The State-Licensed Care Facilities Oversight Committee

Final Report

December 15, 2019

Submitted Pursuant to LR104 (2019)

Acknowledgements

The State-Licensed Care Facilities Oversight Committee wishes to thank Jerall Moreland, Deputy Ombudsman for Institutions, for generously sharing his time and expertise with the committee. His guidance and suggestions throughout the committee's work were invaluable.

Additional thanks go to the Legislative Research Office for providing staff support to the committee and assisting with the preparation of the Final Report.

Committee Members

Senator Curt Friesen, Chairperson
Legislative District 34

Senator Lynne Walz, Vice Chairperson
Legislative District 15

Senator Steve Halloran
Legislative District 33

Senator Lou Ann Linehan
Legislative District 39

Senator Dave Murman
Legislative District 38

Senator Dan Quick
Legislative District 35

Senator Anna Wishart
Legislative District 27

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Background

In 2004 the Nebraska Legislature passed LB1083 (the Nebraska Behavioral Health Services Act) to reform how the state provides behavioral health services. Key provisions of the act include: creation of a new division within DHHS to oversee the public behavioral health system; tasking the six behavioral health regions with developing and providing community-based behavioral health services; and ultimately, closure of the regional centers.

The new division was charged with "encouraging and facilitating" the statewide development and provision of an appropriate array of community-based behavioral health services and continuum of care in order to: (a) provide greater access to services and improved outcomes for consumers; and (b) reduce the necessity and demand for regional health center behavioral health services.[1]

With community-based services in place, it would be possible to gradually transition persons from the regional centers to the community, resulting in a reduction in the necessity and demand for regional center services and the eventual closure of the Norfolk and Hastings regional centers. All funds saved from reducing or discontinuing the provision of regional center services would be reallocated to develop and provide statewide community-based behavioral health services.[2]

As envisioned, people have transitioned from the regional centers, but significant gaps in the availability of community-based services have left many individuals who experience serious mental illness[3] on their own without the services and supports they need. Among the most significant gaps is the lack of appropriate residential options. Consequently, a segment of the population with serious mental illness has turned to assisted-living facilities to fill their housing needs. Courts, guardians, and family members have also placed individuals in their charge into these facilities. Assisted-living facilities are not well-suited to serving

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[1] Neb. Rev. Stat. sec. 71-810

[2] Health and Human Services Committee, Nebraska Legislature. Committee Statement: LB 1083. (2004). Retrieved from https://nebraskalegislature.gov/FloorDocs/ 98/PDF/CS/LB1083.pdf

[3] Serious mental illness is defined as having, at any time during the previous year, a diagnosable mental, behavioral, or emotional disorder that causes serious functioning impairment that substantially interferes with or limits one or more major life activities. Serious mental illnesses include conditions such as major depression, schizophrenia, and bipolar disorder. (Federal Register Vol. 64, No. 121)

individuals suffering from serious mental illness. While many facilities do a good job, others fall far short, even to the point of posing a health and safety risk to the individuals living in them.

All assisted-living facilities must be licensed. DHHS licenses and oversees assisted-living facilities pursuant to Title 175 Chapter 4 of the Nebraska Administrative Code as authorized by the Assisted Living Facility Act[4] and the Health Care Facility Licensure Act.[5]

In 2018, after the death of a resident at one such substandard facility -- Life Quest in Palmer, Nebraska -- and a failure by the Department of Health and Human Services (DHHS) to take timely and appropriate action, the Legislature created the State-Licensed Care Facilities Oversight Committee via LR296 (Walz).

The LR296 Committee was established to study the following:

- the closure of the Life Quest mental health centers in Palmer and Blue Hill, Nebraska;
- the living conditions in state-licensed assisted-living facilities housing large populations of residents diagnosed with serious mental illness;
- the quality of treatment provided for residents in assisted-living facilities with a diagnosed serious mental illness;
- how effectively DHHS performs its oversight function in the licensing and regulation of assisted-living facilities;
- how DHHS implements and administers behavioral health services through the behavioral health regions;
- DHHS's progress in implementing the recommendations of its consultant, the Technical Assistance Collaborative (TAC) on developing better housing alternatives for individuals diagnosed with serious mental illness; and
- the adequacy of the steps DHHS is taking to ensure behavioral health services are being administered pursuant to regulations in the Americans with Disabilities Act requiring that public agencies provide services in the most community-integrated setting appropriate.

In December 2018, the LR296 Committee issued a final report with 20 recommendations for actions to be taken by DHHS, the Legislature, and others. A copy of the recommendations put forth by the LR296 Committee is attached as Appendix 1.

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[4] Neb. Rev. Stat. secs. 71-5901 to 71-5908
[5] Neb. Rev. Stat. secs. 71-401 to 71-459

The recommendations included continuing the State-Licensed Care Facilities Oversight Committee. Among its duties, the new committee would:

- monitor DHHS's progress in strengthening its facility inspection process;
- study how the behavioral health regions are serving residents in assisted-living facilities suffering from severe mental illness;
- monitor DHHS's progress in implementing the recommendations in the TAC report; and
- continue the review of the incidents leading to the closure of the Life Quest facility in Palmer, Nebraska, and the sufficiency of DHHS's response.

