BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

BHECN

2009-2011
LEGISLATIVE REPORT

December 1, 2011

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Forward

The Nebraska Unicameral created the Behavioral Health Education Center of Nebraska (BHECN) in July 2009, with the passage of LB 603. The newly formed BHECN was a unique effort unmatched in the history of behavioral mental healthcare in the United States and was established to address critical behavioral healthcare workforce shortages.

The behavioral healthcare workforce shortages had been identified as a crisis for both urban and rural environments. The 2008 Workforce Report "A Critical Match", detailed the workforce deficiencies, indicating a shortage as well as an unequal distribution of behavioral healthcare providers. The problem was compounded by a parallel national workforce crisis. Large scale workforce studies indicated a need for an additional 56,000 behavioral health prescribers to meet the current prescribing needs nationwide.

BHECN initially began an assessment and planning period to address the legislative mandates. BHECN's findings revealed that 50% of the psychiatrists and 70% of the psychiatric nurse practitioners trained in the state of Nebraska left the state upon graduation, lured by higher salaries, more collaborative practice, and readily available jobs. Similar problems were found with other licensed professionals including psychologists and social workers. The initial assessment also found that while statutes were in place for licensing mental health practitioners and licensed alcohol and drug counselors, problems existed with both the basic clinical education and availability of supervisors required for training during provisional licensure. As indicted in "A Critical Match", the numbers of licensed providers was critically low; unequally distributed, with a significant portion facing retirement within the next five years. Additionally, efforts to recruit and train peer specialists are unconnected with the development of the rest of the workforce.

BHECN's initial assessments attempted to identify additional causes of the behavioral healthcare workforce shortage. The results indicated that there was no single factor responsible. Several decades of low levels of recruitment, low in-state retention, and an erosion of reimbursement from all forms of payers had all but eliminated the culture of providing behavioral health workforce development in Nebraska. The assessments found that not only were there too few behavioral health care providers, but there were far too few behavioral healthcare educators. The majority of the behavioral healthcare providers and educators were operating in independent professional silos; seldom crossing training lines or collaborating. The remaining educators and providers had narrowly focused mission statements designed to ensure only the most basic operations. Most were suffering from provider fatigue and financially unable to stretch in order to include expansion of the workforce into their existing mission. The initial assessments reveal that the educational and clinical culture required to generate a new workforce had been all but eliminated.

Despite these issues, BHECN has continued to focus on the mandates outlined by the Unicameral. Without question, progress has been made with support from several community based resources. BHECN had several champions supporting the effort, notably Ken Stinson and Rhonda Hawks, who advocated for the redevelopment of the culture of behavioral healthcare within Nebraska. Educators

at UNMC's Munroe Meyer Institute and UNMC's College of Nursing simultaneously received large federal behavioral workforce training grants emphasizing telecommunications which allowed BHECN to leverage limited resources. Behavioral healthcare professionals and administrators from Lasting Hope and Community Alliance stepped forward and examined their missions to stretch their clinical training capacity. Creighton and UNMC's Departments of Psychiatry altered their residency programs to include telehealth and rural outreach. Members of the State Division of Behavioral Health, individual regional networks and the office of Consumer Affairs continue to participate in planning sessions to set priorities for new models of behavioral healthcare workforce expansion. Educators, administrators, information technology specialists, legal experts, consumers and providers from across the state have given time and energy to attend the Behavioral Health Care Technology Summits to address barriers and develop policy for using telecommunications for service delivery. Each activity required the commitment of time, personnel and resources that were essential to accomplishing BHECN's mission.

Using existing resources, BHECN has defined a broad based mission statement, forged collaborative partnerships and made significant gains in building collaborative investment in expanding Nebraska's Behavioral Healthcare Workforce. The steps required to reinvigorate expansion of the behavioral healthcare workforce are complex and require addressing a complex series of negotiations and collaborative activities.

BHECN's success has been a collaborative effort with hundreds of people across the state of Nebraska. We wish to thank the many people who have made BHECN's work possible.

Susan Boust, MD
Medical Director
BHECN

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Associate Director
BHECN

EXECUTIVE SUMMARY

The Behavioral Health Education Center of Nebraska (BHECN) was established in July of 2009 in response to a directive handed down from the Nebraska Legislature to address the pressing behavioral healthcare workforce shortages. BHECN was given the urgent charge of developing the education and clinical training of the state-wide behavioral health care workforce to meet the needs of all Nebraskans through a new, inter-disciplinary behavioral healthcare educational model. Today, BHECN's efforts are an evolving, collaborative effort that spans multiple behavioral professions (psychiatry, psychology, social work, psychiatric nurse practitioners, counseling, and marriage and family therapy), and university partners from UNMC, Creighton, UNO, UNL and UNK.

The legislative mandate (LB 603) made it paramount that BHECN move forward decisively and swiftly in developing a workable, efficient plan and infrastructure to address the critical shortage of trained behavioral health providers, particularly in rural and other underserved areas, across Nebraska. In order to do this, BHECN is collaborating throughout the six behavioral healthcare regions that cover all of Nebraska and continues to move forward to build a dynamic organization that supports and facilitates the recruitment, education, training and retention of a highly competent behavioral health workforce. BHECN is building a unique paradigm in the formation of collaborative educational partnerships designed to increase the competency of behavioral health professionals and evidence based outcomes for the people of Nebraska.

This is the first report required of the Behavioral Health Education Center of Nebraska, pursuant to LB 603. It is intended to provide an overview of BHECN and its programs, activities and accomplishments for the first two fiscal years 2009-2011.

BHECN has achieved impressive results, including:

- Over 760 behavioral professionals trained across the state
- Funding of four additional psychiatry residents and sixteen graduate students, specializing in rural behavioral health and outreach intern sites in 20 rural counties
- Formed numerous academic partnerships statewide to focus on quality training initiatives for behavioral health professionals across the state
- Three statewide telehealth conference summits, broadcast via distance technologies
- Establishment of two interprofessional training sites at Lasting Hope Recovery Center and Community Alliance to support statewide training initiatives
- Twelve statewide community tour visits to facilitate regional collaboratives
- Rural Community-based Participatory Research projects initiated in three communities to assess rural needs and resources

A full Legislative Impact/Achievement Summary can be found on Page 9 of this report.

Though a great deal has been accomplished to date, BHECN's tasks ahead are enormous. A priority going forward is to continue to ascertain the most effective and efficient use of BHECN's limited

resources in the face of such overwhelming needs of communities, consumers, academic institutions, governmental authorities, and provider organizations. BHECN will continue to focus on our greatest strength which lies in our organization's collective ability to leverage limited resources through innovative collaborations that foster quality training and development opportunities for behavioral health professionals across the state of Nebraska.

Future priorities are to:

- Strengthen and expand BHECN's infrastructure and ability to identify shared priorities and negotiate conflict between partners
    - Establish an Executive Committee of the Advisory Council to improve the function of the Advisory Council
    - Provide feedback from other statewide advisory groups to improve priority setting
    - Maintain and strengthen BHECN's strategic plan to communicate priorities and measure success in achieving legislative mandates
    - Strengthen consumer and family member participation in BHECN activities
- Request completion of BHECN funding for the established legislation
- Strengthen BHECN's relationships with rural communities and partners who support rural communities by further developing BHECN Sites
- Increase BHECN's use of professional social networking communication strategies to assure that interested parties are aware of BHECN activities and can comment on decisions and outcomes
- Finalize plans for BHECN space that will support statewide partner participation in training and education
- Increase BHECN's connection with national initiatives in behavioral health workforce development to ensure continuity of the behavioral healthcare workforce in the future
- Strengthen BHECN's relationships with diverse academic partners through the Academic Support Workgroup and the BHECN faculty to synergize efforts that support BHECN's mission

BACKGROUND

LB 603 AND START OF BHECN JULY 1, 2009

BHECN was created at a time of crisis in Nebraska. This crisis had been a long time coming. Numbers of behavioral health providers were low or non-existent in rural areas. There exists a shortage of faculty available to train a new generation of providers. State hospitals had been closed, and law enforcement and the Department of Corrections bore an increasing burden for the care of the mentally ill. People with serious health problems were returned to community care providers, but were not receiving adequate due to the absence of trained behavioral health care professionals in those communities. Increasingly, the mentally ill were ending up in emergency rooms, homeless clinics, jails and the streets.

BHECN's creation was intended to address the shortage of a competent workforce to meet the needs of the state.

The Behavioral Health Education Center of Nebraska (BHECN) was created July 1, 2009, and is administered by the University of Nebraska Medical Center. The Nebraska legislature identified the need for an education center when Nebraska changed the emphasis of the system of care from an institutional to a community-based model with the passage of LB 1083 in 2004. The legislature also further recognized that there were an insufficient number of skilled behavioral health providers to meet the needs of the people of Nebraska with the passage of LB 603 in 2009, … "*finding that there are insufficient behavioral health professionals in the Nebraska behavioral workforce and further that there are insufficient behavioral health professionals trained in evidence-based practice. These shortages led to well-documented problems of consumers waiting for long periods of time in inappropriate settings because appropriate placement and care is not available. As a result, mentally-ill patients end up in hospital emergency rooms which are the most expensive level of care or are incarcerated and do not receive adequate care, if any. As the state moves from institutional to community-based behavioral health services, the behavioral health services workforce shortage is increasingly felt by the inability to hire and retain behavioral health professionals in Nebraska. In Laws 2004, LB 1083, the Legislature pledge to promote activities in research and education to improve the quality of behavioral health services, the recruitment and retention of behavioral health professionals, and the availability of behavioral health services. The purpose of the Behavioral Health Workforce Act is to realize the commitment made in LB 1083 to improve community-based behavioral health services for Nebraskans and thus focus on addressing behavioral health issues before they become a crisis through increasing the number of behavioral health professionals and training these professionals in evidence-based practice and alternative delivery methods which will improve the quality of care, including utilizing the existing infrastructure and telehealth services which will expand outreach to more rural areas in Nebraska."*

BHECN was formed to accelerate the development of an education system paradigm that could meet the needs of the changing behavioral health care system in an effective and efficient manner.

The Nebraska Legislature passed LB 603 in April 2009 with the intent of developing a Behavioral

Health Education Center that would be interprofessional in nature and reach across the state to address the shortage of trained behavioral health providers to rural and underserved areas.

LB 603, Sec. 14 (1) outlines the required BHECN activities addressed in this report:

1. Provide funds for two additional medical residents in a Nebraska-based psychiatry program each year starting in 2010, until a total of eight additional psychiatry residents are added in 2013. Beginning in 2011 and every year thereafter, the center shall provide psychiatric residency training experiences that serve rural Nebraska and other underserved areas. As part of their residency training experiences, each of the center-funded residents shall participate in the rural training for a minimum of one year. Beginning in 2012, a minimum of two of the eight center-funded residents shall be active in the rural training each year.

