Comments are invited on the Nebraska Uniform FFY 2020/21 MH/SAPT Block Grant Application.

Nebraska has been invited to submit an application to the Federal Substance Abuse Mental Health Services Administration (SAMHSA) for the Uniform FFY 2020-2021 Block Grant Application for Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant.

- To review the Nebraska Application for SAMHSA Uniform FFY 2020-2021 MHBG and SAPTBG please visit the Division of Behavioral Health website: [http://dhhs.ne.gov/Pages/Behavioral-Health.aspx](http://dhhs.ne.gov/Pages/Behavioral-Health.aspx)

- To provide comment on the Nebraska Uniform FFY 2020/21 MHBG and SAPTBG Block Grant Application.

  Public comment can be submitted via email to:
  John Trouba – Federal Aid Administrator
  [John.Trouba@nebraska.gov](mailto:John.Trouba@nebraska.gov)
  Nebraska Department of Health and Human Services
  Division of Behavioral Health
  301 Centennial Mall South, 3rd Floor
  PO Box 95026
  Lincoln, NE 68509-5026

  Public comment via Survey Monkey at link:
  [https://www.surveymonkey.com/r/BG2020-21](https://www.surveymonkey.com/r/BG2020-21)

- Links to DBH reference documents:
  Nebraska Behavioral Health Needs Assessment

  DBH Strategic Plan 2017-2020
Nebraska

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022

(generated on 08/30/2019 1:29:53 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development
State Information

Plan Year
Start Year 2020
End Year 2021

State SAPT DUNS Number
Number 808819957
Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant
Agency Name Nebraska Department of Health and Human Services
Organizational Unit Division of Behavioral Health
Mailing Address 301 Centennial Mall South, Third Floor, PO Box 95026
City Lincoln
Zip Code 68509-5026

II. Contact Person for the SAPT Grantee of the Block Grant
First Name Sheri
Last Name Dawson
Agency Name Nebraska Department of Health and Human Services
Mailing Address 301 Centennial Mall South, Third Floor, PO Box 95026
City Lincoln
Zip Code 68509-5026
Telephone 402-471-7856
Fax 402-471-7859
Email Address Sheri.Dawson@nebraska.gov

State CMHS DUNS Number
Number 808819957
Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant
Agency Name Nebraska Department of Health and Human Services
Organizational Unit Division of Behavioral Health
Mailing Address 301 Centennial Mall South, Third Floor PO Box 95026
City Lincoln
Zip Code 68509-5026

II. Contact Person for the CMHS Grantee of the Block Grant
First Name Sheri
Last Name Dawson
Agency Name NE DHHS Division of Behavioral Health
III. Third Party Administrator of Mental Health Services
Do you have a third party administrator?  Yes ☐  No ☐

First Name
Last Name
Agency Name
Mailing Address
City
Zip Code
Telephone
Fax
Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)
From
To

V. Date Submitted
Submission Date 8/30/2019 1:28:35 PM
Revision Date

VI. Contact Person Responsible for Application Submission
First Name Susan
Last Name Adams
Telephone 402-471-7820
Fax 402-471-7859
Email Address susan.adams@nebraska.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
### Fiscal Year 2020

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
as required by  
Substance Abuse Prevention and Treatment Block Grant Program  
as authorized by  
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
and  
Title 42, Chapter 6A, Subchapter XVII of the United States Code

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions...
to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a “covered transaction” and verify each lower tier participant of a “covered transaction” under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,”
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801-3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

**THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:**

1. **Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

2. **Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

3. **Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.**

4. **The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

5. **Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.**

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: 

Name of Chief Executive Officer (CEO) or Designee: Sheri Dawson, RN

Signature of CEO or Designee: 

Title: Director, Division of Behavioral Health

Date Signed: 

If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
May 15, 2019

Wendy Pang
Grants Management Specialist
DGM/OFR/SAMHSA
5600 Fishers Lane, Rm. 17E21C
Rockville, MD 20857

Dear Ms. Pang:

On behalf of the State of Nebraska, I hereby authorize Dannette R. Smith, Chief Executive Officer of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant (CFDA 93.958); the Substance Abuse Prevention and Treatment Block Grant (CFDA 93.959), the Projects for Assistance in Transition from Homelessness (PATH) grant (CFDA 93.150):

Dannette R. Smith, MSW
Chief Executive Officer
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the three programs listed above to:

Sheri Dawson, RN, Director
Division of Behavioral Health
Nebraska Department of Health and Human Services
P.O. Box 95026
Lincoln, NE 68509-5026

Thank you for your attention to this matter.

Sincerely,

Pete Ricketts
Governor
May 15, 2019

Wendy Pang  
Grants Management Specialist  
DGM/OFR/SAMHSA  
5600 Fishers Lane, Rm. 17E21C  
Rockville, MD 20857

Dear Ms. Pang:

On behalf of the State of Nebraska, I hereby authorize Sheri Dawson, RN, Director, Division of Behavioral Health of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant (CFDA 93.958); the Substance Abuse Prevention and Treatment Block Grant (CFDA 93.959), the Projects for Assistance in Transition from Homelessness (PATH) grant (CFDA 93.150):

Sheri Dawson, RN, Director  
Division of Behavioral Health  
Nebraska Department of Health and Human Services  
P.O. Box 95026  
Lincoln, NE 68509-5026

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the three programs listed above to:

Sheri Dawson, RN, Director  
Division of Behavioral Health  
Nebraska Department of Health and Human Services  
P.O. Box 95026  
Lincoln, NE 68509-5026

Thank you for your attention to this matter.

Sincerely,

Dannette R. Smith, MSW  
Chief Executive Officer  
Department of Health and Human Services
**State Information**

**Chief Executive Officer’s Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]**

**Fiscal Year 2020**

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
Funding Agreements  
as required by  
Substance Abuse Prevention and Treatment Block Grant Program  
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Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

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LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions;"
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into.

Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C 5 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

**THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:**

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Nebraska

Name of Chief Executive Officer (CEO) or Designee: Sheri Dawson, RN

Signature of CEO or Designee: Sheri Dawson, RN

Title: Director, Division of Behavioral Health

Date Signed: 07/09/2019

If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
# State Information

**Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]**

**Fiscal Year 2020**

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
Funding Agreements  
as required by  
Community Mental Health Services Block Grant Program  
as authorized by  
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
and  
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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### Title XIX, Part B, Subpart II of the Public Health Service Act

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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee’s policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,”
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801-3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee:  Sheri Dawson, RN

Signature of CEO or Designee:\footnote{1}{If the agreement is signed by an authorized designee, a copy of the designation must be attached.}

Title:  Director, Division of Behavioral Health  Date Signed:  

\footnote{1}{If the agreement is signed by an authorized designee, a copy of the designation must be attached.}

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
May 15, 2019

Wendy Pang
Grants Management Specialist
DGM/OFR/SAMHSA
5600 Fishers Lane, Rm. 17E21C
Rockville, MD 20857

Dear Ms. Pang:

On behalf of the State of Nebraska, I hereby authorize Dannette R. Smith, Chief Executive Officer of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant (CFDA 93.958); the Substance Abuse Prevention and Treatment Block Grant (CFDA 93.959), the Projects for Assistance in Transition from Homelessness (PATH) grant (CFDA 93.150):

    Dannette R. Smith, MSW
    Chief Executive Officer
    Nebraska Department of Health and Human Services
    P.O. Box 95026
    Lincoln, NE 68509-5026

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the three programs listed above to:

    Sheri Dawson, RN, Director
    Division of Behavioral Health
    Nebraska Department of Health and Human Services
    P.O. Box 95026
    Lincoln, NE 68509-5026

Thank you for your attention to this matter.

Sincerely,

Pete Ricketts
Governor
May 15, 2019

Wendy Pang  
Grants Management Specialist  
DGM/OFR/SAMHSA  
5600 Fishers Lane, Rm. 17E21C  
Rockville, MD  20857

Dear Ms. Pang:

On behalf of the State of Nebraska, I hereby authorize Sheri Dawson, RN, Director, Division of Behavioral Health of the Department of Health and Human Services, to make all required applications, agreements, certifications and reports related to the Community Mental Health Services Block Grant (CFDA 93.958); the Substance Abuse Prevention and Treatment Block Grant (CFDA 93.959), the Projects for Assistance in Transition from Homelessness (PATH) grant (CFDA 93.150):

Sheri Dawson, RN, Director  
Division of Behavioral Health  
Nebraska Department of Health and Human Services  
P.O. Box 95026  
Lincoln, NE  68509-5026

Effective immediately and until further notice, please send all Grant Awards and similar notices concerning the three programs listed above to:

Sheri Dawson, RN, Director  
Division of Behavioral Health  
Nebraska Department of Health and Human Services  
P.O. Box 95026  
Lincoln, NE  68509-5026

Thank you for your attention to this matter.

Sincerely,

Dannette R. Smith, MSW  
Chief Executive Officer  
Department of Health and Human Services
**State Information**

**Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]**

**Fiscal Year 2020**

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
Funding Agreements  
as required by  
Community Mental Health Services Block Grant Program  
as authorized by  
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
and  
Title 42, Chapter 6A, Subchapter XVII of the United States Code

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| Section 1953 | Continuation of Certain Programs                               | 42 USC § 300x-63    |
| Section 1955 | Services Provided by Nongovernmental Organizations             | 42 USC § 300x-65    |
| Section 1956 | Services for Individuals with Co-Occurring Disorders            | 42 USC § 300x-66    |
ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11908; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to
State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
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2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

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1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Sheri Dawson, RN

Signature of CEO or Designee: [Signature]

Title: Director, Division of Behavioral Health

Date Signed: 07/09/2019

If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
# Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

**Standard Form LLL (click here)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Sheri Dawson, RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Director, Division of Behavioral Health</td>
</tr>
<tr>
<td>Organization</td>
<td>NE DHHS</td>
</tr>
</tbody>
</table>

Signature:  

Date:  

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

There are not any lobbying activities to be disclosed. See Attachment Disclose_Lobbying2019_signed.
I. State Information

Disclosure of Lobbying Activities

Are there lobbying activities pursuant to 31 U.S.C. 1352 to be disclosed? Yes ☐ No ☑

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name: Sheri Dawson
Title: Director
Organization: NE DHHS Division of Behavioral Health

Signature: ___________________________ Date Signed: 02-21-19

mm/dd/yyyy
Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:
Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
**B. Planning Steps**

For each of the populations and common areas, states should follow the planning steps outlined below:

*Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.*

Provide an overview of the state’s M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state’s Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

**Nebraska’s Behavioral Health System Overview**

Behavioral Health in Nebraska covers services needs for both Mental Health and Substance Use Disorders. The publicly funded system is only one part of the overall behavioral healthcare system in Nebraska. Private funding sources such as insurance companies, private businesses, and individuals themselves also influence the way behavioral health services are provided in the state. Publicly funded services are administered by many different agencies including three of six different Divisions within the Nebraska Department of Health and Human Services: the Division of Behavioral Health (DBH); the Division of Medicaid and Long-Term Care (MLTC); and the Division of Children and Family Services (CFS).

The DBH provides the four federally recognized tribes state funds, consultation, and technical assistance for both their Mental Health and Substance Use Disorder programs. DBH engages tribal representatives in planning, trainings, and initiatives, as well as supports the culturally appropriate provision of services to tribal members. DBH has customized its Centralized Data System to track the participation of unique services offered to tribal members such as sweat lodge, ceremonies, community responsibilities, and spiritual events.