Legislative History and Activities

Legislative History

The 2019 State-Licensed Care Facilities Oversight Committee (LR104 Committee) was established by LR104 (Walz) and tasked with continuing the work of the LR296 Committee.

Committee Activities

The LR104 Committee conducted the following activities:

Meetings

- The LR104 Committee met three times in 2019: August 23, September 26, and December 2.
- The following individuals provided information to the committee:
  - > Carla and Jereme Hill - Co-owners of Prescott Place Assisted-Living Facility in Lincoln;
  - > Pattie Jurjevich - Region 6 Program Administrator;
  - > Sheri Dawson - Director Division of Behavioral Health (DHHS);
  - > Darrell Klein - Deputy Director Public Health Licensure (DHHS); and
  - > Jerall Moreland - Deputy Ombudsman for Institutions.

Information Requests

- The committee submitted written questions to DHHS. A copy of the questions is attached as Appendix 2.

Findings

Issue 1: Inspection of assisted-living facilities

In 2018, the LR296 Committee determined that DHHS's facility inspection process was inadequate.

In 2018, there were 285 state-licensed assisted-living facilities in Nebraska with 12,768 licensed beds.[6] At that time, DHHS had two full-time staff members responsible for investigating complaints and conducting routine inspections for all 285 facilities. The LR296 Committee felt this number was far too low and recommended that DHHS increase the number of facility inspectors to a level that would allow for an adequate number of inspections, including random inspections.

Today, Nebraska has 285 state-licensed assisted-living facilities with 13,263 beds.[7] DHHS reported to the LR104 Committee that a new Assisted-Living Facility Surveyor position was created in 2018, and that a new surveyor started employment with DHHS in June 2019. The surveyor is based in the Lincoln Office and will cover assisted-living facilities and skilled-nursing facilities in the central part of Nebraska.

The LR296 Committee determined that even though DHHS had a tiered system for triaging the severity of the complaints it received, there were simply too few personnel to quickly and thoroughly investigate serious incidents and complaints.

DHHS advised the LR104 Committee that the Licensure Unit has decreased the response time for complaints triaged as an immediate jeopardy (IJ) situation. State and Federal guidelines allow up to two working days to respond to IJ complaints which, with holidays and weekends, could end up being as many as four days. The Licensure Unit sends surveyors sooner than the two working day requirement, regardless of whether it is a weekend, holiday or after normal business hours.

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[6] Neb. Dept. of Health and Human Services. (2018, November 15). State of Nebraska roster assisted-living facilities. Retrieved from http://dhhs.ne.gov/publichealth/Documents/ALF%20Roster.pdf

[7] Neb. Dept. of Health and Human Services. (2019, November 15). State of Nebraska roster assisted-living facilities. Retrieved from http://dhhs.ne.gov/publichealth/Documents/ALF%20Roster.pdf

DHHS also informed the LR104 Committee that the Licensure Unit reclassified a Staff Assistant II position as a Registered Nurse-Nursing Services Surveyor Consultant (RN-NSSC) Triage and Intake position to increase their capacity to triage the complaints received. DHHS believes this will help streamline the process and provide better service to customers.

Issue 2: Role of the Behavioral Health Regions with assisted-living facilities

The LR296 Committee raised concerns about the role of the behavioral health regions in providing services to residents with serious mental illness living in assisted-living facilities.

According to the Deputy Director of the DHHS Division of Behavioral Health and the Regional Administrator for Region 6, who appeared before the LR104 Committee, regional behavioral health authorities have oversight of the service providers who deliver mental health services to consumers meeting specific financial and clinical eligibility criteria who reside in assisted-living facilities. They do not have oversight or monitoring obligations over the facilities.

Issue 3: DHHS's progress in implementing the recommendations in the TAC report

The Deputy Director of the DHHS Division of Behavioral Health provided the LR104 Committee with a progress update, a copy of which is attached as Appendix 3.

Issue 4: Final Report resulting from the closure of the Life Quest facility in Palmer, Nebraska

The LR104 Committee was advised by the Deputy Director of the DHHS Division of Public Health that the issue had been thoroughly investigated by DHHS. The investigation revealed no problems with established DHHS policies and procedures but there was a failure by certain staff members to follow the existing policies and procedures. The staff in question were terminated. A final report was never issued because the person charged with writing the report left her position and the task was not reassigned.

Issue 5: Concerns raised by assisted-living facility administrators

In 2018, the LR296 Committee repeatedly heard complaints from assisted-living facility administrators that the reimbursement rate for assisted-living facilities serving individuals with serious mental illness is too low.

This concern was again voiced by the administrator of a Lincoln assisted-living facility who appeared before the LR104 Committee. (See Appendix 4 for a copy of her remarks is included as Appendix 4. She detailed some of the challenges they experience in serving residents with severe mental illness. In particular, repairs and maintenance costs are much higher than at a facility that does not serve this population. Doors and windows are repeatedly broken and must be fixed or replaced; dishes get thrown away; beds get destroyed; and holes get punched in walls and have to be patched. At this facility, in the 11 years it has been in operation, the flooring has had to be replaced three times.