2. Focus on the training of behavioral health professionals in telehealth techniques, including taking advantage of a telehealth network that exists, and other innovative means of care delivery in order to increase access to behavioral health services for all Nebraskans.

3. Analyze the geographic and demographic availability of Nebraska behavioral health professionals including psychiatrists, psychiatric nurse practitioners, social workers, community rehabilitation workers, psychologists, substance abuse counselors, licensed mental health practitioners, behavior analysis, peer support providers, primary care physicians, nurses, nurse practitioners, and pharmacists.

4. Prioritize the need for additional professionals by type and location.

5. Establish learning collaborative partnerships with other higher education institutions in the state, hospitals, law enforcement, community-based agencies, and consumers and their families in order to develop evidence-based, recovery-focused, interdisciplinary curriculum and training for behavioral health professionals delivering behavioral health services in community-based agencies, hospitals, and law enforcement. Development and dissemination of such curriculum and training shall address the identified priority needs for behavioral health professionals; and

6. Beginning in 2011, develop two interdisciplinary behavioral health training sites each year until a total of six sites have been developed. Four of the six sites shall be in counties with a population of fewer than fifty thousand inhabitants for a minimum of three behavioral health professionals;

No later than December 1, 2011, and no later than December 1 of every odd-numbered year thereafter, the center shall prepare a report of its activities under the Behavioral Health Workforce Act. The report shall be filed with the Clerk of the Legislature and shall be provided to any member of the Legislature upon request.

BHECN Vision

Everyone in Nebraska will have timely access to comprehensive, effective and efficient behavioral health by 2015.

Mission

Support the recruitment, promotion and retention of the Nebraska behavioral health workforce by providing education and training in evidence-based practice, interprofessional collaboration, and the use of behavioral telehealth services to expand outreach and serve the people of Nebraska.

BHECN's initial focus during the first two years have been on: 1) identifying and addressing the distinct areas of behavioral health professionals in each region; 2) developing working partnerships in each region to plan and implement activities to address regional needs; and 3) aligning activities with the BHECN Strategic Plan Goals (refer to Appendix for Strategic Plan 2010-2014).

BHECN is a dynamic organization and the current Strategic Plan has just been reviewed in a two day interprofessional planning retreat. An updated Strategic Plan will be available for comment by March 31, 2012 and implemented July 1, 2012. This initial legislative report will focus on 2009 – 2011.

BHECN STRATEGIC PLAN

IMPLEMENTATION OF LB 603

Specific program goals are set forth in the LB 603 legislation and were incorporated into a comprehensive strategic plan, finalized April 2010. The strategic plan is dynamic and by design, subject to constant updating as BHECN evolves. An updated strategic plan is under review and will be operational by July 2012. BHECN's strategic plan serves as a roadmap to achieve the mission and goals.

BHECN is mandated to create six training sites across the state that addresses the need for communities to provide local behavioral health care training. BHECN has developed a strategic to comprehensively address the issues identified by this change in location and philosophy of workforce training.

The plan will serve as a roadmap to measure the level of success of BHECN and to form the reports of its activities under the Behavioral Health Workforce Act. Staff Action Plans have also been developed to outline the specific activities that must be undertaken to ensure implementation of each strategy. BHECN leadership is committed to review the plan annually and update Action Plans as needed to achieve the Goals and Key Success Measures. Additionally, each staff member's annual goals and objectives, upon which their performance is evaluated, will be directly tied to the Goals of the Strategic Plan.

The Strategic Plan, based on the legislative mandates, will be used by leadership as a tool for decision making in carrying out their responsibilities. Through the planning process, BHECN has identified top priorities and related strategies, and will use this Plan in making decisions regarding the future direction of BHECN. The legislation identifies five key initiatives. Together these initiatives provide a comprehensive plan to address the need to increase the numbers of professionals especially in rural areas and to encourage education and training that imparts evidence based practice and skills that support team based delivery of care.

The Strategic Plan was based on growing BHECN over four years and funding for the initial two years will not be adequate to address the four year plan outlined in legislation.

Based on legislative language, BHECN developed the following seven strategies:

I. **Behavioral health education and training sites in each region**
BHECN will develop six behavioral health regional sites to support local participation in interprofessional behavioral health workforce development.

II. **Behavioral telehealth training**
BHECN will provide leadership and training in behavioral telehealth and other innovative means of care delivery to the entire behavioral health workforce.

III. **Interprofessional behavioral health training, curriculum development and outcomes research**
BHECN will establish interprofessional learning collaborative partnerships to create, link, and disseminate education and training materials for the development of the behavioral health workforce addressing the recovery-focused needs of consumers.

IV. **Fund psychiatry residents and other behavioral health trainees**
BHECN will fund additional psychiatric residents (two each year up to a total of eight) trained in interprofessional and telehealth service delivery to rural and underserved areas. BHECN will facilitate funding of training of other behavioral health professions.

V. **Behavioral health workforce analysis**
BHECN will facilitate the collection, analysis and dissemination of behavioral health workforce data. BHECN will expedite the prioritization of training and recruitment of behavioral health professionals by type and region.

Supporting Strategies

VI. **Networks**
BHECN will develop resource networks of highly committed, competent and diverse individuals, committees, partners, and champions. The communication and education plan will foster access to resources to support and implement BHECN's mission and goals.

VII. **Resources: Financial and Operational**
BHECN will build a viable infrastructure to meet the goals of BHECN's mission and fund its strategic initiatives.

This plan will serve as a roadmap to measure the level of success of BHECN and to form the reports of its activities under the Behavioral Health Workforce Act.

UNIVERSITY OF NEBRASKA MEDICAL CENTER

Behavioral Health Education Center of Nebraska

BHECN Impact-

LB 603- ACHIEVEMENT HIGHLIGHTS

Collaboration goes a long way...in its first two formative years, BHECN has exceeded its goals, achieving impressive results largely through the strategic leveraging of resources.

Rural Site Development

- ✓ **Two contracted sites in Scottsbluff (Region 1), Kearney (Region II)**
- ✓ **Twelve Statewide visits over two years with 174 Community Participants**

Telehealth

- ✓ **Three Behavioral Health Information Technology Summits have educated 250+ people in telehealth technologies and formed policy for future delivery models**
- ✓ **Telemental health services delivered by UNMC and Creighton Departments of Psychiatry has resulted in 174 distance clinical visits and 13 psychiatry residents trained in telehealth techniques.**

Training of Behavioral Health Professionals

- ✓ **Two inter-professional training sites established at Lasting Hope Recovery Center and Community Alliance to support statewide training initiatives**
- ✓ **782 Behavioral health professionals trained (all training venues)**
- ✓ **1062 Continuing education hours logged**
- ✓ **46 behavioral health professionals completed a fifteen hour "Assessing and Managing Mental Health Problems in Children and Adolescents" training through the REACH initiative.**
- ✓ **40 college students provided with over 80 hours of instruction through Rural Health Education Network, four of which enrolled in UNMC graduate health care education**
- ✓ **Outreach intern sites established through collaborations with behavioral health training grants from the UNMC College of Nursing and Munroe-Meyer Institute in 20 rural counties**

Legislative Impact (continued)

Funding of Medical Residents and Other Students

- ✓ Four rural psychiatry residents funded in 2010-11
- ✓ Sixteen behavioral health graduate students funded in 2010-2011 from psychiatric nursing, psychology, family therapy, social work, and counseling

Behavioral Health Workforce Analysis

- ✓ Comprehensive workforce analysis report completed by UNMC College of Public Health in August 2011
- ✓ Rural Community Based Participatory Research projects initiated in three communities addressing rural needs and resources

PROGRAM ACTIVITIES AND ACCOMPLISHMENTS

Overview

Fiscal year 2009-2010 was the planning year for the development of the Nebraska Behavioral Health Education Center. Initial planning activities were interrupted by the budget cutting special Legislative Session but resumed after funding was stabilized. However, BHECN's planning and implementation remained consistent with the legislative mandates. The initial focus was to bring partners together, and required multiple meetings across the state with a wide range of private, public and academic institutions.

Fiscal year 2010-11 was a growth year for the development of the Nebraska Behavioral Health Education Center. BHECN added five employees to its staff. The team has made substantial headway in the planning and execution of activities under the BHECN Strategic Plan consistent with LB 603 legislative mandates. There has been a significant increase in the interprofessional training, rural training, and one depression module won a national teaching award.

ACTIVITIES AND ACCOMPLISHMENTS SUMMARY:

1. **REGIONAL SITE DEVELOPMENT**

2009-2010:

- A model hospital based interprofessional training site has been established at Alegent Health's, Lasting Hope Recovery Center. Students from Creighton University Department of Psychiatry, UNMC Department of Psychiatry, UNMC College of Nursing, Creighton School of Nursing, UNO School of Social Work. and Creighton and UNMC College of Pharmacy and Peer Support began to undergo behavioral health training. The site provides a model to export interprofessional training throughout the state.
- BHECN created a website to disseminate information on behavioral health workforce issues. Website includes secure access to a social networking area for interprofessional student assignments and collaborative development of new curriculum materials http://www.UNMC.EDU/BHECN
- Behavioral Health Services Regions I and III: Established contractual commitments as part of the legislative mandate for rural site development

2010-2011:

- BHECN has developed rural sites in Region 1 (Scottsbluff) and Region III (Kearney) ahead of schedule.
- Partnership agreements have been renewed with Region I and Region III.
- The second annual statewide site assessment visits to all six regions will be conducted by end of 2011.
- All areas of the state have had increased participation in distance education seminars.

2. **TELEHEALTH DEVELOPMENT**

2009-2010:

- BHECN and the Veterans Administration Medical Center, Creighton University psychiatry and nursing, and UNMC psychiatry and nursing, have developed an interprofessional curriculum to support interprofessional behavioral health telehealth training.
- BHECN conducted a statewide needs assessment tour April 13 - 20, 2010 in all six regions to establish partnerships with professions in each region of the state.
- BHECN hosted a behavioral telehealth summit identifying barriers and proposing solutions for statewide behavioral health education and services.

2010-2011:

- BHECN is partnering with Scottsbluff, Wayne and Columbus to deliver behavioral telehealth. BHECN is delivering telepsychiatry Grand Rounds across the state.
- Psychiatry residents, under supervised by attending psychiatrists at UNMC and Creighton have been assigned to treat patients via telehealth in rural Nebraska.
- BHECN has completed a third annual telehealth summit with 65+ attendees and is working toward solutions to barriers to telehealth.