Additionally, other state and federal agencies (for example, State Probation through the Nebraska Supreme Court, the Nebraska Department of Correctional Services, the Nebraska Department of Education Vocational Rehabilitation, and the Veterans’ Administration) fund or support behavioral health services for specific populations. Partnerships and collaboration among these public and private systems as well as with individuals, families, agencies, and communities are important components in systems of care surrounding each person.

The Nebraska Office of Consumer Affairs (OCA) administers planning, organizing, and development of consumer involvement initiatives to increase consumer involvement at all levels of service planning and delivery. The OCA provides education and technical assistance support for consumers and families of substance abuse, and mental health services throughout the state.
and across DHHS Divisions for the development of programs and services that are recovery focused and consumer and family driven.

**Role of Division of Behavioral Health: SMHA and SSA**

The Nebraska Behavioral Health Services Act designates the DBH as the chief behavioral health authority for the State [§71-806 (1)]. The DBH is both the State Mental Health Authority (SMHA) and the Single State Substance Abuse Authority (SSA). It is important to note that the authority does not extend to MLTC or CFS policy decisions. The DBH administers, oversees, and coordinates the state’s public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The primary goal is to develop a behavioral health system that is co-occurring capable, trauma-informed, recovery-oriented, and person-centered. The DBH is responsible for managing both the Community Mental Health Services Block Grant (CMHSBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). DBH funds priority treatment and support services for individuals without Medicaid and individuals without insurance or who are underinsured, according to financial eligibility based on a sliding scale on income and family size. The OCA focuses on recovery initiatives, planning, research, and advocacy for behavioral health consumers.

**Strategic Planning**

The DBH is designated by federal and state law as the state’s single authority for mental health and substance use disorders. The DBH’s responsibility is to coordinate public behavioral health care under DHHS. The DBH carries out its responsibilities through leadership and partnership.

*ONE NEBRASKA! ONE PLAN!*  
The Division of Behavioral Health Strategic Plan 2017-2020 identifies the following vision and mission.

**Vision** – The Nebraska public behavioral health system promotes wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-driven system.

**Mission** – The Division of Behavioral Health provides leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

The DBH’s strategic plan initiative was a twelve-month endeavor, beginning with a comprehensive needs assessment and ending with an inclusive strategic plan that involved a thorough, highly participatory statewide methodology featuring input from consumers, leadership, providers and advisory groups. The development process encompassed four guiding questions:

1. Where are we? (Conduct a needs assessment),
2. What’s important? (Identify priorities),
3. What must be achieved? (Develop plan goals, objectives) and
4. How are we accountable? (Setting metrics).
1. Where Are We?

A needs assessment was completed in September 2016 by the University of Nebraska Medical Center, College of Public Health. The methodology employed included literature review to identify relevant research articles and technical reports; additional information such as expenditures and service utilization provided by DHHS; and focus groups and surveys among consumers, stakeholders, and the general public. Selections from the 2016 Needs Assessment, offered below, provide a snapshot of the status of mental health and substance use in Nebraska. The complete document Nebraska Behavioral Health Needs Assessment 2016 can be accessed at:
http://dhhs.ne.gov/Behavioral%20Health%20Documents/Needs%20Assessment%20-%202016.pdf#search=needs%20assessment

The results of the needs assessment provided a portrait of “where are we?” and coalesced around three emerging themes; system integration, quality of services, and access to care.

2. What’s Important?

Identifying critical priorities or “what’s important?” for the DBH’s 2017-2020 strategic plan was a four-month process involving input and recommendations from partners, including the Joint State Advisory Committee for Mental Health and Substance Abuse (i.e., Planning Council).

Process for Identifying Key Priorities, Goals and Objectives
A multi-stage methodology was employed to determine strategic plan direction and content. The DBH strategic plan goals, domains, objectives and metrics process included:

Stage 1 – Conduct Needs Assessment and Review Findings
- Consumers, Stakeholders, and General Public
- Joint Advisory Committee
- Regional Administrators

Stage 2 – Identification of Strategic Priority Areas
- Joint Advisory Committee
- DBH Senior Leadership Team
- National Association of State Mental Health Program Directors (NASMHPD)
- Regional Administrators

Stage 3 – Develop Goals, Draft Objectives and Metrics
- Joint Advisory Committee
- DBH Strategic Planning Team
- Regional Administrators

Stage 4 – Finalized Objectives and Metrics
- DBH Senior Leadership Team
- Regional Administrators
3. What Must Be Achieved?

2017-2020 Strategic Goals and Objectives: DBH has organized its work around a focused set of visionary goals, domains and achievable objectives that speak to priorities.

Goals—Pursuit of the Triple Aim of Health Care
The Triple Aim of Health Care framework provided the basis for the DBH strategic plan and the ultimate development of the plan’s strategic goals. The goals for 2017-2020 are:

**Goal 1**: Nebraska Division of Behavioral Health Services are integrated across public and private systems to support consumers and impact health.
**Goal 2**: Nebraska Division of Behavioral Health delivers quality and effective services that help people live better lives.
**Goal 3**: Nebraska citizens experience access to culturally responsive behavioral health services at the right time and place to meet their needs.
Plan Step 1 Assess strengths & organizational capacity of service system to address the specific pops

**Domains**

- The DBH Strategic Plan Domains are:
- Youth System of Care
- Operations Including Centralized Data
- Services, Including Systems Integration, Evidence-based Practices and Diversity in Recovery Oriented Systems of Care
- Prevention Including Disparity
- Workforce

**Objectives:**

Strategic plan objectives provide the “how” mechanism for achieving the identified goals. They are “SMART” in that they are specific, measurable, attainable, realistic and time-framed. Each objective has been examined, analyzed and ultimately incorporated to ensure it adequately addresses the plan goals and domains and, where appropriate, furthers the philosophy and core values of a system of care. DBH has identified 30 objectives for 2017-2020.

**4. How Are We Accountable?**

The DBH carries out its responsibilities through leadership, partnership, transparency and accountability. The DBH efforts, including those specified in the block grant application, are strategically planned (2017-2020 Strategic Plan), aligned with the Triple Aims of Health Care and the Governor’s priorities, recognized and supported by the Governor through the DHHS Dashboard for performance monitoring and the DHHS Business Plan driving performance. The thread of accountability courses throughout these activities.

The DBH holds itself accountable for strategic plan results through Results-Based Accountability (RBA) methodology. RBA is a different way of thinking. It is the framework we use to define, measure, track and describe change within the system. DBH provides training and technical assistance to build the capacity of DBH and its contracted Regional Behavioral Health Authorities (RBHAs) to use RBA for its Performance Accountability System. Within the RBA framework, the DBH and RBHAs utilize continuous quality improvement processes to measure outcomes for established performance metrics.
Plan Step 1 Assess strengths & organizational capacity of service system to address the specific pops

In cooperation with multiple stakeholders statewide, DBH has developed a system roadmap which has guided the transformation of the current system of care to serve individuals with complex needs. As one example, Nebraska has moved the roadmap forward by offering providers and system partners the opportunity to participate in multiple webinars and onsite trainings with national consultants having expertise in Co-Occurring Disorders. These training opportunities provided technical assistance related to creating a welcoming environment and how to improve integrated treatment by refining organizational procedures and policies. Every two years providers have been required to complete self-assessments using the COMPASS EZ to assess their progress in serving individuals with co-occurring/complex needs, and to create plans to improve this ability.

DBH has established RBA processes within the Nebraska System of Care (NeSOC) grant, incorporating continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals and measure outcomes at the system level, practice level, and child and family level. Over the course of the last year, DBH, in partnership with Nebraska Children and Family Foundation, has engaged over 150 stakeholders and youth and family advocates to serve within the System of Care implementation committee structure. These committees have focused on implementation strategies related to policy, funding, service development, quality improvement and cross-system implementation.

Movement forward capitalizes on partner commitment and work completed to date. During the previous year, the Nebraska System of Care (NeSOC) efforts focused on increasing access to services. Through the development of a statewide Youth Mobile Crisis Response program and expansion of intensive case management services and other community based behavioral health services youth and their families experience greater access to needed services and supports. The NeSOC created a common language for care through development of a cross systems glossary of terms and began the process of improving service delivery by eliminating duplication through mapping currently available services and reviewing existing funding streams. This next phase is dedicated to reducing reliance on inpatient and residential services by increasing community-based services. The link to the DBH NeSOC home page is:
http://dhhs.ne.gov/Pages/System-of-Care-Leadership-Board.aspx

The Division of Behavioral Health Strategic Plan 2017-2020 emphasizes a system of care approach for the adult and youth systems. A recovery oriented system of care assists consumers in achieving their optimal level of self-sufficiency and independence by providing mental health, substance use prevention, and treatment and support services at the right time and place. The Nebraska Adult system of care (ASOC) incorporates this conceptual framework and the associated system of care principles and core values into the spectrum of effective, community-based services and supports that is organized within a coordinated system of care network.

The Division of Behavioral Health Strategic Plan 2017-2020 encompasses an overall behavioral healthcare system focus by integrating a Substance Abuse Prevention Statewide Strategic Plan into the document.
Public Behavioral Health System Organization: Division of Behavioral Health

State Level Organization
The DBH provides leadership in the administration, integration and coordination of the public behavioral health system and takes primary responsibility for the development, dissemination and implementation of the Division of Behavioral Health Strategic Plan for 2017-2020. Plan implementation is carried out by DBH and includes the Regional Centers, Office of Consumer Affairs (OCA), the six (6) Regional Behavioral Health Authorities (RBHAs) and system partners. Following is an expanded description of each component of the operational structure.

At the state level, the DBH is comprised of three sections: DBH Central, Regional Centers, and Office of Consumer Affairs.

DBH Central

DBH Central is comprised of five operational components:

1. Community-Based Services (CBS): Consists of services and the workforce essential for delivery of statewide, community-based mental health and substance use disorder prevention, treatment, recovery and support services.

2. Data and Quality Improvement (QI): Undertakes systematic and continuous actions that lead to measurable (via data) improvement in divisional operations, health care services and the health status of the consumer.

3. Fiscal: Provides oversight and administration of DBH’s funds from multiple sources including state general funds and block grant funds. It also manages the billing system for services and the development and execution of contracts.

4. Nebraska System of Care (NeSOC): Provides a coordinated framework within which behavioral health care is delivered to adults (ASOC) and youth (YSOC).

5. Prevention: Promotes safe and healthy environments that foster youth, family, and community development through the implementation of early intervention and prevention best practices.

The DBH contracts with the six RBHAs for community based mental health and substance use disorder services. Originally established in 1974 as mental health regions, the Nebraska Behavioral Health Services Act passed in 2004 incorporated substance use disorder services and revised the regional administrative entities into six RBHAs, to mirror designation of the DBH as the state’s chief behavioral health authority. See the Local Level Organization section below for more details on the RBHAs.