Reimbursement per resident is only $1,149 per month. After covering the facility's basic expenses such as the mortgage, taxes, licenses, insurance, staffing, and food, little is left over to cover these significant and unplanned for maintenance costs.

Additional issues raised by this administrator included the difficulty of removing violent or combative clients, the need to offer mental health workers the same statutory protections against assault while on the job as those offered to health care workers, and the financial difficulties incurred when Social Security payments or Aid to the Aged, Blind, and Disabled (AABD) funds are delayed for extended periods of time which happens regularly when a client comes from another facility or the regional center.

Conclusion

The testimony provided to the LR104 Committee shows progress in some of the key areas of concern identified by the LR296 Committee. In addition, DHHS advises that, in the near future, it expects to strengthen the regulations applied to assisted-living facilities. Other concerns identified by the LR296 Committee such as the lack of appropriate housing, especially for those in crisis situations, are ongoing and will need future attention.

In its Final Report, the LR296 Committee noted that it had encountered difficulty obtaining information from DHHS and recommended that DHHS be more timely and forthcoming in responding to legislative requests for information. If this pattern were to continue, the report noted that the Legislature might need to consider mechanisms to ensure better compliance. This recommendation has yet to be implemented. DHHS was asked to submit information for inclusion in this report. Despite repeated assurances that it would be forthcoming, at the time this report was prepared, DHHS had failed to provide any of the requested information.

Recommendations from LR296 Committee Final Report

I. Actions by the Department of Health and Human Services

(A) Incident Investigation and Inspection

Recommendations:

1. Increase the number of facility inspectors to a level that will allow for an adequate number of inspections to keep facilities mindful that they may be randomly inspected at any time.
2. Designate separate staff to investigate complaints/incidents and staff to conduct routine inspections.
3. Continue the comprehensive five-year inspections but conduct more frequent drop-in inspections for all facilities. Facilities with a history of repeated violations or a large number of complaints should be a high priority for drop-in inspections.
4. Require assisted living facilities to self-report incidents or rule violations such as resident on resident violence; resident on staff violence; or the discovery of bed bugs, and institute policies to ensure compliance.

(B) Improved Cooperation and Communication with the Legislature and Improved Data Capability

Recommendations:

1. DHHS should modify its current data reporting capability or put in place a data system capable of monitoring facility complaints and performance history that can produce data for individual facilities in a timely and useable format.
2. DHHS should respond to legislative requests for data and information in a more timely and forthcoming manner. Consideration may need to be given to establishing a protocol requiring DHHS to regularly report to the Legislature on key behavioral health indicators.

Appendix 1

(C) Better Coordination with First Responders

RECOMMENDATION:

1. Establish a protocol to facilitate communication between DHHS Regulations and Licensure and first responders so that incident reports or other matters of concern can be shared with appropriate DHHS personnel in a timely manner.

(D) Planning for Facility Closures

RECOMMENDATION:

1. DHHS should develop a contingency plan of action in the event a facility closes to prevent residents from becoming homeless.

II. REIMBURSEMENT AND FUNDING

(A) Reimbursement Rates

RECOMMENDATION:

1. Establish a special provider rate for assisted living facilities serving large populations of residents diagnosed with serious mental illness. DHHS may have to develop a plan for finding known behavioral health service consumers living in assisted living facilities since this is not information currently tracked by DHHS.

(B) New Funding Streams and Innovative Programs

RECOMMENDATIONS:

1. Undertake a study of how effectively and equitably current funds for behavioral health services are being used and pursue new funding streams such as additional Medicaid Section 1115 behavioral health waivers.

2. Research innovative best practices used by other states to provide housing and supportive services for individuals with serious mental illness.

III. Residential Alternatives

(A) More Residential Alternatives

RECOMMENDATIONS:

1. Develop secure crisis residential facilities across the state for short-term placement of people in psychiatric crisis.
2. Develop long-term, semi-permanent group homes for those individuals with serious mental illness who need a level of care between that provided in a secure residential setting and independent community living. These homes should promote as much community integration as is appropriate for each individual according to his or her needs and capabilities.
3. Develop an array of short-term and long-term transitional housing alternatives to facilitate the transition to more permanent housing.
4. Increase the availability of permanent supportive housing in the state following the recommendations of the Technical Assistance Collaborative.
5. DHHS should provide regular updates to the committee on its progress implementing the TAC recommendations.

(B) Greater Collaboration with the Department of Correctional Services

RECOMMENDATION:

1. Create policies and procedures to increase coordination between DHHS and the Department of Correctional Services to ensure that individuals released from incarceration find appropriate housing and supportive services.

IV. Greater Involvement of the Behavioral Health Regions

Recommendation:

1. The behavioral health regions should take a greater role in serving individuals with serious mental illness residing in assisted living facilities.