3. **INTERPROFESSIONAL EDUCATION**

2009-2010

- BHECN with UNMC's Rural Health Education Center, UNO, UNL and Creighton hosted a one hour college course May 16 - 21, 2010 on behavioral health careers for 21 Nebraska college students from around the state to build the workforce pipeline.
- A model community based interprofessional training site was established at Community Alliance. Students from Creighton University Department of Psychiatry, UNMC Department of Psychiatry, UNMC College of Nursing, Creighton School of Nursing, UNMC PA program and UNO School of Social to undergo interprofessional behavioral health training. The setting began accepting students on September 1, 2010.
- The site provides a model to export interprofessional training throughout the state.
- BHECN through Alegent Health's Lasting Hope Recovery Center hosted an annual training conference on suicide assessment and intervention at six locations around the state with **154** participants.
- BHECN with REACH (Resource for Advancing Children's Health) Institute, contracted to offer interprofessional primary care providers training on assessment and treatment of children's mental health problems.

2010-2011:

- Interprofessional training sites have been established at Lasting Hope Recovery Center and Community Alliance.
- BHECN is providing training for 32 rural primary care and pediatric doctors and APRNs in rural areas on the care of children and adolescents with behavioral health problems. This is a six month training.

- Through Alegent Health's Lasting Hope Recovery Center, BHECN hosted an annual training conference on Cognitive Behavioral Therapy for Severe Mental Disorders at six locations around the state with **106** participants
- BHECN collaborated with UNMC's Department of Family Medicine, School of Allied Health, College of Nursing, Center for Continuing Education, Clinical Simulation Laboratory, and UNO's Department of Theatre to create online learning modules in adolescent, adult, and geriatric depression for primary care providers. The first module on adolescent depression received the 2011 Outstanding Innovation in Medical Education Award from a national psychiatry education conference. From September 26 to November 10, the Adolescent Depression Module alone has received over 900 visits on the BHECN website, from 44 cities and towns across Nebraska, 35 states, and 11 countries. **http://www.unmc.edu/bhecn/221.htm**
- The Academic Support Workgroup, comprised of a UNMC/Creighton/UNK collaboration under the leadership of Dr. Joe Evans, has completed the development of BHECN performance measures.
- BHECN has established additional interdisciplinary educational partnerships with other federally funded behavioral health training programs through UNMC's Munroe-Meyer Institute (Graduate Psychology Education) and the College of Nursing (PIPN) projects.
- The NOW (Nebraska/Ohio/Wisconsin) Psychiatric Academic Coalition has created a Bipolar Depression education module (1 CEU) that is being offered free of charge to Nebraska family physicians, psychologists, LMHPs and counselors, nurse practitioners, physician assistants, and nursing professionals.

4. **STUDENTS AND RESIDENTS**

2009-2010:

- The total number of residents in the Creighton/ UNMC Psychiatry Residency Training Program increased from 33 to 35 and rural rotations were initiated.
- BHECN in collaboration with Psychiatry Residency Training Program, Region 4 Behavioral Health Services, Faith Regional Center is developing behavioral telehealth service delivery in Norfolk starting October 2010. Expansion sites considered are O'Neil, Columbus and Wayne.
- BHECN with Creighton/ UNMC Department of Psychiatry residency training began interprofessional didactic and distance service delivery training July 1, 2010. Needed telehealth equipment was purchased in October 2010.

2010-2011:

- Two psychiatry residents were funded by BHECN for fiscal year 2010-2011 and a total of four residents will be funded for 2011-2012, for a total of 37 residents, with an increased focus on rural health delivery.
- Two Medical Family Therapy doctoral trainees have been supported to conduct community-based participatory research in 3 small rural communities.
- Two gradate psychiatric nurse practitioner students have been supported to enhance rural training in psychiatric nursing practice.

- Two UNL Clinical Psychology doctoral students have been supported in an interdisciplinary internship program with MMI, Psychiatry, and Lasting Hope.
- Two MMI Applied Behavior Analysis doctoral interns have received support for "learning through service" internships in primary care settings.
- Six Counseling students from Master's degree programs at UNK, UNO, Doane, and Chadron State College have participated in multidisciplinary practicums in integrated primary care health settings in Nebraska City, Fremont, Crete, Kearney and Chadron.

5. **WORKFORCE ANALYSIS**

2009-2010:

- With UNMC College of Public Health and the Western Interstate Compact on Higher Education (WICHE), BHECN provided a state wide baseline assessment of the behavioral health workforce, academic partners, and behavioral telehealth capacity by November 1, 2010.
- With Nebraska Department of Health and Human Services, statewide project to improve workforce for persons with co-occurring mental illness and substance abuse. The final report was completed in November 2010

2010-2011:

- The UNMC College of Public Health collaborated with the BHECN to complete a statewide behavioral workforce analysis. The final report was completed in August, 2011.

SUPPORTING STRATEGIES

Allied Programs and Projects

In order to address the enormity of its mission to improve access to high quality behavioral health professionals across the entire State of Nebraska, BHECN has collaborated with other Nebraska behavioral health programs and funding sources to expand its training capacity. While the LB 603 legislation emphasized expanding the number of psychiatric residents, BHECN has also recognized the need for additional behavioral health personnel from other behavioral health professions. BHECN provides small amounts of funding to expand the number of trainees in each program. Specifically, some of the "contributed" resources leveraged by BHECN include the following:

- **Primary Integrated Psychiatric Nursing (PIPN) Project**-this three-year Federal training grant under the leadership of Dr. Michael Rice is designed to educate psychiatric nurse practitioners to diagnose and treat individuals with behavioral health disorders throughout the State, particularly in rural areas. Using distance education technology, the PIPN project has created significant opportunities for nurses to become Psychiatric Nurse Practitioners while remaining in their home communities across the State. In less than two years, the PIPN project has increased enrollment in psychiatric nurse practitioner education by more than 170% and graduated 16 Psychiatric Nurse practitioners within the first two years. At the present time, PIPN has students training in 20 different counties across Nebraska.

- **Integrated Rural Behavioral Pediatric Internship Training Program** – With funding from the Federal Health Resources and Services Administration's Graduate Psychology Education training grant and support from an AmeriCorps program, the Munroe-Meyer Institute at UNMC has integrated behavioral health providers into primary medical (Pediatric and Family Medicine) practices across Nebraska. This Graduate Psychology Education program is designed to attract, recruit, train, place, and retain doctoral level psychologists, counselors, social workers, and marriage and family therapists in primary care practices in Nebraska. To date, the MMI training model has placed and retained program graduates in 16 rural primary care Pediatric and Family Medicine practices in Columbus, Hastings, Chadron, Gordon, Kearney, Crawford, Grand Island, Alliance, Fremont, Crete, North Platte, Nebraska City, Plattsmouth, Rushville, Valley, and Wahoo, Nebraska. Additionally, three integrated training and clinical service sites have been developed in Lincoln along with eight integrated sites in Omaha and surrounding communities (Papillion, Bellevue, Ralston, Millard). The program's director, Dr. Joseph Evans, has been honored with the American Psychological Foundation's "Psyche Award" for his work in integrating behavioral health into primary care medical practice.

- **Other Academic Relationships**– BHECN has initiated relationships with academic partners from the State's Behavioral Health Training Programs, including Creighton/ UNMC Psychiatry Residency Training Program, Psychiatric Nursing, Medical Family Therapy, and the Munroe-Meyer Institute's Pediatric Psychology group, UNO's School of Social Work, UNK's School Psychology and Counseling Programs, and UN-L's Marriage and Family Therapy and Clinical Psychology Training Programs.

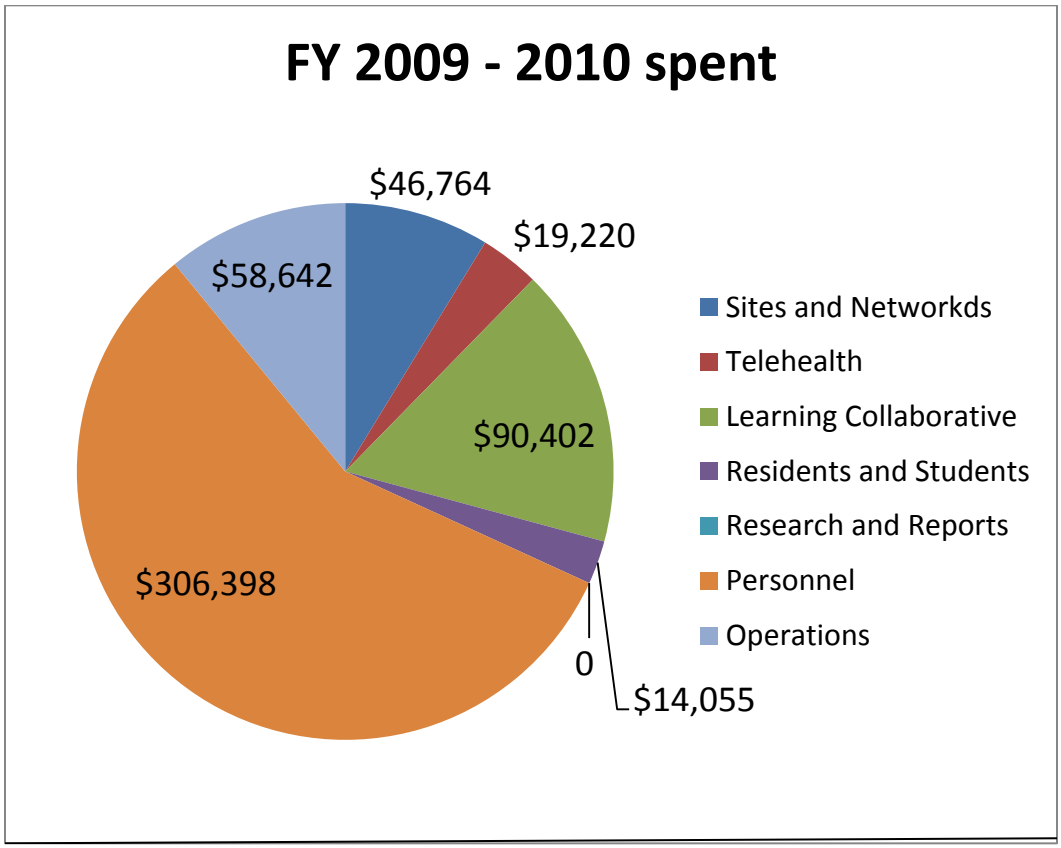
Through collaborations with the Munroe Meyer Institute, the UNMC Psychiatric Nursing Education program, and through coordination with Creighton University, current BHECN supported students have been expanded to include four additional doctoral interns, two psychiatric nurse practitioner students, two marriage and family therapy interns, six counseling trainees, two additional social work interns and two additional counseling interns (with funding reserved for Spring 2012). Overall, in addition to the six psychiatric residents supported from BHECN funds, there are an additional 18 behavioral health trainees who are being partially supported from BHECN stipends who are participating in the interdisciplinary training activities of the program. Through collaborations with these training programs, over 60 students are being trained in evidence-based behavioral health practice with an emphasis upon ensuring that all Nebraskans have access to adequate behavioral health care.