In addition to funding mental health and substance use disorder treatment and prevention services through the RBHAs, the DBH Community Based Services section directly contracts with entities for recovery and support services. Some examples include:
• Trilogy Integrated Services to provide a web portal for consumers to access: a comprehensive directory of behavioral health resources in their area, a databank of articles, factsheets and reports about behavioral health conditions, recovery and treatment, and recovery tools for their personal use;
• Father Flanagan’s Boys Town to operate the Nebraska Family Helpline (888-866-8660) where families can obtain assistance and provide a single contact point 24 hours a day, seven days a week; to connect callers with family organizations to advocate for families with youth experiencing mental/emotional disorders, support the family voice and offer supportive services such as education, support groups, advocacy and mentoring; and,
• Four federally recognized Native American Tribes in the state, with whom the DBH awards 1.5 million dollars of state funds in contracts, for the provision of culturally specific mental health and substance use disorder treatment services as well as relapse prevention activities.

Regional Centers

Regional Centers are the state’s public psychiatric hospitals located in Hastings, Norfolk, and Lincoln.

The Hastings Juvenile Chemical Dependency Program, a Psychiatric Residential Treatment Facility, provides residential substance use disorder treatment for young men. Most youth are on probation and have been in treatment an average of three times. The Hastings Regional Center is a Joint Commission accredited facility.

The Norfolk Regional Center is a Sex Offender Treatment Center providing Phase I services in the Nebraska Sex Offender Treatment Program. The Nebraska Sex Offender Treatment Program is a three-phase treatment program meant to reduce dangerousness and risk of re-offense for patients involved in treatment. Phase I treatment orients patients to the treatment process; begins working with patients to accept full responsibility for their sex offending and sexually deviant behaviors; teaches patients to give and receive feedback and utilize coping skills; and builds motivation for the intensive treatment in Phases II and III which are provided at the Lincoln Regional Center.

The Lincoln Regional Center (LRC) has received Top Performer status by the Joint Commission. The LRC serves people who need specialized psychiatric services and provides services in a highly structured treatment setting. The services provided include:

• Psychiatric Services: These are services for people with severe and persistent mental illness who have been committed by a mental health board due to mental illness and dangerous behaviors and cannot be served at a community-based hospital facility. The primary mission of the programs is to help individuals stabilize and return to live in the community. Interdisciplinary treatment teams develop individualized treatment plans based upon assessments completed at the time of admission. Discharge planning is part of the treatment plan, and starts when an individual is admitted.
• Forensic Services: Psychiatric Services provide evaluation, assessments, and treatment for individuals as ordered by the Nebraska legal system. The Forensic Program serves individuals who need competency evaluation, competency restoration, and who are found Not Responsible by Reason of Insanity. The program offers a structured treatment approach which is tailored to the specific needs of the individual patient.

• Sex Offender Service: This service provides treatment for individuals with a history of sexually harmful behavior. The population includes convicted sex offenders who have been committed under an inpatient mental health board order for sex offender treatment. Additionally, a residential level transition program works to release the patients with the necessary structure to allow them the opportunity to successfully return to the community.

• Whitehall Campus: This service is a Psychiatric Residential Treatment Facility (PRTF) that addresses the treatment needs of male adolescents who have sexually harmed. Each youth has his own room. The program is family-centered and has its own school on the campus. Youth who complete treatment at Whitehall have a low incidence of reoffending sexually based on an independent study that followed the youth over seven years from completion of treatment.

The Regional Center team works closely with the Nebraska Department of Correctional Services behavioral health team and Court Administrator.

For more information on the Regional Centers, see the DHHS DBH web site at: http://dhhs.ne.gov/Pages/Regional-Centers.aspx

Office of Consumer Affairs

The Office of Consumer Affairs conducts activities to promote consumer involvement in the service system and recovery process. Consumers are defined as persons receiving mental health or substance use disorder services. Activities include:

• Facilitation of community forums for consumers to give feedback on the quality of service and to identify gaps in these services.
• Administration of recovery initiatives, planning, research, and advocacy for behavioral health consumers.
• Administration of peer support training and certification.
• Administration of workforce development for peer support specialists.
• Facilitation of OCA’s People’s Council designed to advise the DBH around consumer involvement.
• Administration of family peer support service provision in NE.
• Regional consumer coordination within the RBHAs
• System Transformation initiatives related to trauma informed care and cultural and linguistic appropriate standards.
• Community Health Worker (CHW) and Peer Support Workforce initiatives
• Moving forward to implement Peer Standards and Regulations as directed in LB417
The Office of Consumer Affairs (OCA) provides statewide leadership and resources for the behavioral health system that works to build, promote, and sustain services which incorporate consumer feedback as integral components of the recovery process throughout the system. Activities include planning, organizing, and creating consumer involvement initiatives to increase consumer involvement at all levels of service planning and delivery. Education, technical assistance and support is provided to assist consumer organizations in expanding consumer participation as a priority in state system advocacy initiatives, program development, contract compliance, board development, fiscal management, and recruitment and retention of staff.

The OCA administers the Nebraska Peer Support Services training, testing and certification process. Guidelines for curriculum submission, and the certification process were revised in 2019. See the Consumer Advocacy website:  http://dhhs.ne.gov/Pages/Consumer-Advocacy.aspx

LB 417 was passed during the 105th legislative session. LB 417 added clarifying language to authorize the Division of Behavioral Health to set standards in peer services. Current statute charges the Division with ensuring quality services, including peer support. This bill amended state law to specifically authorize peer support standards for training, credentialing and competencies of a peer recovery workforce. OCA works to raise the bar for the profession and create a culture that widely integrates peers into the workforce and offers support to them as they perform their duties to increase access and quality of care for consumers in Nebraska. In 2019, new training curriculum and certification standards and processes have been implemented and regulations promulgated.

The OCA and the Division of Public Health continue to explore the next steps to incorporate elements of the existing peer support training into the Community Health Worker (CWH) training, and vice versa. This would offer additional training for CHWs who have lived experience with a behavioral health condition and who be able to offer additional support while in the role of a CHW to those they serve. On January 1, 2017 MLTC implemented Heritage Health Heritage Health is a new health care delivery system that combines Nebraska’s physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated system for Nebraska’s Medicaid and CHIP clients. Additional training and certification for CHWs is in alignment with the integrated shift in Nebraska.

CHWs who have additional peer support training will be able to lend their unique insights to the process of personal transformation through improving their health and wellness, living a self-directed life, and striving to reach their full potential. This frontline behavioral and public health worker is a trusted member of and/or has an unusually close understanding of the population/community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. This worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, inspiring hope, community/health education, building informal and formal supports, social support, and advocacy.

The OCA developed and provides oversight of the OCA People’s Council. The People’s Council is chartered to provide state, regional and local consumer perspective, utilizing personal lived
experience, on the DBH/OCA programs and policies affecting consumers and to advocate for systems transformation and a Recovery Oriented System of Care. The council provides recommendations and feedback to the DBH/OCA and serves to support linkage with other stakeholders in efforts to expand consumer involvement in service planning and delivery in Nebraska.

Through the above mentioned functions, the Nebraska OCA People’s Council provides recommendations to guide the DHHS DBH, including the OCA, and related state agency partners on ways to best support adults, children, and their families in the journey of healing, recovery, resiliency, and personal transformation. For more information about the Office of Consumer Affairs, see the DHHS DBH web site at: http://dhhs.ne.gov/Pages/Consumer-Advocacy.aspx

Regional and Local Level Organization

DBH contracts with six RBHAs which authorizes them to purchase services using state general funds, funds received under the Community Mental Health Services block grant and the Substance Abuse Prevention Treatment block grant, and other discretionary federal grants.

By state statute, each RBHHA is responsible for the development and coordination of publicly funded behavioral health services in their region pursuant to rules and regulations of the DHHS. Each RBHHA is governed by a Regional Governing Board consisting of one county board member (locally elected official) from each county in the RBHA. The administrator of the RBHA is appointed by the Regional Governing Board.
Table 1 Nebraska Census by Regional Behavioral Health Authority

<table>
<thead>
<tr>
<th>Regional Behavioral Health Authority (RBHA)</th>
<th>RBHA Office</th>
<th>Counties</th>
<th>Population</th>
<th>% of Population</th>
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<tbody>
<tr>
<td>1 (Panhandle/Western)</td>
<td>Scottsbluff</td>
<td>11</td>
<td>85,293</td>
<td>4.4%</td>
</tr>
<tr>
<td>2 (South Western)</td>
<td>North Platte</td>
<td>17</td>
<td>98,622</td>
<td>5.1%</td>
</tr>
<tr>
<td>3 (South Central)</td>
<td>Kearney</td>
<td>22</td>
<td>231,753</td>
<td>12.1%</td>
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<tr>
<td>4 (Northeast &amp; North Central)</td>
<td>Norfolk</td>
<td>22</td>
<td>205,651</td>
<td>10.7%</td>
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<tr>
<td>5 (Southeast)</td>
<td>Lincoln</td>
<td>16</td>
<td>472,381</td>
<td>24.6%</td>
</tr>
<tr>
<td>6 (Eastern)</td>
<td>Omaha</td>
<td>5</td>
<td>826,376</td>
<td>43.0%</td>
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<td>Totals</td>
<td></td>
<td>93</td>
<td>1,920,076</td>
<td>100.0%</td>
</tr>
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</table>

Source: U.S. Census Bureau, PEPSR6H - Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: April 1, 2010 to July 1, 2017 (June 2018)

As part of the RBHA responsibility for the development and coordination of publicly funded behavioral health services in their region, each RBHA is under contract to provide:

- Network management,
- Consumer service coordination,
- Prevention system coordination,
- Emergency system coordination,
- Youth service coordination, and
- Housing coordination.

Each RBHA is under contract to provide Network Management (developing and managing a comprehensive array of mental health and substance use disorder services with sufficient capacity for their designated geographic area based on a comprehensive needs assessment/strategic plan); Prevention System Coordination (promotion of a comprehensive prevention approach, including a mix of evidence-based programs, policies, and/or practices that best address the selected prevention priorities); Emergency System Coordination (to meet the needs of individuals experiencing a behavioral health crisis/emergency situation including coordination of activities and collaboration of community based partners to ensure that individuals receive the least restrictive and most appropriate level of care); Youth System Coordination (collaboration with providers, family advocacy organizations and other youth serving agencies including Division of Children and Family Services and Administrative Office of Probation in the planning for, and development of the system of care infrastructure for youth and their families experiencing behavioral health disorders); Housing Coordination (leadership, planning activities and system problem solving for regional housing issues for persons with extremely low incomes who have behavioral health disorders, including collaboration with local housing partners) and Consumer Coordination (peers providing leadership in the development of regional planning for recovery-oriented community-based services; promotes and facilitates educational opportunities & other activities that enhance recovery, resiliency, and whole health wellness for consumers and their families.)
It is the responsibility of the DBH and each RBHA to monitor, review, and perform programmatic, administrative, and fiscal accountability and oversight functions on a regular basis with all subcontractors. This includes financial accountability by developing complete and accurate budget plans, compliance with audit procedures, completion of services purchased verifications on all services, ensure timely attainment of financial audits, monitor all funding for compliance with state and federal requirements, compliance with the DBH policy regarding financial eligibility, ensure the DBH funding is used as payment of last resort, monitor all contracts for the purchase of services and related duties.

In addition, each RBHA must secure county and local funding as match against state general funds for the operation of the RBHA and for the provision of behavioral health services in the region. These local match requirements are per state statute [Neb. Rev. Statutes 71-808(3)]. The local tax match for behavioral health services is approximately one local tax dollar for every 7.5 state general fund dollars provided. Each year the RBHA provides documentation explaining how the total match funds are used.