V. Legislative actions

(A) Establish a Permanent Legislative Behavioral Health Task Force

Recommendation:

1. Establish a broad-based permanent legislative behavioral health task force to identify service needs and monitor the provision and effectiveness of behavioral health services in the state

(B) Continue the State-Licensed Care Facilities Oversight Committee

Recommendation:

1. The LR 296 Committee should be reestablished in 2019 with a final report due to the Legislature in December 2019.

Nebraska State Legislature

SENATOR CURT FRIESEN

District 34
2209 East 7 Road
Henderson, Nebraska 68371
(402) 723-5339

Legislative Address:
State Capitol
PO Box 94604
Lincoln, Nebraska 68509-4604
(402) 471-2630
cfriesen@leg.ne.gov

COMMITTEES

Chairperson - Transportation and Telecommunications
Vice Chairperson - Revenue
Committee on Committees

November 26, 2019

To: Darrell Klein, Deputy Director Licensure and Environmental Health Section
Bryson Bartels

From: Senator Curt Friesen, Chairperson, LR104 Committee

Re: Questions from LR104 Committee

We regret that HHS will be unable to brief the LR104 Committee on December 2nd. In lieu thereof, I have attached a list of questions that are of interest to the committee for your response. Should schedules change, you are certainly welcome to appear before the committee rather than submitting written answers.

Appendix 2

QUESTIONS FROM LR104 COMMITTEE

1. What changes are being made in the rules and regulations or operating procedures that are related to the work of the LR296/LR104 committee(s)?

2. Please update the committee on the status of hiring new inspectors. In addition, how many inspectors are there and how are their duties allocated? Has there been any change(s) to the inspection schedule?

3. Please describe the process for handling assisted-living facility complaints. What is the average response time once a complaint is received?

4. For each of the past three years (2016, 2017, and 2018) please identify:
   - Approximately how many assisted living facility complaints were received;
   - Approximately what percent resulted in an action being taken by DHHS; and
   - Were any of the complaints considered life-threatening and, if so, how many?

5. How many facilities currently have disciplinary actions pending?

6. Is the department aware of any facilities in danger of closing within the next 12 months?

7. Have there been any changes, or are any anticipated, in the provider rate for assisted living facilities serving large populations of residents with mental illness?

8. Please update the committee on the department's progress toward implementing the TAC recommendations.

9. In light of the fact that there is no official final report regarding the Palmer incident, please tell the committee what actions have been taken in response to the incident and what safeguards are in place to prevent a similar situation from occurring in the future?

Technical Assistance Collaborative PROGRESS UPDATE

September 2019 (condensed):

Within the Division of Behavioral Health scope, feasibility and achievability, the following specific TAC plan related activities underway include the following:

1. Targets, baselines and collection cycle for housing related assistance and living situation achieved. FY18 stable living at discharge (all services): 82.2%. Target for CY19 is 85% with 81.2% reported at midcycle CY19.

Preliminary FY19 data shows 32,203 persons served. Of those discharged, 1.1% were discharged to "other 24 hour residential care". For the new FY, DBH has added Assisted Living Facility as a living situation at discharge drop down choice to be even more specific in data collection.

1001 persons were served through the Housing Related Assistance programming in FY18 and 1019 in FY19 (preliminary count).

Over the last five years, the Lincoln Regional Center has discharged 741 individuals, not including sex offenders. This is an average of 148 discharges/year. Of those discharges, a total of 37 (4.9%) were discharged to an ALF. In FY20 there have been 31 discharges, with 2 individuals discharged to an ALF. It should be noted that guardians also play a role in living situation at discharge referrals.

2. DHHS housing coordination function within DHHS. A DHHS Housing position has been approved and interviews are underway.

3. Identify the gaps in access to housing by DBH populations, geography, waitlists and capacity data. Data sources: 2016 Needs Assessment; Centralized Data System capacity and waitlist functionality including housing related assistance services and waitlists; implementation of data dashboards for stable living. Data is by region, provider, and populations. Will be entering into a new comprehensive needs assessment cycle fall 2019 through 2020. Olmstead planning also includes housing.

4. The development of best practice standards for supportive housing. Rent Wise tenancy training and landlord education occurs in all Regions. DBH completed supported housing fidelity audits.

5. Create an inventory of housing options for consumers, including types through occupancy rates and types of housing assistance. Tracking of vacancies has been determined to not be feasible solely by DBH. This is a current discussion item with the Technical Assistance Collaborative during the current Olmstead Planning process. Collaboration with the Department of Economic Development and other housing entities is critical.

6. Identify housing funds used by women with dependent children. Data system utilization and fiscal reports for services and housing assistance developed. Funds were appropriated for development, housing related vouchers and voucher specific to women with dependent children in FY20.

7. Compile and review network (regional) housing plans, policies and procedures to address standardization of housing coordination and data. Supportive housing fidelity reviews completed.

Develop metrics and use of rehabilitative services and for stable housing. Achieved. Stable living at discharge is a Governor's dashboard metric.

Appendix 3

9. Align cross system prioritization of housing and services and supports for individuals with a behavioral health diagnoses. Ongoing. Cross system integration for persons with disabilities is a component of Olmstea Planning currently underway.