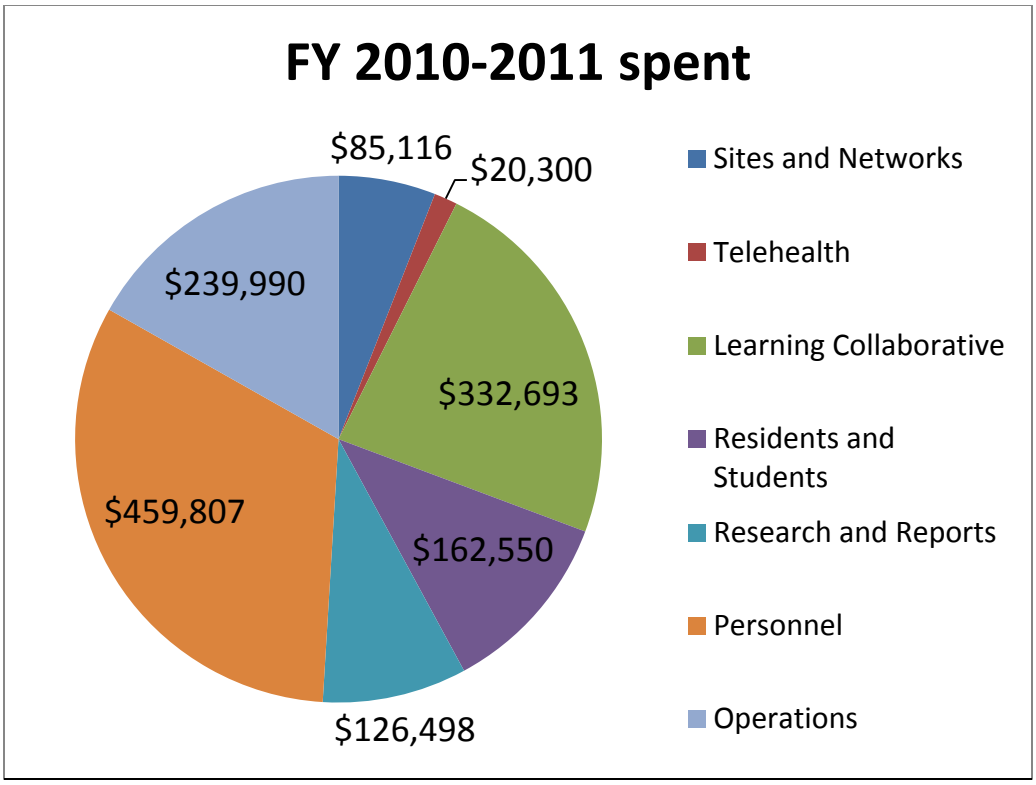
2009-2011 BUDGET SUMMARY

LB 603 FUNDING AND EXPENDITURES

LB 603A appropriated $1,385,160 for FY 2009-2010 for the purpose of implementing the Behavioral Health Education Center. Appropriation for FY 2010-2011 was $1,563,993. During the special budget session of 2009, this responsibility was transferred to the University of Nebraska Medical Center budget. Due to resident salaries and Lasting Hope Recovery Center training activities being delayed until July 2010, UNMC identified $965,000 as necessary for the program in FY 2009-2010. This budget supported aggressive growth of the program, including numerous statewide meetings, extensive focus on rural issues, and initiation of psychaitric outreach via telehealth to rural areas of the state. Of the remianinig funding, $535,481 was expended and $429,519 was carried over to FY 11and combined to FY 11 appropriation of $1,563,993 for a total of $1,993,512.

BHECN expended $1,426,998 of the $1,993,512 budget on Site Development, Telehealth, Inter-professional Education, Psychiatry Residents, Work Force Analysis, BHECN Networks and BHECN administration. Program empahsis moving forward will continue to be on hiring new staff and the development of new partnershios in rural areas outside of Omaha.





BHECN Budget

UNIVERSITY OF NEBRASKA MEDICAL CENTER			
BEHAVIORAL HEALTH EDUCATION CENTER NETWORK			
	FY 2009/10	FY 2010/11	FY 2011/12 (est)
State Appropriation	$ 1,385,160	$ 1,563,993	$ 1,563,993
Salary Increase Continuation	$ -	$ -	$ 39,622
One time FY 2009/10 Special Session Budget Reduction	$ (420,160)	$ -	$ -
Prior Year Carry over	$ -	$ 429,519	$ 566,554
Expenditures	$ (535,481)	$ (1,426,958)	$ (1,801,265)
Net Year-end balance available for Carry-Over	$ 429,519	$ 566,554	$ 368,904

The estimated BHECN appropriation for FY 12 is $1,563,993 with a Salary Increase Continuation of $39,622 for a total of $1,603,615, which has yet to be approved by the legislature. There was a carryover of $566,554 from FY 11 which will be combined with FY 12 appropriation. The projected budget for FY 12 is $1,801,265. It is anticipated that there will be a carryover of $368,904 into FY 13. Program emphasis will be on the integration of behavioral health and primary care, development of rural psychiatry program, education for behavioral health providers and the development of sites and new partnerships in rural areas outside of Omaha and Lincoln.

LOOKING FORWARD
CHALLENGES
RECOMMENDATIONS

BHECN's task is an enormous one – to work within the complex system that educates and trains behavioral health providers of all types, to address the misdistribution of providers and lack of available providers in rural and underserved areas of the state, to speed the adoption of evidence-based and interprofessional practices by members of the workforce, to provide support for communities and consumers of service to impact the training of the workforce, and to analyze and report on the efforts to increase the number and competency of the workforce.

Opportunities are abundant. There are many potential partners who have already identified goals synergistic with BHECN's mission:

- The Nebraska Division of Behavioral Health has great interest in improving the quality, number and rural location of the behavioral health workforce. There are many opportunities to partner together on both state and federal initiatives for workforce development. The Division has extensive advisory groups with statewide membership that can participate in priority setting and feedback on BHECN activities.
- The federal government is promoting integrated behavioral health care with primary care, an opportunity that has the potential to quickly impact availability of behavioral health services in rural areas.
- Technological improvements are under development that will decrease the challenges of providing education, supervision, research, and service delivery to rural areas.
- Numerous organizations, such as the Division of Behavioral Health, the Regions, and hospitals and professional associations, provide some continuing education programs, however these are mostly stand alone trainings without follow-up or assessment of change in providers.
- The Office of Consumer Affairs has an extensive focus on development of trained peer specialists.
- Academic institutions have numerous efforts under way to improve services, training, and research of the behavioral health system.

Challenges include:

- Coordination of the vast number of partners with interest and impact on BHECN's mission
- The rapidly changing service delivery systems due to changes at both the state and federal levels
- Academic accreditation requirements that impact interprofessional and distance training
- Education and training support for both peer specialists and un-licensed workers
- Limited data for behavioral health research and outcome studies
- Significant challenges in the funding of both the service delivery and training systems

The primary challenge is to reach agreements on the priorities for use of limited BHECN resources in the face of such overwhelming needs of communities, consumers, academic institutions, governmental authorities, and provider organizations.

Recommendations and future plans:

- Strengthen BHECN's infrastructure and ability to identify shared priorities and negotiate conflict between partners
    - Establish an Executive Committee of the Advisory Council to improve the function of the Advisory Council
    - Provide feedback from other statewide advisory groups to improve priority setting
    - Maintain and strengthen BHECN's strategic plan to communicate priorities and measure success in achieving legislative mandates
    - Strengthen consumer and family member participation in BHECN activities
- Request completion of BHECN funding for the established legislation
- Maintain and strengthen BHECN's relationships with rural communities and partners who support rural communities by further developing BHECN Sites and collaborating with the Nebraska Office of Rural Health to maximize retention plans
- Increase BHECN's use of social networking communication strategies to assure that interested parties are aware of BHECN activities and can comment on decisions and outcomes
- Finalize plans for BHECN space that will support statewide partner participation in training and education
- Increase BHECN's connection with national initiatives in behavioral health workforce development
- Strengthen BHECN's relationships with diverse academic partners through the Academic Support Workgroup and the BHECN Faculty to synergize efforts that support BHECN's mission

Work on these recommendations is already under way by BHECN staff and partners.

APPENDIX

LB 603 BHECN LEGISLATION

Sections 71-828 to 71-830 shall be known and may be cited as the Behavioral Health Workforce Act.

Laws 2009, LB603, § 12.
Operative Date: May 23, 2009

Sec. 12. Sections 12 to 14 of this act shall be known and may be cited as the Behavioral Health Workforce Act.

Sec. 13. The Legislature finds that there are insufficient behavioral health professionals in the Nebraska behavioral health workforce and further that there are insufficient behavioral health professionals trained in evidence-based practice. This workforce shortage leads to inadequate accessibility and response to the behavioral health needs of Nebraskans of all ages: Children; adolescents; and adults. These shortages have led to well-documented problems of consumers waiting for long periods of time in inappropriate settings because appropriate placement and care is not available. As a result, mentally ill patients end up in hospital emergency rooms which are the most expensive level of care or are incarcerated and do not receive adequate care, if any.

As the state moves from institutional to community-based behavioral health services, the behavioral health services workforce shortage is increasingly felt by the inability to hire and retain behavioral health professionals in Nebraska. In Laws 2004, LB 1083, the Legislature pledged to "promote activities in research and education to improve the quality of behavioral health services, the recruitment and retention of behavioral health professionals, and the availability of behavioral health services". The purpose of the Behavioral Health Workforce Act is to realize the commitment made in LB 1083 to improve community-based behavioral health services for Nebraskans and thus focus on addressing behavioral health issues before they become a crisis through increasing the number of behavioral health professionals and train these professionals in evidence-based practice and alternative delivery methods which will improve the quality of care, including utilizing the existing infrastructure and telehealth services which will expand outreach to more rural areas in Nebraska.