The DBH Title 206 regulations requires nationally recognized accreditation in order to receive funds administered by the DBH for service delivery. A copy of the Title 206 regulations can be found here:  [http://dhhs.ne.gov/Pages/Title-206.aspx](http://dhhs.ne.gov/Pages/Title-206.aspx)

**Independent Peer Review**

DBH ensures the function of Independent Peer Review is addressed to assess the quality, appropriateness, and efficacy of services per the requirements under the Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG). The DBH approach for Independent Peer Review is based on policy guidance received from SAMHSA, with the concurrence of the US Department of Health and Human Services Office of General Counsel. The SAMHSA program policy related to Independent Peer Reviews was changed to allow states the option to demonstrate compliance with 42 USC § 300x-53(a)(1)(A) and 45 CFR § 96.136 by requiring substance abuse treatment programs receiving SABG funds to obtain accreditation from a private accreditation body such as The Joint Commission (TJC) and the Commission on the Accreditation of Rehabilitation Facilities (CARF), Commission on Accreditation or similar organizations as approved by the Director of DBH.

**Prevention System Organization**

The DBH is charged with the development of prevention, treatment and recovery services for the State of Nebraska. DBH strives to maintain a sustainable and effective prevention system by promoting safe and healthy environments that foster youth, family, and community development through best practices in mental health promotion, substance abuse prevention and early intervention. Partnership with the six RBHAs and oversight by DBH’s Network and Prevention Manager provides the infrastructure to support a comprehensive prevention system that promotes overall wellness. DBH contracts with the RBHAs for technical assistance, training, and data
collection to support local coalitions and community entities. The majority of prevention activities purchased by the DBH are carried out by the RBHAs Prevention Coordination system which is designed to operate at the community level, embracing local culture while leading the development of sustainable prevention activities for substance abuse and related societal problems through the life span. Funded primarily by the Substance Abuse Prevention and Treatment Block Grant, and Partnership For Success-Grant, Regional Prevention Coordination staff utilize coexisting prevention efforts such as Strategic Prevention Framework – Partnerships for Success (SPF-PFS) grant, Drug Free Communities grant, and the Garett Lee Smith (GLS) Youth Suicide Prevention grant, to establish common directives and target populations leading to optimal reach when planning training and technical assistance initiatives.

Previously, DBH’s prevention system goals were driven by the priorities set forth in Nebraska’s Five-Year Prevention Statewide Strategic Plan (2013-2017). As a result of DBH’s most recently completed needs assessment, new statewide prevention goals have been identified and are included as part of DBH’s overall strategic plan. These data driven priorities will guide prevention programming, decision-making, and policy development at the State, region and community level for the next 3 years. These priorities are also aligned with those of the Substance Abuse Prevention and Treatment Block Grant.

In cooperation and partnership with Regional Prevention System Coordinators, training events are funded throughout the state to introduce, enhance and improve the use of evidence-based, promising and local prevention strategies most appropriate to their local community goals utilizing the Strategic Prevention Framework (SPF) process. Local goals have included the reduction of underage drinking, reduction of driving under the influence, reduction of binge drinking, and preventing prescription drug abuse and marijuana use among youth. By requiring all communities to use the SPF model, and by providing effective statewide training and technical assistance in the use of the model, greater progress is being achieved in reducing substance abuse and related health consequences across the state.

DBH maintains a leadership role among Nebraska’s State Suicide Prevention Coalition and promotes the goals of the state’s five year strategic plan. This plan can be viewed at https://www.sprc.org/sites/default/files/NEbraska%20STATE%20SUIC%20PREV%20PLAN%202016-2020.pdf.

GLS grant funding has made seven evidence based, best practices available, including on-line and in-person trainings that DBH coordinates to prevent suicides and reduce the number of suicide attempts for youth ages 10-24.

In addition, a Prevention Advisory Council (PAC) has been chartered to provide state and regional system leadership in substance abuse and mental health prevention to Nebraska’s Behavioral Health system (NBHS). As a subcommittee of the State Advisory Council on Substance Abuse Services, the Prevention Council guides the DBH and related state agency partners.
The PAC objectives are as follows:

1. Accomplish the mission and vision of the DHHS DBH Five Year Statewide Strategic Plan as it relates to prevention;
2. Be the driving force for statewide prevention system partnership, collaboration and growth;
3. Continually grow the prevention workforce and improve upon leadership within the Nebraska Behavioral Health System to assist communities to create and/or enhance sustainable, collaborative coalitions which implement effective prevention policies, practices, and programs; and
4. Position DBH’s Prevention System to continue to be in compliance with federal grant requirements and deliverables by monitoring progress.

The PAC has also been instrumental in making recommendations to strengthen the prevention system workforce. After several months of focus groups and consultation with the Behavioral Health Education Center of Nebraska, DBH has introduced a five year (2017-2022) workforce development to help professionalize the substance abuse prevention field. The primary goal of this plan is to increase competency in prevention practices through uniform training and a structured orientation process based on the Nebraska Prevention Core Competencies.

Finally, DBH’s prevention goals are also supported through participation with the Prevention Partnership. This statewide workgroup is comprised of representatives from DHHS (Divisions of Children and Family Services, Behavioral Health, Public Health), Nebraska Department of Education, the Nebraska Supreme Court Office of Probation Administration and the Court Administrator’s Office (Court Improvement Project), the Crime Commission, Nebraska Child Abuse Prevention Fund Board, the Nebraska Children and Families Foundation, State Legislative representatives, and representation from private philanthropy. Several state commissions exist to plan, review, and make recommendations to state leaders on gaps and improvements that can be made in service delivery across multiple systems. Aligned with a common agenda to improve the wellbeing of children, youth, and families in Nebraska, each of these commissions are represented and group members are collectively working within the mandates of their roles. Members have agreed to be conduits for sharing information between and among this group and the various commissions and boards that provide oversight and support to the work of each member organization. Stakeholders helped to define wellbeing through the selection of five outcomes for children and families. These related indicators make up the group’s mission that children, youth, and families in Nebraska are safe; healthy; supported in quality environments; ready for and succeed in school; and successfully transition into adulthood.

**Youth and Adult Services**

The behavioral health services funded by the DBH include, but are not limited to, consumer-provided services, support services, inpatient and outpatient services, and residential and nonresidential services. These services are provided for the prevention, diagnosis, and treatment of behavioral health disorders and the rehabilitation and recovery of adults and youth with such disorders.
Plan Step 1 Assess strengths & organizational capacity of service system to address the specific pops

Table 2 List of Funded Services

<table>
<thead>
<tr>
<th>List of funded Mental Health and Substance Use Disorder Services</th>
<th>Mental Health</th>
<th>Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>(** Shared Medicaid Service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Services &amp; Inpatient Services:</td>
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<td></td>
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<tr>
<td>24 Hour Crisis Line</td>
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<tr>
<td>Crisis Assessment**</td>
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</tr>
<tr>
<td>Crisis Inpatient</td>
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<td></td>
</tr>
<tr>
<td>Crisis Response**</td>
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<td>X</td>
</tr>
<tr>
<td>Crisis Stabilization**</td>
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<td>X</td>
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<tr>
<td>Emergency Community Support</td>
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<td>Emergency Protective Custody</td>
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<td></td>
</tr>
<tr>
<td>Emergency Psychiatric Observation</td>
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</tr>
<tr>
<td>Hospital Diversion &lt;24 hrs</td>
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<td>Hospital Diversion &gt;24 hrs</td>
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<td>Acute Hospital/Subacute**</td>
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<td></td>
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<td>Sub-Acute Hospitalization**</td>
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<tr>
<td>Mental Health Respite</td>
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<td>Social Detox**</td>
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<tr>
<td>Halfway House**</td>
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<td>Inpatient Post Commitment Treatment</td>
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<td>Therapeutic Community**</td>
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<td>Urgent Medication Mgmt</td>
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<td><strong>Outpatient Services:</strong></td>
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<td>Assertive Community Treatment**</td>
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<tr>
<td>Assessment/Evaluation**</td>
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<tr>
<td>Benefit Services</td>
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<td>Client Assistance Program</td>
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<tr>
<td>List of funded Mental Health and Substance Use Disorder Services</td>
<td>Mental Health</td>
<td>Substance Use Disorder</td>
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<tr>
<td>---------------------------------------------------------------</td>
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<td>------------------------</td>
</tr>
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<td>(** Shared Medicaid Service)</td>
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</tr>
<tr>
<td>Community Support**</td>
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<tr>
<td>Day Rehabilitation**</td>
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<tr>
<td>Day Support**</td>
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<tr>
<td>Day Treatment**</td>
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<td>Family Navigator**</td>
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<td>Family Peer Support **</td>
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<tr>
<td>Homeless Transition</td>
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<td>Intensive Case Management</td>
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</tr>
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<tr>
<td>Intensive Outpatient**</td>
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<td>Medication Management**</td>
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<td>Multisystemic Therapy**</td>
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<tr>
<td>Opioid-Methadone Maintenance Therapy</td>
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<tr>
<td>Outpatient Dual**</td>
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<tr>
<td>Outpatient**</td>
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<td>Peer Support**</td>
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<td>Professional Partner</td>
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<td>Recovery Homes (Oxford)</td>
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<tr>
<td>Recovery Support</td>
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<tr>
<td>Substance Abuse Prevention Services</td>
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</tr>
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<td>SOAR</td>
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</tr>
<tr>
<td>Supported Housing</td>
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</tr>
<tr>
<td>Supportive Living</td>
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<td>X</td>
</tr>
<tr>
<td>Youth transition service</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Public Behavioral Health System Organization: DHHS Division Partners

Other Division partners within the DHHS agency include the following:

Division of Medicaid and Long-Term Care

The Division of Medicaid and Long-Term Care (MLTC) provides funding for an array of services to address mental health and substance use issues of children and adults, including the Medicaid Rehabilitative Option (MRO) services. In addition, Nebraska utilizes the Medicaid 1915(b) Substance Abuse Waiver services, allowing the State to maximize SUD funding across payer sources. The MLTC continues to work with the DBH to standardize service delivery expectations (service definitions) to ensure that Medicaid and non-Medicaid individuals are receiving similar services.

In January 2017, the MLTC Nebraska Medicaid managed care program was redesign and renamed Heritage Health. Heritage Health is a health care delivery system that combines Nebraska’s physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated system for Nebraska’s Medicaid and CHIP clients. Heritage Health contracts with three managed care organizations (MCO) who each administer Medicaid’s integrated healthcare delivery system on a statewide basis. Continued cooperation between the DBH and MLTC’s Heritage Health program is a key area of interest and coordination efforts. The DBH has been an active participant in all available Heritage Health implementation meetings. Additionally, DBH has included Heritage Health personnel in ongoing DBH-RBHA meetings to discuss operational efficiency and strategic planning opportunities. There has been active and ongoing coordination between DBH, MLTC and the Heritage Health plans on topics related to implementation of Peer Support as a Medicaid reimbursed service, data collection and sharing opportunities and enhancing the service delivery system. The DBH was a key partner with MLTC and the Heritage Health plans when editing Medicaid service definitions, as well. With the advent of Medicaid expansion in Nebraska by 2020, the opportunities and need for continued and targeted collaboration expand.