10. Assess housing related assistance funding and funding from appropriations. Achieved. Ongoing. Granular reports in development to better understand use of housing related funds by population, one-time/continuation/development. Continued data improvements to capture populations, applications and wait listing. Appropriations for housing related assistance

	FY19	FY20
Region 1	$ 145,718	$ 159,555
Region 2	171,257	187,019
Region 3	375,326	412,018
Region 4	355,191	387,512
Region 5	707,677	782,964
Region 6	1,144,831	1,270,932
	$ 2,900,000	$ 3,200,000

11. Define housing waitlist and implement tracking and monitoring. Achieved. More clarity on indicators is needed however preliminary data indicates approximately and average of 364 individuals on the waitlist. Th majority of these individuals are in Region 6.

Key Categories of the TAC report also addressed in the DBH Strategic Plan include:

1. Infrastructure / Use capacity and waitlist information to verify needs and populations served. Centralized Data System and Electronic Billing Systems implemented 2016-2017 permit the capturing of clinical and financial information; improved waitlist and capacity data functionality; the inclusion of housing related assistance information in the data system; and the implementation of data sharing agreements between DBH and Medicaid. DHHS has created a housing administrator position within DHHS.

2. Maximize supportive housing opportunities. Ongoing discussions with NIFA and the Dept. of Economic Development to enhance cross-department and community-level planning on resources directed towards new development or renovation to address the supply side of housing needs in Nebraska. Recent housing trust fund requests for proposals awarded that support new or renovated development targeting lower income applicants. The State Opioid Response grant is targeting funds to support outreach and expansion of Oxford Recovery Houses. DBH was appropriated $800,000 one-time funding for housing development. As of August 2019, Nebraska has 48 Oxford Houses providing 356 beds.

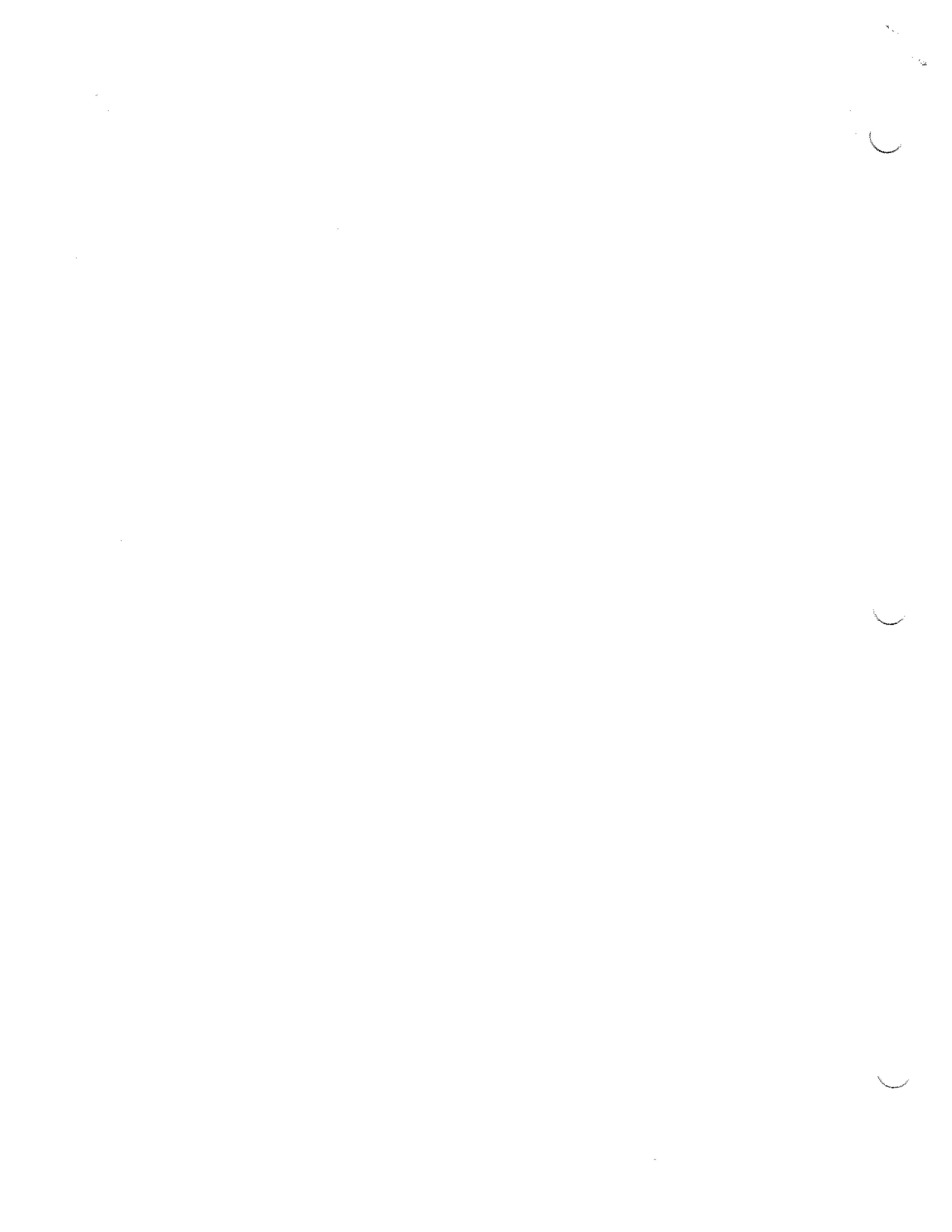
3. Community awareness and positive practices for community inclusion. A "life in the community for everyone" is evidenced through quality improvement auditing of patient centered treatment and rehabilitation plans annually; auditing and surveying of evidenced base practices and outcomes through data calls and dashboard reporting; continued deployment of mental health first aid training statewide through DBH and Public Health which helps people identify, understand and respond to individuals that may need