Sec. 14. (1) The Behavioral Health Education Center is created beginning July 1, 2009, and shall be administered by the University of Nebraska Medical Center.
(2) The center shall:

(a) Provide funds for two additional medical residents in a Nebraska-based psychiatry program each year starting in 2010 until a total of eight additional psychiatry residents are added in 2013. Beginning in 2011 and every year thereafter, the center shall provide psychiatric residency training experiences that serve rural Nebraska and other underserved areas. As part of his or her residency training experiences, each center-funded resident shall participate in the rural training for a minimum of one year. Beginning in 2012, a minimum of two of the eight center-funded residents shall be active in the rural training each year;

(b) Focus on the training of behavioral health professionals in telehealth techniques, including taking advantage of a telehealth network that exists, and other innovative means of care delivery in order to increase access to behavioral health services for all Nebraskans;

(c) Analyze the geographic and demographic availability of Nebraska behavioral health professionals, including psychiatrists, social workers, community rehabilitation workers, psychologists, substance abuse counselors, licensed mental health practitioners, behavioral analysts, peer support providers, primary care physicians, nurses, nurse practitioners, and pharmacists;

(d) Prioritize the need for additional professionals by type and location;

(e) Establish learning collaborative partnerships with other higher education institutions in the state, hospitals, law enforcement, community-based agencies, and consumers and their families in order to develop evidence-based, recovery-focused, interdisciplinary curriculum and training for behavioral health professionals delivering behavioral health services in community-based agencies, hospitals, and law enforcement. Development and dissemination of such curriculum and training shall address the identified priority needs for behavioral health professionals; and

(f) Beginning in 2011, develop two interdisciplinary behavioral health training sites each year until a total of six sites have been developed. Four of the six sites shall be in counties with a population of fewer than fifty thousand inhabitants. Each site shall provide annual interdisciplinary training opportunities for a minimum of three behavioral health professionals.

(3) No later than December 1, 2011, and no later than December 1 of every odd-numbered year thereafter, the center shall prepare a report of its activities under the Behavioral Health Workforce Act. The report shall be filed with the Clerk of the Legislature and shall be provided to any member of the Legislature upon request.

Sec. 15. Sections 2 and 16 of this act become operative three calendar months after the adjournment of this legislative session. The other sections of this act become operative on their effective date.
Sec. 16. Original section 68-915, Revised Statutes Cumulative Supplement, 2008, is repealed.
Sec. 17. Original sections 68-911, 71-801, and 71-808, Revised Statutes Cumulative Supplement, 2008, are repealed.
Sec. 18. Since an emergency exists, this act takes effect when passed and approved according to law.

Behavioral Health Education Center of Nebraska (BHECN)

Strategic Plan
2010 – 2014

The BHECN Strategic Plan has undergone several updates since April 2010. This plan is attached to give a comprehensive history of the BHECN planning process.

April 2010

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THE HISTORY OF BHECN:

The Behavioral Health Center of Nebraska (BHECN) was created July 1, 2009 and is administered by the University of Nebraska Medical Center. The Nebraska Legislature passed LB 603 in April 2009 with the intent of developing a Behavioral Health Education Center that would be inter-professional in nature and reach across the state to address the shortage of trained behavioral health providers in rural and underserved areas.

The Center will be largely virtual in nature relying on health information technologies and have an infrastructure that supports collaboration across institutions, across professions, and distance. This infrastructure will include people, technology, and numerous physical locations that facilitate training and collaboration between partners. Geographically the sites will be organized along the lines of the Behavioral Health Regions with participation from interested local Public Health Departments, institutions of higher education, hospitals, law enforcement, community-based agencies, consumers and their families and area Health Education Centers. A key function of sites will be supporting the local training, recruitment and retention of behavioral health professionals.

THE NEED FOR PLANNING:

The Nebraska legislature identified the need for an education center when Nebraska changed the system of care from institutional to community-based with passage of LB 1083 in 2004. The legislature recognized the crisis of insufficient numbers of skilled behavioral health providers to meet the needs of the people of Nebraska. BHECN was formed to accelerate the development of an education system paradigm designed to meet the needs of a more responsive and efficient health care system. The purpose of this document is to outline the planning and start-up for the Behavioral Health Education Center. Thus, we have undertaken a strategic planning process to ensure that all our organizational efforts are focused on the achievement of our Vision:

"To provide innovative education and training that supports the behavioral health workforce throughout Nebraska"

THE NEXT STEPS:

The new strategic plan is dynamic and, by design, subject to constant updating as BHECN evolves. It serves as a roadmap to achieve the mission and goals. This plan will be the basis for measuring success. While it may be adjusted in minor ways from time to time, this plan will keep BHECN focused on our most important goals.

We will use the plan to measure the level of success of the Center and to form the reports of its activities under the Behavioral Health Workforce Act. Staff Action Plans have also been developed to outline the specific activities that must be undertaken to ensure implementation of each strategy. Center leadership is committed to review the plan annually and update Action Plans as needed to achieve the Goals and Key Success Measures. Additionally, each staff member's annual goals and objectives, upon which their performance is evaluated, will be directly tied to the Goals of the Strategic Plan.

The Strategic Plan will be used by leadership as a tool for decision-making in carrying out their responsibilities. Through the planning process, BHECN has identified top priorities and related strategies, and will use this Plan in making decisions regarding the future direction of BHECN.

For questions or concerns contact:
Susan J. Boust, M.D., Interim Medical Director, Behavioral Health Education Center of Nebraska
sboust@unmc.edu. BHECN Main Number: 402 552-7697, Fax: 402 552-7699

Strategic Initiatives

In order to reach this mission, BHECN commits efforts to the following 7 strategies:

Mission Driven Strategies

I. **Behavioral health education and training sites in each region -** BHECN will develop six behavioral health regional sites to support local participation in interprofessional behavioral health workforce development.

II. **Behavioral telehealth training** - BHECN will provide leadership and training in behavioral telehealth and other innovative means of care delivery to the entire behavioral health workforce.

III. **Interprofessional behavioral health training, curriculum development and outcomes research -** BHECN will establish interprofessional learning collaborative partnerships to create, link, and disseminate education and training materials for the development of the behavioral health workforce addressing the recovery-focused needs of consumers.

IV. **Fund psychiatry residents and other behavioral health trainees -** BHECN will fund additional psychiatric residents (two each year up to a total of eight) trained in interprofessional and telehealth service delivery to rural and underserved areas. BHECN will facilitate funding of training of other behavioral health professions.

V. **Behavioral health workforce analysis -** BHECN will facilitate the collection, analysis and dissemination of behavioral health workforce data and the prioritization of training and recruitment of behavioral health professionals by type and region.

Supporting Strategies

VI. **Networks – BHE**CN will develop resource networks of highly committed, competent and diverse individuals, committees, partners, and champions. The communication and education plan will foster access to resources to support and implement BHECN's mission and goals.

VII. **Resources: Financial and Operational** – BHECN will build a viable infrastructure to meet the goals of BHECN's mission and fund its strategic initiatives.

BHECN VISION, MISSION, AND VALUES

Vision

To provide innovative education and training that supports the behavioral health workforce throughout Nebraska.

Mission

Support the recruitment, retention, and competency of the Nebraska behavioral health workforce by providing education and training in evidence-based practice, interprofessional collaboration, and use of behavioral telehealth services to expand outreach and serve the people of Nebraska.

Values

BHECN is committed to

Collaboration

- Respect
- Inclusiveness
- Accountability
- Transparency/openness

Standards of Professional Practice

- Ethical conduct
- Sensitivity to diversity
- Continuous improvement
- Commitment to quality
- Interprofessional collaboration
- Consumer centered

Management/Operational Values

- Efficiency/Cost Effectiveness
- Transparency
- Accountability
- Teamwork
- Forward thinking
- Data driven

STRATEGIC PLAN - SUMMARY

High-Level Summary - Strategies, Goals, and Key Success Measures

MISSION DRIVEN STRATEGIES

STRATEGY I. BEHAVIORAL HEALTH EDUCATION AND TRAINING SITES IN EACH REGION - BHECN will develop six behavioral health regional sites to support local participation in interprofessional behavioral health workforce development.	
Goal: I.1. Sites are identified in each region with capacity to champion and support interprofessional behavioral health training, recruitment, and retention.	*Key Success Measures* • Beginning 2011, develop 2 interdisciplinary behavioral health training sites each year for a total of 6 sites. (4 of 6 in counties with population of fewer than 50,000 inhabitants.) • All 6 regions have selected a regional site by 2011. • Meaningful consumer participation is established.
Goal: I.2. Sites will facilitate interprofessional training that supports local recruitment and retention of the behavioral workforce.	*Key Success Measures* • Each site provides annual interdisciplinary training opportunities for a minimum of 3 behavioral health professionals. • Learning collaborative partnerships with institutions of higher education, hospitals, law enforcement, community-based agencies, and consumers and their families are formed. • Once established, each region hosts an annual training event • Sites create opportunities for relevant training that enhances recruitment and retention of local workforce. • Community agencies and hospitals increase frequency of interprofessional training. • Employers, professionals, institutions utilize BHECN support to enhance access to continuing professional development and interprofessional effectiveness.
Goal: I.3. Sites will participate in setting priorities for the development of the local workforce.	*Key Success Measures* • The site activities will facilitate the identification of behavioral workforce needs in the region.

STRATEGY II. BEHAVIORAL TELEHEALTH TRAINING - BHECN will provide leadership and training in behavioral telehealth and other innovative means of care delivery to the entire behavioral health workforce.	
Goal: II.1. Increase use of telehealth techniques and other innovative technologies to improve access to behavioral health workforce through distance education, distance supervision and distance service delivery.	*Key Success Measures* • Needs and resource assessment is conducted to identify needs, priorities and barriers to expanded use of telehealth techniques. • Access to care is expanded. • Clinical supervision is more accessible. • Outcome review is conducted.
Goal: II.2. Develop and distribute interprofessional training for distance education, distance supervision and distance service delivery.	*Key Success Measures* • BHECN serves as leader in statewide collaboration on curriculum development. • Learning collaboratives develop education and training materials to increase the relevance, effectiveness, and accessibility of telehealth training and education. • Relevant training materials are developed, standardized and disseminated throughout the state.