DBH works closely with MLTC staff on a regular basis; key projects currently include active engagement by MLTC in the implementation of the Nebraska System of Care (NeSOC). State Targeted Response to the Opioid Crisis and State Opioid Response grants and DBH’s involvement in MLTC annual parity reviews of each Heritage Health plan. DBH and MLTC are also partnering on workforce development, training and monitoring activities including training on Matrix IOP service and engaging in consultation for Assertive Community Treatment service delivery.

The DBH manages the contract for Preadmission Screening and Resident Review (PASRR) to provide screening and evaluations for mental illness/intellectual disabilities for Medicaid persons entering nursing home care. The PASRR contractor, Ascend, A MAXIMUS Company (Ascend), conferenced with the DBH and the MLTC staff to review new Center for Medicare and Medicaid Services (CMS) requirements and problem-solve other issues relating to screening and evaluation. Ascend is surveying nursing homes in Nebraska to identify barriers to serving individuals with mental illness to allow opportunities for training and technical assistance from
the state on areas where staff need additional support.

DBH and MLTC have entered into three Memoranda of Understanding to provide for sharing data and identifying Medicaid eligibility to facilitate DBH’s duties as the chief behavioral health authority for the State of Nebraska and directing the administration and coordination of the public behavioral health system. These include Memoranda of Understanding to provide high level reporting related to eligibility, expenditures and utilization for Medicaid eligible individuals (2015), sharing of Medicaid consumer data for the NeSOC (2017) and most recently the integration with DBH Centralized Data System (2017) to provide a more complete and accurate identification of Medicaid eligibility which has enabled the State to better ensure and utilize the most appropriate funding source for services funded by both MLTC and DBH.

The Division of Public Health

This Division of Public Health (DPH) is responsible for preventive and community health programs and services. It is also responsible for the regulation and licensure of health-related professions and occupations, as well as the regulation and licensure of health care facilities and services. DPH and DBH work collaboratively on mental health and substance use provider agency issues which may impact both quality of care and consumer accessibility in order to promote positive outcomes for consumers and public safety. Specific system issues addressed have included partnering in development of the State Health Improvement Plan for Public Health, developing legislation to align mental health and substance abuse treatment center facility licensure, sharing state priorities and strategies tied to binge drinking and Nebraska health rankings work with the Behavioral Health Education Center of Nebraska, and shared media campaigns including those directed at opioid use disorder. Additionally, the Director of DBH sits on the DPH, Office of Rural Health - Rural Health Commission.

The DPH includes public health programs like WIC, Tobacco Free Nebraska, WISEWOMAN, Health Disparities and Health Equity, and Emergency Medical Services. They work collaboratively with DBH on education and collaboration around health problems commonly seen in the behavioral health population.

DPH partners with the OCA to promote and integrate the use of CLAS standards in the behavioral health system. In August 2016 the Office of Minority Heath at the US DHHS conducted a survey on the awareness, knowledge, adoption, and implementation of CLAS standards at the Nebraska DHHS. The results of the study have helped guide strategic planning efforts. DPH serves as an expert partner consultant to DBH on matters related to strategic planning and CLAS.

The OCA and DPH have continued to explore the next steps to incorporate elements of the existing peer support training into the CHW training, and vice versa. This would offer additional training for CHWs who have lived experience with a behavioral health condition and who be able to offer additional support while in the role of a CHW to those they serve.

With the addition of Peer Support as a Medicaid reimbursed service, CHWs who have required
peer support training will be able to lend their unique insights to the process of personal transformation through improving their health and wellness, living a self-directed life, and striving to reach their full potential. This frontline behavioral and public health worker is a trusted member of and/or has an unusually close understanding of the population/community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. This worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, inspiring hope, community/health education, building informal and formal supports, social support, and advocacy.

Staff from the DBH/OCA and Public Health participate in Region VII SAMSHA sponsored focus meetings on integrated services and coordination of peer provided services with respect to standards, training, and certifications.

Division of Children and Family Services

The Division of Children and Family Services (CFS) is comprised of three sections—the Office of Juvenile Services, Economic Assistance and Protection and Safety. The Director’s leadership team includes Deputy Directors for each section and administrators for Offices: Protection and Safety; Research, Planning and Evaluation; Economic Assistance; Office of Juvenile Services; Prevention Administrator and Divisional Financial Officer. This organizational structure allows CFS to focus attention on and support the priorities identified by the division.

The CFS Office of Juvenile Services (OJS) oversees the operation of two Youth Rehabilitation and Treatment Centers (YRTC). The YRTCs serve youth between 12 and 18 years that have been adjudicated as a juvenile offender and committed to the Office of Juvenile Services. The CFS Economic Assistance Unit is responsible for the administration of the Supplemental Nutrition Assistance Program (SNAP), Aid to Dependent Children, refugee resettlement, energy assistance, child care subsidies and child support enforcement.

The CFS Protection and Safety Unit, is responsible for Title IV-B Subpart 1 (Child Welfare Services), IV-B Subpart 2 (Promoting Safe and Stable Families), Title IV-E (Foster Care and Adoption Assistance), Child Abuse Prevention and Treatment Act (CAPTA), Chafee Foster Care Independence Program (CFCIP), and Chafee Education and Training Vouchers (ETV). In addition, this section operates the statewide Child/Adult Abuse and Neglect Hotline and is responsible for conducting all initial safety assessments. Services are primarily delivered through the five, state-administered, local Service Areas and through tribal-administered child welfare programs.

Case management functions are state-administered in the Western Service Area (WSA), Central Service Area (CSA), Northern Service Area (NSA) and Southeast Service Area (SESA). CFS contracts for case management and service coordination in the largest service area, the Eastern Service Area (ESA), with PromiseShip. CFS has contracted with Saint Francis Ministries to assume these services effective January 1, 2020. The Judicial Districts as set forth by the Supreme Court do not conflict with the CFS service area boundaries which as a result allows for
greater coordination of service delivery between CFS and the Judicial Branch across the state. The DBH works collaboratively with the CFS Service Areas/caseworkers in accessing services and monitoring waitlists for services for women with dependent children.

CFS also provides technical assistance to Nebraska’s four federally recognized tribal nations: the Santee Sioux Nation, the Winnebago Tribe, the Omaha Tribe and the Ponca Tribe.

CFS and DBH OCA have individual contracts with the family organizations in Nebraska for the provision of Family Peer Support. DBH OCA and CFS jointly manage the contracts to provide consistency in service delivery for families across Nebraska.

A map of the CFS service areas is below:

*Figure 4  Division of Children and Family Services Service Areas*

The DBH and CFS work closely together on a variety of important systems issues. CFS is an active participant in the implementation of the System of Care initiative in the state. One primary outcome of the System of Care is to reduce the reliance of out of home placement and treatment, which is a priority initiative for CFS as well. Additionally, CFS currently reports that a high proportion of youth being taken into CFS custody are brought to the attention of the system due to parental substance use; the DBH and CFS are working collaboratively to identify ways to address this. These are just two examples of the ongoing collaboration between CFS and the DBH at an administrative level. However, there is also critical work that happens “in the field”. Each of the RBHAs have working relationships with their local CFS offices. It is an expectation that there is ongoing coordination between the RBHA and CFS to keep operations running smoothly across the state.
The Division of Developmental Disabilities

The Division of Developmental Disabilities (DDD) administers publicly-funded community-based disability services. The DDD is responsible for overseeing services to individuals with developmental disabilities throughout Nebraska. This responsibility is focused in two areas: Community Based Services and State Operated Services.

The DDD is involved in an array of planning and implementation activities to ensure that quality developmental services are provided at the Beatrice State Developmental Center (ICF-ID) and in community-based services throughout Nebraska. The DBH, MLTC and the DDD work collaboratively to provide services for individuals who have been determined to meet the eligibility criteria for DDD and experience a behavioral health disorder(s).

Nebraska Supreme Court and the Administrative Office of the Courts & Probation, Justice Behavioral Health Committee

The Administrative Offices of the Courts and Probation’s (AOC / AOP) reach into the service delivery system has expanded over the past few years. The AOP is committed to delivering a system of seamless services (corrections, juvenile and restorative justice) founded on evidenced-based practices. The community-based programs section has newly created adult and juvenile behavioral health section that works collaboratively with DBH on service development, quality assurance, rates, data systems and data sharing as well as the youth System of Care initiative. DBH staff participate on justice committees including justice reinvestment, Fee for Service Voucher Advisory Committee, and local probation/region/DBH networking meetings.

The DBH staff co-chair the Justice Behavioral Health Committee whose mission is to ensure integration, cooperation, and active communication between the justice system and treatment systems; substance abuse and mental health. The Justice Behavioral Health Committee provides a venue for a collaborative working relationship between justice and treatment providers for the ultimate goal of effective competent client care. Its vision involves educational endeavors, data monitoring, provider competency, and strategic planning.

Nebraska Department of Correctional Services

Pursuant to Legislation, Nebraska Department of Correctional (DOC) Services formed a workgroup focused on re-entry into the community for inmates completing their sentences. The DBH participates to ensure timely access to mental health and substance use disorders for inmates leaving corrections facilities. Recent work includes training on Medication Assisted Treatment and access to medications by the DOC for persons discharging from the facilities. The DOC Reentry Team offer individualized reentry services to all incarcerated people at the beginning of their sentence, throughout incarceration, and after release.
Addressing the Needs of a Diverse Population

The DBH is dedicated to providing excellent behavioral health services that are accessible to all members of the community, including racial/ethnic minorities, Native Americans, refugees, and newly-arrived immigrant groups. The DBH functions in accordance with the DHHS Office of Health Disparities & Health Equity (OHDHE), striving for appropriate cultural and linguistic specificity for all recipients of behavioral health services. All RBHAs and their contractors are required to provide services that are culturally and linguistically appropriate. The DBH also contracts directly with the four federally recognized tribes of Nebraska (Ponca, Winnebago, Omaha and Santee Sioux) for behavioral health services and provides staff assistance to the tribes as needed, and works to promote cultural awareness and diversity in the workforce through leadership, training, and direct funding of continuing education classes for providers. Each RBHA is also expected to address the needs of the diverse populations within their designated geographic area based on a comprehensive needs assessment/strategic plan. Each RBHA has an advisory committee consisting of consumers, providers, and other interested parties.

Although Nebraska is often viewed as having a homogenous population, it is becoming increasingly diverse with African American, Hispanic, Native Americans, and immigrants from the continents of Africa and Asia. This being said, the consumer population remains nearly universal when it comes to language preference. In FY2018, 78.6% of individuals receiving Behavioral Health services funded through the DBH indicated English as their preferred language.