assistance and helps communities of recovery and inclusion. Mental health and substance use prevention coalitions deploy EBPs and address stigma. Training to landlords and tenant based training are positive practices for community inclusion. Wellness Recovery Action Plans (WRAP), Whole Health Management (WHAM) target strategies at the individual level to support community inclusion. Upgrades to the Network of Care website includes information on policies, practices, laws to promote community awareness. The Network of Care also provides access to communication, advocacy and recovery tools for individuals and families. Nebraska is celebrating Recovery Month in September with a variety of public and private activities.

4. Initiate and lead and Olmstead Planning process. LB 570 in the 2019 legislative session authorizes the continuation of Olmstead Planning work initiated in 2018 with a plan due December 2019.

5. Maximize services and funding strategies to support community integration work.

- New opportunities through the Opioid response grants are expanding recovery housing options.
- DBH was appropriated development and housing related assistance voucher funds for FY20.
- Consumers receive trainings such as Rent Wise to build tenancy knowledge.
- Funds support training to build and sustain landlords serving the target population.
- The Medicaid State Plan Amendment for peer support affords a growing opportunity to maximize resources and grow service provision.
- Fidelity audits of the selected evidenced-base practices of supportive housing and employment completed.
- Best practices now targeted at stable living, employment and education as strong determinants of health that support sustained and integrated community living.
- Performance Dashboards are now routinely reviewed by providers, regions, and DHHS.



Thank you, Senators, for having us today. My name is Carla Hill. I am the administrator for Prescott Place assisted living facility located here in Lincoln Ne. Next to me is my husband, Jereme Hill, who helps run the facility, who overseas Transportation and who oversees our "transitional living" program, which we will talk about later.

I did some research as to the reasoning behind the Senators visit to Prescott Place last fall and the committee's continued research into housing for mentally ill. I am familiar with LB 570 so I will not bore you with the facts of that bill, however, I am going to bring to your attention issues that we are seeing with the mentally ill and their choices for housing.

When doing research, I came across a breakdown by the National Alliance on Mental Health entitled "Securing Stable Housing." Since our model at Prescott is similar to the NAMH model, I decided it would be best to address each type of housing and the issues we personally are incurring in Nebraska.

Supervised Group Housing In Nebraska this can be defined as a licensed assisted living facility.
*It provides 24/7 care and assistance with medication management, daily living skills, meals, etc.

Issue 1. Not every client is assisted living eligible. Some residents are high functioning.

Solution1: No one is forced to be in assisted living unless court ordered or by guardian say. A solution to making sure that mental health individuals who come to live in assisted living be:

A) Be mental health board committed
B) Guardian approved
C) Doctor/Hospital Recommended- client still has final say and choice of facility
D) Elective of client

At our facility we have a step process, clients can be referred by the regional center, hospitals, doctors or other agencies. While at Prescott, our clients work on day to day skills with their case management for example: cleaning, laundry, showering, though still prompted by staff. Depending on the individual client and with doctor's approval the client can take their meds on their own. During this time staff are there to observe changes in behavior and to help answer questions regarding changes in medication. Then with recommendations from the client's team of care providers including myself and Jereme the client takes the next step into moving out on their own. This process time is variable depending on the client.

Issue 2. Funding per client is a low $1149/per client/month=$38.00/day. This amount includes social security and an AABD grant given by DHHS. This does not account for any Medicaid waiver clients. And to be clear, our facility is not equipped to handle Medicaid waiver.

*Out of these rents we pay the mortgage, taxes, licenses, insurance, staffing, food, and the list goes on

*as cost of living goes up, budgets increase. Our increase in funding is based on a social security increase. Social Security has only increased $139 per client over the course of the last 11 years.

*at the end of the day there is little money available to make the facility a nicer place to live as repairs and maintenance are a constant

*doors and windows are broken, dishes thrown away, beds replaced, holes in walls fixed

*in 11 years, we are now onto our 3rd flooring

*We also cover bed bug treatment which is an ongoing battle - by being frugal we were able to to purchase 2 sets of commercial grade bed bug heaters at a cost of around

Appendix 4

$6000.00. This cost doesn't include the special wiring we had installed to accommodate the heaters. We currently heat treat our facility 2 times a year, and spot heat treat rooms if a client notices a problem. We combine this with spray treatment. So, you can imagine our electric bill when commercial grade heaters are running 12 hours a day for 3-4 weeks twice a year.