STRATEGY III. INTERPROFESSIONAL BEHAVIORAL HEALTH TRAINING, CURRICULUM DEVELOPMENT AND OUTCOMES RESEARCH - BHECN will establish interprofessional learning collaborative partnerships to create, link, and disseminate education and training materials for the development of the behavioral health workforce addressing the recovery-focused needs of consumers.	
Goal: III.1. Education and training needs of behavioral health professionals are identified.	*Key Success Measures* • Needs and resource assessment surveys are developed and utilized. • Regional partnerships between institutions of higher education, hospitals, law enforcement, community-based agencies, and consumers and their families are formed and participate in workforce needs assessment. • Consumer and family member participation is established.
Goal: III.2. Learning collaboratives develop education and training materials to increase the relevance, effectiveness, and accessibility of training and education.	*Key Success Measures* • BHECN serves as leader in statewide collaboration on relevant education and training development. • Relevant training materials are developed, standardized and disseminated to partners throughout the state. • BHECN identifies, facilitates and supports attainment of grants to form Learning Collaboratives to develop and distribute education and training materials.
Goal: III.3. Establish interprofessional training models.	*Key Success Measures* • A model hospital-based interprofessional learning collaborative training model is established for Nebraska. • A model community-based interprofessional learning collaborative training is established for Nebraska • BHECN disseminates lessons learned from model sites to the rest of the state. • BHECN identifies, facilitates and supports attainment of grants for interprofessional training sites, education and training materials.
Goal: III.4. BHECN supports collaboration, facilitates awareness and disseminates model curriculum, education and training systems.	*Key Success Measures* • BHECN serves as a leader in statewide collaboration on curriculum development. • Relevant training materials are developed, standardized and disseminated to partners and behavioral health professionals throughout the state. • Outcomes assessment is completed and disseminated.

STRATEGY IV. FUND PSYCHIATRY RESIDENTS AND OTHER BEHAVIORAL HEALTH TRAINEES - BHECN will fund additional psychiatry residents (two each year up to a total of eight) trained in interprofessional and behavioral telehealth service delivery to rural and underserved areas. BHECN will facilitate funding of trainees in other behavioral health professions.	
Goal: IV-1. Fund additional psychiatric residents.	*Key Success Measures* • Two additional psychiatry residents in Nebraska-based psychiatry program each year until eight are established in 2013 and ongoing.
Goal: IV-2. Provide psychiatric residency training experience that serves rural and other underserved areas in Nebraska.	*Key Success Measures* • As part of his or her residency training experiences, each center-funded psychiatry resident shall participate in the rural training for a minimum of one year. • Beginning in 2012, a minimum of two of the eight center-funded psychiatry residents shall be active in the rural training each year. • Psychiatry residency training funds will be directed toward the development of behavioral telehealth health connections in rural areas. • Psychiatry residency training focused on behavioral telehealth techniques and other innovative means of care delivery increases access to behavioral health services for all Nebraskans.
Goal: IV-3. Conduct outcome studies of psychiatry residency training.	*Key Success Measures* • Improved rural recruitment and retention of behavioral health workforce.
Goal: IV-4. Fund training for other behavioral health professions.	*Key Success Measures* • Other behavioral health professions are funded based on identified needs and priorities.

STRATEGY V. BEHAVIORAL HEALTH WORKFORCE ANALYSIS–BHECN will facilitate the collection, analysis and dissemination of behavioral health workforce data and the prioritization of training and recruitment of behavioral health professionals by type and region.	
Goal: V.1. Collaborate with sources of historical, current and projected behavioral health geographic, demographic, recruitment, training, and retention workforce data.	*Key Success Measures* • Partnerships with institutions of higher education, hospitals, law enforcement, governmental, community-based agencies, and consumers collecting behavioral workforce data are formed.
Goal: V.2. Disseminate historical, current and projected behavioral health geographic, demographic, recruitment, training and retention workforce data.	*Key Success Measures* • Retention rates and projections are developed and reported. • Geographic and demographic information is available on Nebraska behavioral health workforce by type and location. • White Paper is produced on the historical, current and projected behavioral health workforce geographic, demographic, recruitment, training and retention workforce data.
Goal: V.3. Identify and prioritize workforce needs for behavioral health professionals by type and location.	*Key Success Measures* • Anticipated pipeline of future behavioral health workforce is identified. • Needs and priorities for additional professionals are established by type and location.
Goal: V. 4. Report on challenges, barriers and supports for recruitment, education, training, credentialing, and retention of the workforce.	*Key Success Measures* • Barriers and supports for workforce training, recruitment, credentialing and retention are identified and disseminated.

SUPPORTING STRATEGIES

STRATEGY VI. NETWORKS - BHECN will develop resource networks of highly committed, competent and diverse individuals, committees, partners, and champions. The communication and education plan will foster access to resources to support and implement BHECN's mission and goals.	
Goal: VI - 1. Partnerships with institutions of higher education, hospitals, law enforcement, community-based agencies, government agencies, community leaders, and consumers and their families are formed.	*Key Success Measures* • Partners and stakeholders collaborate with BHECN in achieving its mission. • Increases in participation are documented annually.
Goal VI.2. Develop and successfully execute an education and communications plan that increases the visibility of BHECN as a resource.	*Key Success Measures* • BHECN is a leading resource for information on behavioral health workforce, education, training and interprofessional delivery of services of value to stakeholders, the public and the professions.
Goal: VI.3. Conduct and/or participate in statewide and/or regional meetings to enhance collaboration, facilitate awareness and disseminate model education, training and delivery systems.	*Key Success Measures* • BHECN is a leading resource supporting the behavioral health workforce.

STRATEGY VII. RESOURCES: FINANCIAL & OPERATIONAL – Build a viable infrastructure to meet the goals of BHECN's mission and fund its strategic initiatives.	
Goal VII.1. Maintain an organization that operates in an efficient and fiscally responsible manner.	*Key Success Measures* • Five-year budget is developed, approved and followed with fiscal planning aligned with strategic plan. • Financial reports inform decision-making. • No substantial financial or management issues are noted in Audit Report. • Financial decision-making is effective, transparent and consistent with Strategic Plan. • Grant opportunities are identified, sought and attained.
Goal VII.2. Develop and maintain a committed staff to support BHECN's Strategic Plan.	*Key Success Measures* • BHECN has competent staff to meet goals. • Staff has the necessary skills to accomplish current and anticipated responsibilities. • Appropriate balance of in-house staffing and outsourcing with partners and contractors effectively support the BHECN mission. • Performance is optimal and policies are consistently followed by staff, partners, and contractors.
Goal VII.4. Resources enable the organization to operate in an efficient and fiscally responsible manner.	*Key Success Measures* • BHECN offices are an effective work environment. • Resources support BHECN's mission.

GLOSSARY OF TERMS

DESIGNATION AS A MEDICALLY UNDERSERVED AREA OR MEDICALLY UNDERSERVED POPULATION (MUA/P) allows communities to pursue federal funding for a Federally Qualified Health Center. The Index of Medical Underservice consists of four components: 1. The percentage of the population below poverty; 2. The percentage of the population that is elderly; 3. The infant mortality rate; and 4. The availability of primary care physicians. To see a list of currently designated MUA/Ps, visit http://muafind.hrsa.gov/index.aspx.

INTERPROFESSIONAL EDUCATION refers to occasions when students from two or more professions learn with, from, and about each other to improve collaboration and quality of care during all or part of their professional training with the object of cultivating collaborative practice for providing client and/or patient centered care. Interprofessional learning involves students learning from students from other professions, as well as learning with students from other professions, for example in the classroom, and learning about other professions. Associated terms are "multi-professional education", "common learning", "shared learning", and "interdisciplinary learning." (Wikipedia, accessed January 28, 2010 at http://en.wikipedia.org/wiki/Interprofessional_education.) . "…the application of principles of adult learning to interactive, group-based learning that relates collaborative learning to collaborative practice within a coherent rationale..." (Barr, H. 2002).

Learning collaborative is outlined by the Institute for Healthcare Improvement integrates interdisciplinary practice and interprofessional learning in continuous improvement as part of the daily work of health services delivery and health professions education. Through shared learning, teams from a variety of organizations work with each other and informed faculty to rapidly test and implement changes that lead to lasting improvement. The "learning collaborative" approach includes clinical staff working together to redesign their systems to become more patient-focused and efficient.

PARTNERS include those entities that participate in achieving the BHECN mission and share common goals. Partners will include persons who have interest in behavioral health care education, training, and delivery, including recipients of care and their family members, academics, professional associations, public health departments, service delivery facilities, law enforcement, criminal justice, educational institutions from high schools through graduate schools, funders and government officials. Partners will be involved through activities in a learning collaborative model as outlined by the Institute for Healthcare Improvement and as required by the legislation. This model establishes partnerships in order to develop and disseminate evidence-based, recovery-focused, interprofessional curriculum and training for behavioral health professionals delivering services in community-based agencies, hospitals, and law enforcement.

PARTNERSHIPS are defined as collaborative working relationships among organizations formalized through one or more written agreements. Agreements should involve, at a minimum, the substantial and meaningful contributions of personnel, expertise, money, equipment, facilities or other important resources to and from each of the partners, and appropriate data-sharing agreements. Partner organizations must represent at least two different sectors (including, but not limited to, academics, purchasers, providers, payers, public health entities, community groups, etc.). Although partnerships may include major research institutions and individuals who primarily conduct research, they also must include institutions and individuals that are primarily engaged in workforce development, provision, coordination, or purchasing of health care or the payment for health care services. The Agency for Healthcare Research and Quality (AHRQ) encourages partnerships that include: (1) rural areas, (2) public hospitals and primary care programs such as community health centers, or (3) strong involvement of a diverse group of lay citizens.

STAKEHOLDERS include those persons or organizations (e.g., consumers, behavioral health organizations, educational institutions or the public), who are actively involved in the project or whose interests may be positively or negatively affected by the performance or completion of the project.

EXECUTIVE SUMMARY-COPH 2011 WORKFORCE ANALYSIS REPORT

As a rural state, Nebraska faces unique challenges with its behavioral health system. Rural areas have a greater burden of mental health diseases and health care workforce shortages than do urban areas. Mental health providers are less likely to practice in rural and frontier counties. This rural-urban disparity in behavioral health workforce supply and distribution holds true for Nebraska.

Assessing current workforce supply is, however, complicated by the lack of regularity and consistency in the collection of data on the behavioral health workforce. Additionally, the behavioral health workforce is complex in that it encompasses many different disciplines. The disciplines' professional roles are not clearly defined, and there is a lack of distinction between their scopes of practice. In spite of these challenges, estimating the behavioral health workforce supply and need is critical to the state's health workforce planning efforts.

In June 2011, the staff of the Nebraska Center for Rural Health Research completed an assessment of Nebraska's current and past behavioral health workforce. The aim of this project was to provide the Behavioral Education Center of Nebraska with the critical information needed to guide future planning efforts of the state with regards to priority areas and regions to focus on.