Table 3 Nebraska 2017 Estimates of Population by Race and Ethnicity

<table>
<thead>
<tr>
<th>Nebraska 2017 Population Estimates By Race and Ethnicity</th>
<th>Number</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
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<tr>
<td>American Indian and Alaska Native</td>
<td>27,965</td>
<td>1.5%</td>
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<tr>
<td>Asian</td>
<td>49,912</td>
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<tr>
<td>Black or African American</td>
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<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
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<tr>
<td>White</td>
<td>1,700,881</td>
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<tr>
<td>Two or more races</td>
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<td>Total</td>
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<tr>
<td>Total</td>
<td>1,920,076</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, PEPSR6H - Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: April 1, 2010 to July 1, 2017 (June 2018)
### Table 4 Division of Behavioral Health Community Based Services Consumer Race Categories

<table>
<thead>
<tr>
<th>Race of Persons Served</th>
<th>Number</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian and Alaska Native</td>
<td>1,062</td>
<td>3.3%</td>
</tr>
<tr>
<td>Asian</td>
<td>195</td>
<td>0.6%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>2,748</td>
<td>8.4%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>125</td>
<td>0.4%</td>
</tr>
<tr>
<td>White</td>
<td>23,478</td>
<td>72.1%</td>
</tr>
<tr>
<td>Two or more races</td>
<td>423</td>
<td>1.3%</td>
</tr>
<tr>
<td>Some other race</td>
<td>1,210</td>
<td>3.7%</td>
</tr>
<tr>
<td>Not Available</td>
<td>3,338</td>
<td>10.2%</td>
</tr>
<tr>
<td>Total</td>
<td>32,579</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>2,789</td>
<td>8.6%</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>24,418</td>
<td>75.0%</td>
</tr>
<tr>
<td>Not Available</td>
<td>5,372</td>
<td>16.4%</td>
</tr>
<tr>
<td>Total</td>
<td>32,579</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: DBH Centralized Data System, SFY 2018

The RBHAs provide services to diverse populations as demonstrated by comparing the persons served data from State Fiscal Year 2018 to the U.S. Census 2017 population estimates. The percentages of persons who are other than Asian and White served are proportionally higher among all DBH service recipients, compared to their proportion in the total state population. The current data system does not capture LGBTQ information. The DBH continues to review policy on the collection of data pertaining to gender affiliation and sexual preference.

**System Strengths Summary**

The Director of the Nebraska Health and Human Services Division of Behavioral Health (DBH) is the designated State Mental Health Authority and Single State Agency. DBH is recognized as the chief authority of the state to administer, oversee and coordinate the state’s public behavioral health system, in collaboration with Regional Behavioral Health Authorities and other partners. While many strengths exist across the state, some of the greatest strengths the DBH has to leverage for continuous improvement include behavioral health consumer involvement at numerous if not all levels of decision making, a wide variety of behavioral health services in state hospitals and community settings, a workforce dedicated to meeting consumers’ complex needs, and engaged system partners who play a vital role in supporting an effective behavioral health system. Continued training for providers will further develop and maintain a system that is co-occurring capable, trauma-informed, recovery-oriented, and person-centered.

In 2016 DBH conducted two core statewide planning activities, the Nebraska Behavioral Health Needs Assessment and the Division of Behavioral Health Strategic Plan 2017-2020. This
document draws on these activities to summarize the behavioral health landscape.

Summary of System Strengths:

- Quality Assurance/Performance Improvement (QA/PI) measures that are holistic, particularly the use of the Compass EZ Tool,
- Multiple Continuous Quality Improvement (CQI) processes, ensuring checks and balances,
- Two fully engaged behavioral health advisory committees, State Advisory Committee on Substance Abuse Services and State Advisory Committee on Mental Health Services, whose members have a strong commitment to improving access to care throughout the state,
- Suicide Prevention Plan that is holistic and evidenced-based,
- A valuable and well thought out, data-driven Centralized Data System (CDS) which promotes standards for the delivery of care and offers real time outcome tracking and measurement,
- Development and implementation of the DBH Electronic Billing System (EBS) that provides an in-house system to collect, manage, and report financial information,
- Integration between the DBH CDS and EBS leverages technology platforms to provide comprehensive system planning,
- A Mental Health Court that harnesses peer-support to provide an alternative to incarceration for Serious Mental Illness/Serious Emotional Disturbance (SED/SMI) population,
- A strong consumer group, called the Peoples Council, has the support of the SMHA/SSA, is focused on recovery and advocates for expansion of peer-support and access to services in rural areas,
- DBH funding of core Evidence-Based Practices (EBPs) and the requirement that RBHAs incorporate EBPs into their budgets,
- The development and implementation of behavioral health workforce development model,
- Leadership in promoting a culture of change through a multi-faceted approach to infuse health parity throughout the behavioral health care system,
- Employment of consumer surveys to inform programming and practices by DBH, RBHAs and providers; results also are shared with DBH advisory groups,
- Consumer satisfaction with access to services is higher than the national average,
- Readmission rates for state hospitals, both 30 and 180 days, are below the national average, and
- Consumer employment rates are higher than the national average.
Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:
This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative\(^{16}\) HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

B. Planning Steps

For each of the populations and common areas, states should follow the planning steps outlined below:

Step 2: Identify the unmet service needs and critical gaps within the current system.

This step should identify the unmet service needs and critical gaps in the state’s current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state’s M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state’s priorities and goals. This could include data and information that are available through the state’s unique data system (including community-level data), as well as SAMHSA’s data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

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Identifying Unmet Needs and Critical Gaps within Current System

Nebraska understands how important a data driven approach is in order to understand the dynamic needs of our state as well as is necessary to make informed decisions about the services funded for individuals dependent upon the Division of Behavioral Health (DBH) for treatment and recovery. Nebraska has evaluated data from a variety of internal sources on treatment and prevention data collected in addition to external resources that have historically been used to monitor and inform decision making such as the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), and the Uniform Reporting System (URS). The 2015 Behavioral Health Barometer report for Nebraska was also used to identify specific areas of need.

Through review of the aforementioned data sources and reports, the DBH put together an initial needs assessment which was reviewed with the six Regional Behavioral Health Authorities in February 2019 as well as in April 2019 with both of the state Advisory Committees and May 2019 with the State Epidemiological Outcomes Workgroup. These initial reviews provided opportunities for the DBH to receive feedback from valuable stakeholders necessary to help complete the needs assessment and identify Block Grant priority areas and strategies for system improvement. Both committees again were provided information on behavioral health needs in Nebraska during a meeting in August 2019. This meeting was followed by a posting of the draft Block Grant Application sections which, covered identification of service system gaps and consumer needs. The draft application was also posted on the DBH website for public review and comment. Each of these provided opportunity for feedback and suggestions on which areas of need should be prioritized for FY20/FY21.

State Epidemiological Outcomes Workgroup (SEOW)

Formed in March 2007, the SEOW is comprised of administrators, epidemiologists, and key stakeholders who collaborate to make decisions regarding the collection and reporting of data. The SEOW seeks to produce sustained outcomes to prevent the onset and reduce the progression of substance abuse, mental illness, and related consequences.
Currently, the SEOW is composed of Epidemiologists from Behavioral Health and Public Health, administrators from each of the six behavioral health regions and administrators from the DBH and the Division of Public Health. In addition, stakeholders from the public school system, the Office of Highway Safety, the Nebraska Children and Families Foundation, the Nebraska Crime Commission, Ponca Tribe, and the University of Nebraska-Lincoln are also vital members of the group as each provides expertise in their field.

One of the main functions of the SEOW is data review. The SEOW works collectively to identify the availability of data, utilization of data and prioritization of substance abuse data gaps, including missing or incomplete data. In December of 2007, the *Substance Abuse and Associated Consequences in Nebraska – An Epidemiological Profile* was published. Updates were provided in the summer of 2012 and in 2017 to highlight shared or common risk and protective factors that impact both substance abuse and mental health disorders. Through a formal charter, this work will be accomplished by continuation of the Strategic Planning Framework planning process, working across disciplines and implementing strategies that are specifically designed to create environments that support behavioral health and the ability of individuals to withstand challenges.

One of the many contributions the DBH provides to the workgroup is data from the community based substance abuse treatment information which is collected and tracked within the DBH Centralized Data System (CDS) and the Nebraska Prevention Information Reporting System (NPIRS). The DBH leads the workgroup in its efforts to identify priority substance use disorder issues and problems associated with related mental health disorders to maximize use of resources at the state and community level. In many areas, the state has a wealth of data available from which the SEOW will be able to draw assessment information. For example, the Nebraska Young Adult Alcohol Opinion Survey, the Nebraska Risk and Protective Factor Student Survey and the Youth Risk Behavioral Survey provide excellent data for monitoring underage drinking and other youth substance abuse issues. However, in other areas, such as surveillance
systems for monitoring Fetal Alcohol Spectrum Disorders or substance use among older adults, information is minimal. Often, data drives decisions about resources; absence of data impacts the attention directed toward major public health issues. Therefore, ensuring sustainability and ongoing operation of a SEOW is vital to coordinate a public health surveillance system that is capable of providing a comprehensive, focused assessment and analysis.

As part of its work to develop a more inclusive epidemiological profile, the SEOW is continuing to update the Nebraska Statewide Epidemiological Profile of Substance Use and Mental Health to include additional measures of the consequences and effects of substance use and Mental Health conditions. In 2017 the SEOW added information on the number of children removed from households due to parental substance use, economic costs of substance use in Nebraska by business sector, hospitalization due to mental illness, emergency department visit rates for intentional self-harm and prevalence of frequent mental distress in Nebraska.

**Note on Community Behavioral Health Data**

The DBH currently uses its own data management system, the DBH CDS, which was implemented in May 2016. The CDS collects all DBH data related to community behavioral health. The DBH contracts with the six Regional Behavioral Health Authorities (RBHAs) and the RBHAs contract with local providers or, in some cases, directly provide the services. At the service provision level, data are collected and reported directly into the CDS. In this section these notes apply:

1. Data source: Centralized Data System.
   i. Persons Served (unduplicated consumer-level data)
   ii. Service Utilization (encounter-level data)
   iii. Statistics reported do not include number of service utilization or number of persons served at the Regional Centers (state hospitals) unless otherwise noted
2. MH ONLY category means the individual was only served in one or more Mental Health (MH) services funded by the DBH via the six RBHAs.

3. SUD ONLY category means the individual was only served in one or more Substance Use Disorder (SUD) services funded by the DBH via the six RBHAs.

4. DUAL Primary category means the individual was only served in a service category where both Mental Illness and Substance Use Disorder are the primary diagnosis.

5. COMBO means the individual was served in a service category with a combination of both Mental Illness and Substance Use Disorder, where one is listed as the primary diagnosis and the other is listed as a secondary diagnosis.

6. Unless otherwise specified in this report, youth means age 0-17; adult means age 18 and older even though in the State of Nebraska the age of majority is 19.

**Overview of Adults and Youth Served for Mental Health and Substance Abuse**

In Fiscal Year 2018 (FY18), the DBH funded community-based services for 32,579 individuals. When considering service breakdown, 11,854 received treatment for substance use disorders and, including state hospital services, there were 24,889 individuals who received treatment for mental health disorders. There were 10,993 adults served with SMI and 1,667 youth with SED.\(^1\)

**Adults with Serious Mental Illness (SMI)**

The DBH, through the six RBHA networks, serves Adults with Serious Mental Illness (SMI). SMI means that:

- The person is 18 years old or older **AND**

\(^1\)CDS FY18 Treatment Data MH: FY2018 URS table 2A, 14A
Plan Step 2 Identify unmet service needs & critical gaps within current system

The following data tables are from treatment data entered by providers into the DBH CDS and as reflected in the Nebraska FY2018 Uniform Reporting System (URS).

