Health Referral form and submits to Regional Transition Team by youth 17th birthday; CFS is responsible for providing all necessary information for transition planning to begin

STEP TWO

- Regional Transition Team acknowledges receipt of the request for consultation within 60 days. Regional Transition Team may make recommendations at this time. These recommendations may include: youth eligible or not eligible for transition team review, youth case review should be scheduled for target date, consideration of next steps for CFS, notation of potential Behavioral Health services, request for more information, etc.
- CFS retains responsibility for care coordination for youth, makes determination of next steps
- CFS initiates contact with Magellan for youth 18 year old that will need coordination for adult mental health services

STEP THREE

- CFS considers appropriate planning, proceeds with responsibilities as appropriate for youth and per State guidelines
- CFS may re-engage Regional Transition Team for transition planning partnership; continued contact as appropriate

STEP FOUR

- CFS initiates continued contact with Regional Transition Team , provides required and relevant information; retains responsibility for youth care. Submits Section B (and Section C if necessary) of the Referral Form
- Regional Transition Team collaboratively assists CFS with appropriate team to identify service availability and care coordination opportunities. May consider/recommend use of Magellan Youth Transition Planning Checklist Reference Guide

STEP FIVE

- CFS submits Referral Form Section C to Regional Transition Team . As appropriate CFS, youth and Regional Transition Team collaborate to create transition plan. Regional Transition Team responsible for facilitating their transition team process, for clarifying available programs/services via Regional Transition Team and potentially within community, but CFS retains responsibility for youth and care plan implementation
- CFS retains ultimate responsibility for youth care coordination until guardianship ends.

STEP SIX

- CFS assists and empowers youth to determine transition plan, utilizing Regional Transition Team to assist particularly with behavioral health care plan. As appropriate, services are initiated.
- Regional Transition Team provides recommendations for care regarding planning, action steps, resources, adult services, collaboration with providers, etc. Able to initiate when appropriate and agreed upon by CFS and youth.

Behavioral Health and Child Welfare Collaboration

From 2001 through 2009 the Regions partnered with Children and Family Services in the development and management of a public care coordination model to address the needs of children with behavioral health needs. These partnerships ended with the onset of Child Welfare Reform in 2010.

- **Integrated Care Coordination Units** which were designed to effectively manage, at the local level the care of youth who are in the custody of the state who experience multiple and complex needs utilizing wraparound principles and family-centered practices.

- **Early Integrated Care Coordination** which was designed to
  - Decrease the number of youth in the Child Welfare System.
  - Decrease the number of referrals to the County Attorney for legal action
  - Increase the parent's ability to adequately meet their children's needs through the wraparound process.
  - Develop intensive, early intervention strategies to prevent the child from being removed from their home and community.
  - For children in the state's custody to decrease the length of time they were in the child welfare system.