Nebraska is ahead of many states in terms of collecting data on the supply of health professionals practicing in the state. The Health Professions Tracking Service (HPTS) at the College of Public Health, University of Nebraska has been tracking the state's behavioral health professional workforce for a decade. The data for this project were obtained from the Health Professions Tracking Service (HPTS) annual survey database from 2000 to 2010. The study estimated the current and past supply and distribution of behavioral health professionals and current and future need for behavioral health professionals, as well as described training programs in the state, best practices in behavioral health workforce development and provided recommendations for future workforce planning efforts.

Key Findings

Psychiatrists

- Among the 161 actively practicing psychiatrists in Nebraska in 2010, 137 were board certified, and 24 were board eligible.
- Only 15 of Nebraska's 93 counties had at least one practicing psychiatrist in 2010.
- The majority (81.4%) of Nebraska's psychiatrists were actively practicing in metropolitan counties in 2010.
- Half (50.0%) of psychiatrists (including all MDs and DOs specialized in psychiatry and excluding residents) were older than 50 years and likely to retire within the next 10 to 15 years.
- Over half (52.2%) of psychiatrists received their medical training in Nebraska, and 29.2% were foreign medical graduates.

Psychiatric Nurse Practitioners

- There were 62 nurse practitioners (NPs) who were specialized and trained (i.e., board certified) in psychiatry actively practicing in Nebraska in 2010.
- In 2010, psychiatric NPs were practicing in only 13 counties. In five of these counties (Box Butte, Cuming, Custer, Dodge, and York), NPs were the only psychiatric prescribers available.
- Almost two-thirds (64.1%) of NPs practicing psychiatry were practicing in metropolitan counties in 2010.
- Over half (69.3%) of NPs practicing psychiatry were older than 50 years.

Psychologists

- There were 318 full-time and part-time psychologists in Nebraska in 2010. The ratio of psychologist to population in 2010 was lower than the national ratio in 2006.
- In 2010, only 22 counties of Nebraska's 93 counties had at least one practicing psychologist.
- The majority (77.7%) of Nebraska's psychologists were actively practicing in metropolitan counties in 2010.
- Over half (58.7%) of psychologists were older than 50 years.
- Over a third (37.7%) of Nebraska's psychologists, were trained in the state, while over half were trained outside the state.

Aging of Mental Health Providers

- In nine of the 15 counties with at least one practicing psychiatrist, 30% or more of the psychiatrists practicing in the county were in the pre-retirement age group (55 years and older) as of 2010.
- In five of the 13 counties where NPs were practicing psychiatry in 2010, 30% or more of the NPs practicing in the county were in the pre-retirement age group.
- In 16 of the 22 counties with at least one psychologist, 30% or more of the psychologists practicing in the county were in the pre-retirement age group.

Mental Health Shortage Areas

- In 2011, 88 of Nebraska's 93 counties are federally designated mental health professional shortage areas. Only mental health catchment area 6 (Cass, Dodge, Douglas, Sarpy, and Washington) are not federally designated mental health professional shortage areas in 2011.
- In 2010, 81 of Nebraska's counties were state-designated shortage areas for psychiatrists and mental health, and nine counties (Butler, Cass, Dodge, Gage, Otoe Saunders, Saline, Seward, and Washington) were state-designated as a partial shortage area. Only three counties (Douglas, Lancaster, and Sarpy) and areas within a 25 mile buffer surrounding the cities of Lincoln and Omaha are not eligible to be state designated shortage areas.

Counties with High Mental Health Needs

- In 2009, 74 out of Nebraska's 93 counties were identified as having unusually high needs for mental health services based on the Health Resources and Services Administration's (HRSA) mental health professional shortage criteria.
- In 2009, 70 out of the 74 Nebraska counties that were identified as having unusually high needs for mental health services were also identified as having no psychiatrist or the ratio of psychiatrist-to-population was below 1:15,000.

Conclusions

Based on the findings of this study, it is clear that:

- Nebraska faces a critical shortage of behavioral health providers and this shortage is likely to get worse, if proactive steps to address regional shortages are not taken.
- Nebraska has many areas with high need for mental health services and many of these high mental health need areas also have low health care provider supply.
- There is significant geographical mal-distribution of the behavioral health workforce which could be positively impacted by the increased availability of training opportunities in rural and frontier areas.
- In addition, another issue of concern is the graying of the mental/behavioral health workforce. This coupled with an aging population that is becoming increasingly more diverse, would likely drive further demand for mental/ behavioral services in the future.
- A coordinated approach to workforce development will be necessary to address all of these issues.

Recommendations

The findings of the study were disseminated to practicing behavioral health professionals and educators in the state and their feedback was incorporated in to the recommendations. The recommendations are as follow:

- Identify and integrate core performance measures in behavioral health workforce development with new and existing data collection methods.
- Strengthen current programs aimed at recruitment and retention of behavioral health professionals in rural (non-frontier) areas of the state.
- Expand tele-health and other telecommunications models to deliver mental and behavioral health services for hard to reach populations in frontier areas of the state.
- Continue to produce the BHECN/ UNMC College of Public Health workforce analysis reports on the licensed behavioral health workforce on a bi-annual basis.
- Expand the scope of the behavioral health workforce analysis report to include the recruitment/retention of the licensed behavioral health workforce, the integration of behavioral health care into primary care and include an analysis of the unlicensed behavioral health workforce (direct care workers).
- Identify barriers to expand workforce supply in shortage areas.
- Create a report on the educational pipeline that includes professions' definitions, educational requirements, scope of practice, needs of provisional licensure and training during professional development and continuing education requirements, and the impact of workforce participation rates and board eligibility on the workforce's ability to meet the mental health needs of patients.

2009 Behavioral Health Information Technology Summit

Executive Summary

On October 30, 2009, the Nebraska Behavioral Health Education Center sponsored the first UNMC Behavioral Health Information Technology Summit to discuss cost effective ways to provide behavioral health education and service delivery. The goals of the conference were to stimulate a collaborative discussion about behavioral health distance education and services to Nebraska for the purposes of:

- Increasing collaboration
- Leveraging resources between existing projects
- Discussing barriers, challenges, and solutions

The summit was attended by 30 key participants from 17 different departments within UNMC to develop a vision for behavioral health information technology (BHIT) in three areas: 1) Clinical Supervision/Education, 2) Service Delivery and 3) Administration/Technical Support.

Barriers to BHIT

A series of existing barriers to BHIT development were identified. The current barriers fell into eight categories:

1. Workforce Issues
2. Training Problems
3. Funding Regulatory Issues
4. Data Issues
5. Infrastructural Issues
6. Technology: Standardization
7. Personnel Issues
8. Models

Solutions

Once the barriers were identified, the participants focused on the development of solutions that would facilitate the vision for BHIT. Overall, the attendees agreed upon a need to develop system wide task forces to identify strategic goals for the three areas of BHIT needs.

Breaking the Barriers to Behavioral Health Technology Second Annual Behavioral Health Information Technology Summit October 29, 2010

Executive Summary

The 2010 Behavioral Health Information technology (BHIT) summit focused on further refining the barriers and examining various solutions to effective use of any form of telecommunications for behavioral health care workforce shortages.

The conference began with a presentation a virtual care model by Andrew Barbash, MD, Medical Director, Neurosciences and Stroke Program Holy Cross Hospital, Maryland. Dr. Barbash's presentation on real time telecommunications strategies is consistent with the emerging evidence on the effectiveness of using both telehealth, and secured web conferencing to deliver behavioral health care education and services.

Solutions to Implement the Vision

The 2010 BHIT Summit workgroups addressed the four major issues of developing clinical supervision/education models, designing a model for state wide infrastructure of BHIT, Implementing plans for BHIT service delivery and addressing regulatory issues that would hamper the growth of telecommunications solutions for behavioral health care. Recommendations were:

Group 1

• Identification and use of the existing behavioral health care workforce.
• Partner with rural providers to reduce professional silos and isolation associated with being the only provider in rural areas.
• Work on recognition and use of consumers in a service delivery role as peer specialists within the interprofessional model.
• Use new forms of telecommunications using the American Telehealth Association guidelines which expanded the number of platforms used to deliver services.
• Develop shared courses on telecommunications services that could be taken by all healthcare professionals

Group 2

• Development of a statewide point of access/tiered system across multiple platforms.
• Integration with the NeHI system across all Telehealth platforms.

Group 3

• Ensure that all telehealth telecommunications methods comply with HIPAA and FIP 142 standards for confidentiality and encoding of all patient related information.
• Rely on more than one model of telehealth\telecommunications for service solutions
• Use of both telehealth network and web based technology to maximize flexibility of tools.
• Address regulatory and reimbursement issues with Medicaid, CMS and Joint Commission.

Group 4

• Form a task force of select individuals to examine the regulatory and reimbursement problems with Medicaid and Medicare

• Map out solutions for BHIT within the regulations for Nebraska.

Summary

The four workgroups demonstrated a convergence of opinions on the development of future telecommunications efforts for BHIT across Nebraska. The work groups advocated for an approach that utilized multiple levels of telecommunications technologies available through a one site internet source which then broke out into a variety of secure technologies dependent on the self determined level of need. The group also advocated for the development of task forces to address the issues of reimbursement and regulatory issues that hampered the implementation of BHIT for the state of Nebraska.