Table 1 URS Table 2A for FY18. Profile of Persons Served in Mental Health Services Age 18+

<table>
<thead>
<tr>
<th>Total Age 18+</th>
<th>21,034</th>
<th>84.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total in MH Services</td>
<td>24,889</td>
<td>100%</td>
</tr>
</tbody>
</table>

Of this population reported on URS Table 2A, 41.7% were between the ages of 25-44 (10,382) and 26.1% are between the ages of 45-64 (6,497), while only 2.8% were described as 65 years or older (689). In FY2018, 52.3% of adults 18 years and older receiving mental health services were described as having a Serious Mental Illness (SMI). The percentage of adults described as SMI has declined from FY2016 (67.8%) and FY2017 (63.3%).

Table 2 URS Table 14A for FY18. Profile of Persons with SMI served Age 18+

<table>
<thead>
<tr>
<th>Total Age 18+ with SMI</th>
<th>10,993</th>
<th>52.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Age 18+</td>
<td>21,034</td>
<td>100%</td>
</tr>
</tbody>
</table>

Youth with Serious Emotional Disturbance (SED)

The DBH, through the six RBHA networks, serves Youth with Serious Emotional Disturbance (SED). SED means that:

- The persons has a GAF score less than 60 OR
- The person is served in one of the Nebraska Behavioral Health System (NBHS) funded Community Mental Health Rehabilitation Based Services (Community Support, Assertive Community Treatment, Psychiatric Residential Rehabilitation, Day Treatment, Day Rehabilitation, Day Support, Vocational Support, or related psychiatric rehabilitation services) OR
- The service provider has indicated that the person has a functional deficit OR
- The person is SSI/SSDI eligible or potentially eligible OR
- The service provider indicates that the person meets SMI criteria.
- The person is between 3 and 17 years old (NE SED definition/URS) AND
- The person has an ICD-10 diagnosis of 'F20.0', 'F20.1', 'F20.2', 'F20.3', 'F20.5', 'F20.81', 'F20.89', 'F20.9', 'F22', 'F23', 'F24', 'F25.0', 'F25.1', 'F25.8', 'F25.9', 'F28', 'F29', 'F30.10', 'F30.11', 'F30.12', 'F30.13', 'F30.2', 'F30.3', 'F30.4', 'F30.8', 'F30.9', 'F31.0', 'F31.10', 'F31.11', 'F31.12', 'F31.13', 'F31.2', 'F31.30', 'F31.31', 'F31.32', 'F31.4', 'F31.5', 'F31.60', 'F31.61', 'F31.62', 'F31.63', 'F31.64', 'F31.70', 'F31.71', 'F31.72', 'F31.73', 'F31.74', 'F31.75', 'F31.76', 'F31.77', 'F31.78', 'F31.81', 'F31.89', 'F31.9', 'F32.0', 'F32.1', 'F32.2', 'F32.3', 'F32.4', 'F32.5', 'F32.8', 'F32.9', 'F33.0', 'F33.1', 'F33.2', 'F33.3', 'F33.40', 'F33.41', 'F33.42', 'F33.8', 'F33.9', 'F34.8', 'F34.9', 'F39', 'F44.89', '300.01', '300.21', '300.3', '301.13', '307.1', '307.23', '307.51', '309.81', '312.34', '314', '314.01', '314.1', '314.2', '314.8', '314.9', 'F40.01', 'F41.0', 'F42', 'F43.10', 'F43.11', 'F43.12', 'F44.89', 'F50.00', 'F50.01', 'F50.02', 'F50.2', 'F63.81', 'F90.0', 'F90.1', 'F90.2', 'F90.8', 'F90.9', 'F95.2' AND
- SSI/SSDI eligible or potentially eligible OR
- The person has been admitted to Professional Partner Services, Special Education Services, Day Treatment Mental Health Services, Intensive Outpatient Mental Health Services, Therapeutic Consultation/School Wrap, Respite Care Mental Health Services OR
- The service provider indicated that the person meets SED criteria.

The following data tables are also from treatment data entered by providers into the DBH CDS and as reflected in the Nebraska FY2018 Uniform Reporting System (URS).

Table 3: URS Table 2A for FY18. Profile of Persons Served, All Programs Age 0-17

<table>
<thead>
<tr>
<th>Total Age 0-17 Years</th>
<th>3,447</th>
<th>13.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total in MH Services</td>
<td>24,889</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

In FY2018, 13.8% of all individuals receiving mental health services funded by the DBH were youth and of those 48.4% were described as having a Serious Emotional Disturbance (SED). The percentage of youth described as SED has declined from FY2016 (57.7%) and FY2017 (52.2%).

Table 4: URS Table 14A for FY18. Profile of Persons with SED served Age 0-17

<table>
<thead>
<tr>
<th>Total Age 0-17 Years with SED</th>
<th>1,667</th>
<th>48.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Age 0-17 Years</td>
<td>3,447</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Capacity Management and Waiting List System for Priority Populations

The DBH operates capacity management and waiting list systems for all services, including services for those who are discharging from the state psychiatric hospital, who have a mental health commitment, are intravenous drug users, pregnant women, or women with dependent children. The annual contract between the DBH and the six RBHAs establishes these reporting requirements. DBH moved the waitlist tracking process into the CDS. As a result, individuals are classified according to the highest priority population they qualify for at the time they are seeking service.

Priority populations are determined by federal and state statutes and/or regulations. Persons in these priority populations require priority admission into treatment services. Contracted providers receiving funds must offer priority populations immediate admission into the appropriate recommended treatment or offer priority placement on the waiting list and federal interim services within 48 hours of the request for treatment. Engagement services must be provided until they are admitted into appropriate recommended treatment.

Mental Health Priority Groups

Priority classification for mental health include individuals who had Mental Health Board (MHB) Commitments for inpatient services, outpatient services, or MHB discharged from the Lincoln Regional Center. Mental health service priority populations include:

- Priority Population 1 - Discharged from Regional Center
- Priority Population 2 - Mental Health Board Commitment – Inpatient
- Priority Population 3 - Mental Health Board Commitment – Outpatient
Plan Step 2 Identify unmet service needs & critical gaps w/in current system | Page 9 of 45

Table 5 MHB Discharged from Lincoln Regional Center (LRC)

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for MHB Discharged from Lincoln Regional Center (LRC)</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # PERSONS SERVED (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>DUAL (primary)</td>
<td>COMBO</td>
</tr>
<tr>
<td>FY2016</td>
<td>9</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>FY2017</td>
<td>62</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>FY2018</td>
<td>54</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.

Table 6 Table Mental Health Board (In-Patient Commitment)

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for Mental Health Board (Inpatient Commitment)</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # persons served (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>DUAL (primary)</td>
<td>COMBO</td>
</tr>
<tr>
<td>FY2016</td>
<td>17</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>FY2017</td>
<td>83</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>FY2018</td>
<td>50</td>
<td>22</td>
<td>16</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.

Table 7 Table Mental Health Board (Out-Patient Commitment)

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for Mental Health Board (Outpatient Commitment)</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # PERSONS SERVED (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>DUAL (primary)</td>
<td>COMBO</td>
</tr>
<tr>
<td>FY2016</td>
<td>47</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>FY2017</td>
<td>696</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td>FY2018</td>
<td>779</td>
<td>48</td>
<td>57</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.
Substance Use Priority Groups

Priority classification for substance use include individuals who are intravenous drug users, pregnant women, or women with dependent children. Substance use priority populations include:

- Priority Population 1 - Pregnant and current intravenous drug using women
- Priority Population 2 - Pregnant substance abusing women
- Priority Population 3 - Current intravenous drug users
- Priority Population 4 - Women with dependent children, including those attempting to regain custody of their children

In FY2018, 11,854 individuals (unduplicated) received some level of services for substance use. Of this population, 57.3% were between the ages of 25-44 (6,787), 20.3% are between the ages of 45-64 (2,405), and 19.9% are between the ages of 18-24 (2,359), while only 1.0% were described as 65 years or older (113). Of those served, 1,198 (10.1%) were persons classified into substance use priority populations. The average wait time for services ranged from 1.82 to 9.59 days for those classified into the various priority populations.

Priority Population 1 - Pregnant and Current Intravenous Drug Using Women

The DBH, through the six RBHA networks, serves youth and adults who are pregnant injecting drug users. The unduplicated counts in Table 8 do not include individuals served through Medicaid and other funding sources. Generally, this priority group represents only a small percentage of persons served. However, an increasing trend can be observed in Table 8. The percentage of women who were pregnant and using intravenous drugs has been increasing from FY2016 through FY2018, .004%, .026%, and .049% respectively. Nevertheless, there has been a decrease in the wait time to service admission for this priority group.
Table 8 Total Services to Pregnant Injecting Drug Users

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for Priority #1</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # PERSONS SERVED (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>SUD (only)</td>
<td>DUAL (primary)</td>
</tr>
<tr>
<td>FY2016</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>FY2017</td>
<td>0</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>FY2018</td>
<td>0</td>
<td>17</td>
<td>2</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.

Priority Population 2 - Pregnant Substance Abusing Women

The DBH, through the six RBHA networks, serves youth and adults who are pregnant substance abusing women. The unduplicated counts in Table 9 do not include individuals served through Medicaid and other funding sources. Generally, less than one percent of the persons served are pregnant substance abusing women. Table 9 presents unduplicated data which indicates an increase from FY2016 to FY2018 (.007% to .117%) of the total number of persons served were classified as pregnant women who were abusing substances.

Table 9 Services to Pregnant Substance Abusers

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for Priority #2</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # PERSONS SERVED (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>SUD (only)</td>
<td>DUAL (primary)</td>
</tr>
<tr>
<td>FY2016</td>
<td>0</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>FY2017</td>
<td>0</td>
<td>41</td>
<td>1</td>
</tr>
<tr>
<td>FY2018</td>
<td>2</td>
<td>36</td>
<td>4</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.
Priority Population 3 - Persons Who Inject Drugs

The DBH, through the six RBHA networks, serves youth and adults who are injecting drug users. The unduplicated counts in Table 10 do not include individuals served through Medicaid and other funding sources. There is an increasing trend in the number of the persons served who are injecting drug users. Table 10 presents unduplicated data for persons served which indicate an increase from .07%, 2.06%, and 2.15% were injecting drug users in FY2016 through FY2018 respectively. However, days waiting for admission has decreased substantially over the same time period.

Table 10 Services to Injecting Drug Users

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for Priority #3</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # PERSONS SERVED (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>SUD (only)</td>
<td>DUAL (primary)</td>
</tr>
<tr>
<td>FY2016</td>
<td>0</td>
<td>45</td>
<td>7</td>
</tr>
<tr>
<td>FY2017</td>
<td>7</td>
<td>801</td>
<td>149</td>
</tr>
<tr>
<td>FY2018</td>
<td>15</td>
<td>1081</td>
<td>216</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.

Priority Population 4 - Women with Dependent Children

The DBH, through the six RBHA networks, serves youth and adults who are women with dependent children (WWDC). The unduplicated counts in Table 11 do not include women served through Medicaid and other funding sources. The percentages of women with dependent children served have decreased between FY2016 through FY2018 were 3.24%, 10.72%, and 1.36% respectively. There was also a decrease in their wait time for services in FY2018.
Table 11 Services to Women with Dependent Children

<table>
<thead>
<tr>
<th></th>
<th># SERVICE ENCOUNTERS for Priority #4</th>
<th>Average wait time per encounter (days*)</th>
<th>Total # PERSONS SERVED (unduplicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH (only)</td>
<td>SUD (only)</td>
<td>DUAL (primary)</td>
</tr>
<tr>
<td>FY2016</td>
<td>47</td>
<td>1329</td>
<td>72</td>
</tr>
<tr>
<td>FY2017</td>
<td>19</td>
<td>643</td>
<td>124</td>
</tr>
<tr>
<td>FY2018</td>
<td>20</td>
<td>587</td>
<td>119</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of cases for which a value was reported.