Solution2: Though this part is not what everyone wants to hear, 'the State of Nebraska needs to increase the grant given to assisted livings for mental health.' This money can be used for hiring more staff, for cleaning, for teaching client classes on how to cook, clean, or budget. It could be used for maintenance, aesthetic improvements or a combination of all the above. In order to continue to receive the increased grant, the facility would have to adhere to certain criteria like hiring more staff, showing improvements or showing what the monies are being used for.

Issue3. Collection of funds-

*It can be months waiting on payments from Social Security, AABD or guardians if they have come from another facility or the regional center. If you are small like we are, this makes a big impact on the monthly budget. We can't just put someone in a tent and not feed them until their money comes in.

*If they leave without notice-can't collect

Solution3: Have a procedure where the client's grant covers the living cost of the facility for the months that the facility is waiting for the social security funds. Once the funds from Social security have been received, the facility returns that money to the State. If the funds are not received through no fault of the facility, the facility can request a waiver on returning those monies. Also have a deposit covered by Economic assistance to cover damages and rents if the client leaves early without notice or causes damages.

Issue 5. Client removal-

*Right now it is a 30-day written notice

* had to evict through legal process and pay out of pocket

*no police support for removal of violent residents

*I have been assaulted, my staff have been assaulted and each time the client was just given a ticket

*Basically, we assume all the risk but we have to take people to stay in business so it is hard to manage risks.

Solution5: Make client removal easier. Make it easier for the police to remove a combative and/or intoxicated client from the property by taking them to detox, jail or the hospital. Protect mental health workers by revising statutes 28-929→931 which states it is a 3rd degree felony to assault a health care worker while on the job. Have those statutes include "mental health workers?" This helps the client realize that they won't just be receiving a ticket for disturbing the peace.

You once asked me if I preferred inspections being more often and less time verses every five years and more time. I will repeat what I said then, it really doesn't matter to me because we are a small facility and our investigations do not take an obscene amount of time.

The one issue that I do have when it comes to investigations is when I have a client who loves to claim that they are being "abused" because they are not getting their way so they make constant calls to

DHHS to claim abuse. It would be nice to have a system in place that stops this from happening. However, I don't know what that is system looks like.

The next category under 'securing stable housing' is:
Partially Supervised Group Housing:
*This is where there is some support for the resident but it is not staffed 24/7.
*Residents are left alone, no medication management, they can clean and cook, have a job or participate in a day program.
*The resident must do something during the day whether it be work or day program.
*They still get transportation services and have access to staff "landlords"
*Case Managers check in and make sure clients are keeping the living areas clean and that they are taking their medications regularly

*Nebraska does not have this type of housing.

The third and final category I am addressing under securing stable housing is
Supportive Housing
It provides limited assistance. Clients live independently and are "helped" by case managers/staff infrequently. They do have someone to call and resources are still available to them. They can cook, clean, and make their own doctor's appointments just to give some examples.

Our house across from Prescott though called transitional living could fall under this category but in Nebraska it actually falls under Landlord/tenant law. In order to live there, the client has to agree to either work or attend a day program. Take their medications regularly and go to their doctor's appointments. However, because of the Landlord/Tenant law we have very limited say in what the client can and cannot do. We can encourage day programs or jobs. We can help them with transportation to and from day program or doctors' appointments however, our hands are tied when it comes to coming in and making sure the resident is cleaning, eating properly or taking their medications.

Our goal is not to have clients live in assisted living for their whole lives. We want to work on getting our clients rehabilitated to a point where they can live on their own. However, we understand that everyone learns/rehabilitates at their own pace and there are some people who won't be able to reach their ability to live independently. This is why there will always be a need for assisted living.

Now I will turn it over to Jereme.

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Thank you, Senators, for having us today. My name is Carla Hill. I am the administrator for Prescott Place assisted living facility located here in Lincoln Ne. Next to me is my husband, Jereme Hill, who helps run the facility, who overseas Transportation and who oversees our "transitional living" program, which we will talk about later.

I did some research as to the reasoning behind the Senators visit to Prescott Place last fall and the committee's continued research into housing for mentally ill. I am familiar with LB 570 so I will not bore you with the facts of that bill, however, I am going to bring to your attention issues that we are seeing with the mentally ill and their choices for housing.

When doing research, I came across a breakdown by the National Alliance on Mental Health entitled "Securing Stable Housing." Since our model at Prescott is similar to the NAMH model, I decided it would be best to address each type of housing and the issues we personally are incurring in Nebraska.

Supervised Group Housing In Nebraska this can be defined as a licensed assisted living facility.
*It provides 24/7 care and assistance with medication management, daily living skills, meals, etc.

Issue 1. Not every client is assisted living eligible. Some residents are high functioning.