BHECN ROUTINE MEETINGS AND ADVISORY GROUPS

BHECN Advisory Council
Purpose: This group is developed to provide broad partner participation on review of plans, priorities and activities of BHECN. Advisory Council members include the primary partners: UNMC, Creighton, UNO, The Nebraska Medical Center, Alegent Health, Community Alliance, community leaders, consumers, state agency personnel, government officials. Work groups may be created to focus on special issues. An Executive Committee of the Advisory Council will review and comment on detailed plans and budget and set the agenda for Advisory Council meetings.
Membership: Beth Baxter, Region 3 Behavioral Health, Carol Coussons de Reyes, NE Department of Health and Human Services, Scot Adams, Director, NE Department of Health and Human Services, Blaine Shaffer, Chief Clinical Officer, Nebraska Department of Human Services, Rowen Zetterman, Dean, CUMC, Rhonda Hawks, Community Leader, Carol Boye, Chief Executive Officer, Community Alliance, Thomas Lynch, Director, Veterans Administration, Eleanor Howell, Director of Creighton College of Nursing, David Crouse, Associate Vice Chancellor of Academic Affairs, UNMC, Sheree Keely, Vice President, Alegent Health, Timothy Cuddigan, President, National Alliance of Mental Illness, Ken Stinson, Community Leader, BJ Reed, Dean, Public Affairs UNO, Rod Markin, Dean, UNMC Glen Fosdick CEO, Nebraska Medical Center, Gary Hastings, Region 1 Nebraska Panhandle Area Health.
Meeting Frequency: Three times a year

Executive Committee of the BHECN Advisory Council
Purpose: The purpose of the Executive Committee is to review the BHECN strategic plan and budget in detail and make comments. Committee members are also available for urgent suggestions if necessary. The Executive Committee will set the agenda for Advisory Council Meetings.
Membership: Chair Rod Markin, M.D.; Steve Wengel, M.D.; Dan Wilson, M.D., Ph.D.; Eleanor Howell, Ph.D., RN; Rhonda Hawks
Meeting Frequency: At least three times a year

BHECN Region I Advisory Council
Purpose: Support the recruitment, retention and competency of Region 1 behavioral workforce by providing education and training in evidence-based practice, inter-professional collaboration and use of behavioral telehealth services to expand outreach and serve residents of the counties within Region 1.Advisory Council Members: Jennifer Sibal, Mary Wernke, Melissa Van Galder, Mike Gaudreault, Jessica Davis, Sue Herdt, Donna DeForge, Patsy Fulk
Meeting Frequency: Monthly

BHECN Region III Advisory Council
Purpose: Support the recruitment, retention and competency of Region 1 behavioral workforce by providing education and training in evidence-based practice, inter-professional collaboration and use of behavioral telehealth services to expand outreach and serve residents of the counties within Region 1.Advisory Council Members: Rosie Anderson, Beth Baxter, Melissa Craig, Sarah Cunningham, Tammy Fiala, Kay Glidden, Kris Hervert, Katilynn Killion, Wanda Kjar-Hunt, Lori McArthur, Cindi McDowell, Mandy Meyer, Matt Mims, James Newland, Denise O'Brien, Rebecca Ott, Marilyn Reilly, Beth Reynolds,
Greg Urbanek, Maha Younes, KaCee Zimmerman, Denise Zwiener
Meeting Frequency: Quarterly

Academic Support Work Group
Purpose: Review performance measures for BHECN, participate in grant applications and set priorities for development of shared curriculum materials. University graduate faculty in psychology, psychiatry, nursing, social work, pharmacology, medical family therapy, substance abuse treatment, public health, and counseling, will participate with BHECN to improve the recruitment, retention and education and training available to the behavioral health workforce in all areas of the state.
Membership:

1. Chair - Child Psychology	Joe Evans, PhD	UNMC/MMI Psychology
2. UNMC Psychiatry	Steve Wengel, MD	UNMC Psychiatry
3. Marriage & Family Therapy	Dave Robinson, PhD	UNMC/UN-L MFT
4. Psychology	Will Spaulding, PhD	UN-L Psychology
5. Psychiatric Nurse Practitioners	Michael Rice, PhD	UNMC Nursing
6. Social Work	Jane Woody, PhD	UN-O Social Work
7. Counseling	Grace Mims, PhD	UN-K Counseling & School
8. Creighton Psychiatry	Jim Madison, PhD	CU Psychiatry
9. Child Psychiatry	Howard Liu, MD	UNMC Psychiatry

Meeting Frequency: Quarterly

BHECN Executive Faculty Meeting
Purpose: Provide a timely review of BHECN activities, review and prioritize opportunities for grants, training and education and assure the interprofessional nature of BHECN projects.
Membership: Michael Rice, Howard Liu, Joe Evans, Susan Boust, and Brent Khan
Meeting Frequency: Weekly

BHECN Staff Meeting
Purpose: Provide a review and update on all BHECN activities and assure staff support for successful completion of BHECN projects.
Membership: Susan Boust, Brent Khan, Carla Swartz, Kim Carpenter, Stephanie Paul, Robin Bayless,
Meeting Frequency: Weekly

BHECN/ LHRC Steering Committee
Purpose: Provide oversight to the joint BHECN/ LHRC interprofessional training site
Membership: Sheree Keely, Steve Wengel, Robin Conyers, Bill Roccaforte, Susan Boust, Brent Khan, Jim Madison, Staci Rosche, Trent Jensen, Steve Spelic,
Meeting Frequency: Monthly

BHECN/ LHRC Implementation Subcommittee
Purpose: Provide rapid staff work to implement Steering Committee decisions
Membership: Steve Spelic, Jim Madison, Brent Khan, Trent Jensen, Susan Boust
Meeting Frequency: Weekly

BHECN/ Community Alliance Steering Committee
Purpose: Provide oversight to the joint BHECN / Community Alliance interprofessional training site
Membership: Carole Boye, Aileen Brady, Bill Baerentzen, Michael Rice, Susan Boust, Brent Khan, Nancy Enquist
Meeting Frequency: Monthly

BHECN / Community Alliance Implementation Subcommittee
Purpose: Provide rapid staff work to implement Steering Committee decisions

Membership: Michael Rice – Chair, Sheritta Strong, Rebecca Wysoske, Jennifer Sparrock, Bill Baerentzen, Jim Wilson, Susan Boust
Meeting Frequency: Weekly

BHECN/ Psychiatry Residency Training Committee
Purpose: Provide oversight to the implementation of BHECN psychiatry resident initiatives of LB 603
Membership: Jim Madison, Steve Wengel, Tom Svolos, Bill Roccaforte, Dan Wilson, Susan Boust, Brent Khan
Meeting Frequency: Monthly

BHECN / Information Science and Technology (IS&T) Learning Group
Purpose: Increase collaboration between BHECN and UNO's IS&T to solve technical problems and obtain grants to improve IT support of behavioral health.
Membership: Dr. Susan Boust, Brent Khan, Ann Fruhling, PJ Pokhrel, Dr. Carl Greiner, GJ DeVreede
Meeting Frequency: Twice a month

BHECN Depression Module Development Team
Purpose: to design and develop interactive depression module series
Membership:

Catherine Bevil, EdD, RN
Susan Boust, MD
Angie Brennan, MD
Darwin Brown, PA-C, MPH
Patricia Carstens, MS
Lois Colburn
Richard Fisher
Teri Gabel, PharmD, BCPP
LiJoan Husted, HRM, CMP
Diana Hutchison, MS, Ed
Brent Khan, MA
Heidi Keeler, PhD, RN
Howard Y. Liu, MD
Brenda McIlnay, LCSW, LIMHP
Dennis McNeilly, PsyD
Chelsea Neumann, BA
Paul Paulman, MD
Michael Rice, PhD, APRN-NP, FAAN
Dave Robinson, PhD
Steven Wengel, MD
Nicole Westercamp, BS
James Wilson, PharmD, BCPP
Kathleen Yao, MSN, APRN-WH

Meeting Frequency: Twice a month

BHECN PARTNER SUPPORT

Region 3
Behavioral Health Services
4009 6th Avenue, Suite #65 • P.O. Box 2555 • Kearney, Nebraska 68848-2555
Phone: 308-237-5113 • FAX: 308-236-7669
WEBSITE: www.region3.net

July 14, 2011

Dear Members of the Nebraska Legislature:

My name is Beth Baxter, Regional Administrator for Region 3 Behavioral Health Services (Region 3) in Kearney, Nebraska. I am writing as a community partner who has greatly benefited from the programs, educational opportunities and support of the Behavioral Health Education Center of Nebraska (BHECN).

Region 3 has partnered with BHECN in the formation of a regional project and advisory council serving twenty-two counties in central and south central Nebraska. Through the support of BHECN's Community Outreach Specialist the Region 3 BHECN project has been able to bring together major stakeholders in our area with an interest in strengthening both the educational opportunities for behavioral health professionals and increasing the number of professionals in our area.

We have completed a formalized workforce needs assessment and identified several priority areas to focus our efforts. This will assist us in addressing the behavioral health workforce needs identified throughout our region and strengthening our recruitment and retention efforts. BHECN is also assisting us in better interfacing with physical health providers and moving towards a more integrated model to address both the behavioral health and medical needs of the individuals we serve across the region.

BHECN has also supported our efforts to increase the utilization of evidence-based practices to better serve children and adolescents who experience behavioral health challenges and their families. BHECN co-sponsored with Region 3 the *Impacting Children's Mental Health A Trauma-Focused Cognitive Behavioral Therapy* Training that trained 23 practicing clinicians in the Kearney, Grand Island, Broken Bow and Hastings areas.

We are looking forward to continuing the strong partnership with BHECN in order to strengthen the behavioral health workforce throughout central and south central Nebraska. I would like to urge you to continue your support of the Behavioral Health Education Center of Nebraska and the valuable resources it brings to rural Nebraska. Without BHECN resources, we would not have been able to accomplish many of our workforce efforts.

Sincerely,

Beth Baxter

Beth Baxter
Regional Administrator

Counties: Adams, Blaine, Buffalo, Clay, Custer, Franklin, Furnas, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler

NP-AHEC, Inc.
2620 College Park
Scottsbluff, NE 69361

NEBRASKA PANHANDLE AHEC
Area Health Education Center

Telephone: (308) 635-6711
Fax: (308) 635-6704
www.np-ahec.org

August 18, 2011

Dear Dr. Boust,

I am Gary Hastings Executive Director of the Nebraska Panhandle Area Health Education Center (NP-AHEC). On behalf of the Nebraska Panhandle AHEC, I would like to offer support the need for the outreach focused on mental health. The need to provide mental health for children and adolescents is greatly needed in the panhandle of Nebraska. Our population base is very rural and the availability for behavioral Health care is very limited due to the travel distance parents are required to transport their children and the scarcity of providers who are well trained to provide the care that the children and adolescents need.

This opportunity comes at an especially important time as we focus on the training of providers. We are supportive your efforts through the Behavioral Health Education Center of Nebraska (BHECN) program to find solutions to the important issues of the mental health of children and adolescents. We are willing to collaborate in any way we can. We recognize that the BHECN program could provide mental health care for children and adolescents in the panhandle of Nebraska which is rural and an underserved area.

We have a Native American population that is being affected by a large increase in the suicide rate of their adolescents. The farming communities are struggling to the high cost of operation and continual increase in the mechanization of the farming industry. Jobs are hard to find and this has brought about a noticeable effect on the family and especially their children.

Please do not hesitate to contact our office if there is any assistance you need. We are excited at the prospect of what BHECN does.

Sincerely,

Gary Hastings
Executive Director of NP-AHEC
Scottsbluff, NE 69361

"Connecting Students to Careers, Professionals to Communities, and Communities to Better Health"

"Working Together to Shape Healthy Communities"

A nonprofit Area Health Education Center (AHEC) operating in partnership with the University of Nebraska Medical Center, Nebraska AHEC Program Office, funding in part through the Health Resources & Services Administration, Bureau of Health Professions Federal Grant U76 HP 00592.