Solution1: No one is forced to be in assisted living unless court ordered or by guardian say. A solution to making sure that mental health individuals who come to live in assisted living be:

A) Be mental health board committed
B) Guardian approved
C) Doctor/Hospital Recommended- client still has final say and choice of facility
D) Elective of client

At our facility we have a step process, clients can be referred by the regional center, hospitals, doctors or other agencies. While at Prescott, our clients work on day to day skills with their case management for example: cleaning, laundry, showering, though still prompted by staff. Depending on the individual client and with doctor's approval the client can take their meds on their own. During this time staff are there to observe changes in behavior and to help answer questions regarding changes in medication. Then with recommendations from the client's team of care providers including myself and Jereme the client takes the next step into moving out on their own. This process time is variable depending on the client.

Issue 2. Funding per client is a low $1149/per client/month=$38.00/day. This amount includes social security and an AABD grant given by DHHS. This does not account for any Medicaid waiver clients. And to be clear, our facility is not equipped to handle Medicaid waiver.

*Out of these rents we pay the mortgage, taxes, licenses, insurance, staffing, food, and the list goes on

*as cost of living goes up, budgets increase. Our increase in funding is based on a social security increase. Social Security has only increased $139 per client over the course of the last 11 years.

*at the end of the day there is little money available to make the facility a nicer place to live as repairs and maintenance are a constant

*doors and windows are broken, dishes thrown away, beds replaced, holes in walls fixed

*in 11 years, we are now onto our 3rd flooring

*We also cover bed bug treatment which is an ongoing battle - by being frugal we were able to to purchase 2 sets of commercial grade bed bug heaters at a cost of around

$6000.00. This cost doesn't include the special wiring we had installed to accommodate the heaters. We currently heat treat our facility 2 times a year, and spot heat treat rooms if a client notices a problem. We combine this with spray treatment. So, you can imagine our electric bill when commercial grade heaters are running 12 hours a day for 3-4 weeks twice a year.

Solution2: Though this part is not what everyone wants to hear, 'the State of Nebraska needs to increase the grant given to assisted livings for mental health.' This money can be used for hiring more staff, for cleaning, for teaching client classes on how to cook, clean, or budget. It could be used for maintenance, aesthetic improvements or a combination of all the above. In order to continue to receive the increased grant, the facility would have to adhere to certain criteria like hiring more staff, showing improvements or showing what the monies are being used for.

Issue3. Collection of funds-

*It can be months waiting on payments from Social Security, AABD or guardians if they have come from another facility or the regional center. If you are small like we are, this makes a big impact on the monthly budget. We can't just put someone in a tent and not feed them until their money comes in.

*If they leave without notice-can't collect

Solution3: Have a procedure where the client's grant covers the living cost of the facility for the months that the facility is waiting for the social security funds. Once the funds from Social security have been received, the facility returns that money to the State. If the funds are not received through no fault of the facility, the facility can request a waiver on returning those monies. Also have a deposit covered by Economic assistance to cover damages and rents if the client leaves early without notice or causes damages.

Issue 5. Client removal-

*Right now it is a 30-day written notice

* had to evict through legal process and pay out of pocket

*no police support for removal of violent residents

*I have been assaulted, my staff have been assaulted and each time the client was just given a ticket

*Basically, we assume all the risk but we have to take people to stay in business so it is hard to manage risks.

Solution5: Make client removal easier. Make it easier for the police to remove a combative and/or intoxicated client from the property by taking them to detox, jail or the hospital. Protect mental health workers by revising statutes 28-929→931 which states it is a 3rd degree felony to assault a health care worker while on the job. Have those statutes include "mental health workers?" This helps the client realize that they won't just be receiving a ticket for disturbing the peace.

You once asked me if I preferred inspections being more often and less time verses every five years and more time. I will repeat what I said then, it really doesn't matter to me because we are a small facility and our investigations do not take an obscene amount of time.

The one issue that I do have when it comes to investigations is when I have a client who loves to claim that they are being "abused" because they are not getting their way so they make constant calls to

DHHS to claim abuse. It would be nice to have a system in place that stops this from happening. However, I don't know what that is system looks like.

The next category under 'securing stable housing' is:
Partially Supervised Group Housing:
*This is where there is some support for the resident but it is not staffed 24/7.
*Residents are left alone, no medication management, they can clean and cook, have a job or participate in a day program.
*The resident must do something during the day whether it be work or day program.
*They still get transportation services and have access to staff "landlords"
*Case Managers check in and make sure clients are keeping the living areas clean and that they are taking their medications regularly

*Nebraska does not have this type of housing.

The third and final category I am addressing under securing stable housing is
Supportive Housing
It provides limited assistance. Clients live independently and are "helped" by case managers/staff infrequently. They do have someone to call and resources are still available to them. They can cook, clean, and make their own doctor's appointments just to give some examples.

Our house across from Prescott though called transitional living could fall under this category but in Nebraska it actually falls under Landlord/tenant law. In order to live there, the client has to agree to either work or attend a day program. Take their medications regularly and go to their doctor's appointments. However, because of the Landlord/Tenant law we have very limited say in what the client can and cannot do. We can encourage day programs or jobs. We can help them with transportation to and from day program or doctors' appointments however, our hands are tied when it comes to coming in and making sure the resident is cleaning, eating properly or taking their medications.

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