Federal Interim Services for Substance Use

DBH operates a capacity management and waiting list systems for all services. DBH changed the waitlist tracking process when it was activated in the CDS during 2017. As a result individuals are only tracked according to the highest priority population for which they qualify.

Persons in a priority population receive priority admission into treatment services or, if treatment is not immediately available, are offered priority placement on the waiting list and provided interim services within 48 hours of the request for treatment. Engagement services must be provided until they are admitted into appropriate recommended treatment.

In July 2017, CDS added a new data element, “Federal Interim Services Delivered Date,” to enhance collection and monitoring in capacity and waiting list systems. Providers now enter the date interim services were provided to indicate the date of delivery which allows DBH to track provider compliance to interim service expectations. Contracts with providers require data collection and tracking to maintain this monitoring and reporting capability.

The count of unique persons who received treatment services for substance use disorders in FY2018 was 11,854. Looking specifically at individual encounters where the
individual was placed on a waitlist during FY2018 for SUD and Dual type services, there were 1,396 encounters of which 484 were indicated to have a priority population status, leaving 912 with “None” or “Unknown” as the priority status indication (Table 12). Federal Interim Service Delivery dates were only recorded for 235 of the encounters where a priority population status was recorded. This data indicates work must continue in order to educate providers on the importance of offering Interim Substance Use Disorder Services to priority populations seeking treatment when a provider is not able to admit a pregnant woman within 48 hours or an individual who injects drugs within 14 days after making a request for admission to treatment.

Table 12 Persons Placed on a Waitlist for Admission to SUD or Dual Services in FY2018

<table>
<thead>
<tr>
<th>Priority Population by Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>5</td>
</tr>
<tr>
<td>Pregnant and Current Intravenous Drug Using Women</td>
<td>6</td>
</tr>
<tr>
<td>Pregnant Substance Abusers</td>
<td>27</td>
</tr>
<tr>
<td>Injecting Drug Users</td>
<td>275</td>
</tr>
<tr>
<td>Women with Dependent Children</td>
<td>167</td>
</tr>
<tr>
<td>Mental Health Board Commitment - Inpatient</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health Board Commitment – Outpatient</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,396</strong></td>
</tr>
</tbody>
</table>

Behavioral Health Services for Individuals in Rural Areas

The DBH provides community based services to individuals with mental health and/or substance use disorders who live in rural areas, which geographically represents much of Nebraska. The U.S. Census Bureau defines an urban areas and urban clusters as relatively “densely developed territory”, [which] encompass residential, commercial, and other non-residential urban land uses (2010 Census Urban and Rural Classification and Urban Area Criteria). Urban areas have populations of 50,000 or more people; urban
clusters have populations of at least 2,500 but less than 50,000 people. All areas that are not urban are considered rural.²

As of July 1, 2018, the U.S. Census estimated that Nebraska’s total population was 1,929,268, with approximately 34.43% of persons living in rural counties.³ Unduplicated data from FY2016 to FY2018 indicated that 37.21%, 34.17%, and 33.10% of the total number of persons served resided in rural areas. Table 13 references the Metropolitan Statistical Areas in Nebraska, including urban areas and urban clusters. Given the significant infrastructural difference between urban and rural counties in Nebraska, Table 14 indicates the encounter service unit counts by type of service, by age category, and fiscal year for persons residing in rural counties. The overall number of service encounters and persons served in rural counties indicated similar pattern to the state averages in FY16 through FY18.

⁴ Thirteen (13) counties in Nebraska are designated Metropolitan Areas by the U.S. Office of Management and Budget based on the application of published standards to U.S. Census Bureau data. For the purposes of reporting this measure, the remaining 80 Nebraska Counties are classified as rural.
⁵ U.S. Census Bureau, Population Division
Table 13 Urban Counties in Nebraska

<table>
<thead>
<tr>
<th>Urban Areas &amp; Urban Clusters</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lincoln, NE</strong></td>
<td></td>
</tr>
<tr>
<td>Lancaster County, NE</td>
<td>317,272</td>
</tr>
<tr>
<td>Seward County, NE</td>
<td>17,318</td>
</tr>
<tr>
<td><strong>Omaha-Council Bluffs, NE-IA</strong></td>
<td></td>
</tr>
<tr>
<td>Cass</td>
<td>26,159</td>
</tr>
<tr>
<td>Douglas County, NE</td>
<td>566,880</td>
</tr>
<tr>
<td>Sarpy County, NE</td>
<td>184,459</td>
</tr>
<tr>
<td>Saunders County, NE</td>
<td>21,303</td>
</tr>
<tr>
<td>Washington County, NE</td>
<td>20,667</td>
</tr>
<tr>
<td><strong>Grand Island, NE Area</strong></td>
<td></td>
</tr>
<tr>
<td>Hall County, NE</td>
<td>61,607</td>
</tr>
<tr>
<td>Hamilton County, NE</td>
<td>9,280</td>
</tr>
<tr>
<td>Howard County, NE</td>
<td>6,468</td>
</tr>
<tr>
<td>Merrick County, NE</td>
<td>7,733</td>
</tr>
<tr>
<td><strong>Sioux City, IA-NE-SD Area</strong></td>
<td></td>
</tr>
<tr>
<td>Dakota County, NE</td>
<td>20,083</td>
</tr>
<tr>
<td>Dixon County, NE</td>
<td>5,709</td>
</tr>
<tr>
<td><strong>Urban (above)</strong></td>
<td>1,264,938</td>
</tr>
<tr>
<td><strong>Rural Total</strong></td>
<td>664,330</td>
</tr>
<tr>
<td><strong>State of Nebraska Total</strong></td>
<td>1,929,268</td>
</tr>
</tbody>
</table>
Table 14 Behavioral Health services to people living in rural areas

<table>
<thead>
<tr>
<th>Services to people in RURAL AREAS</th>
<th>FY2016</th>
<th>FY2017</th>
<th>FY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MH (only)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth service encounters</td>
<td>949</td>
<td>951</td>
<td>1033</td>
</tr>
<tr>
<td># Youths served</td>
<td>821</td>
<td>833</td>
<td>876</td>
</tr>
<tr>
<td>Adult service encounters</td>
<td>8817</td>
<td>9340</td>
<td>8935</td>
</tr>
<tr>
<td># Adults served</td>
<td>4846</td>
<td>4291</td>
<td>4639</td>
</tr>
<tr>
<td><strong>SUD (only)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth service encounters</td>
<td>75</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td># Youths served</td>
<td>63</td>
<td>27</td>
<td>16</td>
</tr>
<tr>
<td>Adult service encounters</td>
<td>6128</td>
<td>5669</td>
<td>5236</td>
</tr>
<tr>
<td># Adults served</td>
<td>3208</td>
<td>2840</td>
<td>2436</td>
</tr>
<tr>
<td><strong>DUAL (primary)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth service encounters</td>
<td>18</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td># Youths served</td>
<td>14</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Adult service encounters</td>
<td>1151</td>
<td>1076</td>
<td>993</td>
</tr>
<tr>
<td># Adults served</td>
<td>513</td>
<td>549</td>
<td>490</td>
</tr>
<tr>
<td><strong>COMBO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth service encounters</td>
<td>19</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td># Youths served</td>
<td>15</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Adult service encounters</td>
<td>1491</td>
<td>1723</td>
<td>1693</td>
</tr>
<tr>
<td># Adults served</td>
<td>659</td>
<td>742</td>
<td>704</td>
</tr>
<tr>
<td><strong>RURAL TOTAL</strong> (residents of rural counties)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encounters Across All Services</td>
<td>18,702</td>
<td>19,874</td>
<td>21,433</td>
</tr>
<tr>
<td>Average Wait Time (days)</td>
<td>2.50</td>
<td>2.03</td>
<td>1.19</td>
</tr>
<tr>
<td># Persons served</td>
<td>10,184</td>
<td>10,495</td>
<td>10,785</td>
</tr>
<tr>
<td><strong>Nebraska DHHS-DBH TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encounters Across All Services</td>
<td>51,979</td>
<td>58,723</td>
<td>63,613</td>
</tr>
<tr>
<td>Average Wait Time (days)</td>
<td>2.29</td>
<td>2.43</td>
<td>1.58</td>
</tr>
<tr>
<td># Persons served</td>
<td>27,366</td>
<td>30,715</td>
<td>32,579</td>
</tr>
</tbody>
</table>

*Average wait time is based on number of encounters for which this statistic was reported in the CDS.
**Totals reflect both rural and urban services/persons served that were documented in the CDS.
Priority Areas for FY2020/2021

In addition to providing foundational understanding of the general profile of adults and youth served in the current behavioral health service system, data sources highlighted specific areas of need. The most current set of data indicate the need for work focused on:

1. Prevention of binge drinking among youth and young adults;
2. Increasing the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use;
3. Increasing support for consumers to secure and maintain permanent housing;
4. Increasing support for consumers to sustain and acquire employment;
5. Increasing access to community-based services for priority populations;
6. Increasing the number of persons admitted into treatment for first-episode psychosis;
7. Referral to services for persons with tuberculosis.

Data in support of each focus area are provided below.

Alcohol Use among Youth and Young Adults

According to the United Health Foundation for American's Health Rankings 2018 Nebraska has a very high prevalence of binge drinking. This study indicated that 21.7% of Nebraska adults report binge drinking, which places Nebraska as the 46th out of 50 states. In addition, underage alcohol consumption continues to be a problem among youth in Nebraska. The National Survey of Drug Use and Health (NSDUH) indicates youth alcohol use rates, and binge drinking in particular, are higher in Nebraska compared to national rates. According to 2016-2017 NSDUH results, 29% of people aged 12 or older in Nebraska reported binge drinking in the past month compared to the national average of 24.34%.
Additionally, the Behavioral Risk Factor Surveillance System (BRFSS) survey has noted Nebraska binge drinking has been above the U.S. overall rate for the last five years. In 2017, it found that among Nebraska adults 18 and older, 20.6% reported binge drinking, compared to 17.4% among the U.S. population overall (Figure 1).

![Figure 1 Percentage of Adults Indicating Binge Drinking in Past 30 Days, NE vs US](image)

The BRFSS data from to 2017 (Figure 2) indicate that the most common ages for binge drinking are from 18 to 34 years old. Binge drinking begins to decrease significantly at age 35 and continues to decrease as individuals get older. When accounting for race and ethnicity (adjusting the results for age) the two highest groups for binge drinking are Whites (23.4%) and American Indians (21.9%) (Figure 3).
Plan Step 2: Identify unmet service needs & critical gaps within current system

Figure 2: Adult Current Binge Drinking by Age

Figure 3: Current Binge Drinking (age-adjusted) among Nebraska Adults by Race/Ethnicity

*Adults 18 and over reporting binge drinking during the 30 days preceding the survey
Source: Behavioral Risk Factor Surveillance Survey (BRFSS)
Based on the NSDUH data for those 12 and older, clear trends emerged related to concerning alcohol use trends in Nebraska. The trends for alcohol abuse and binge drinking in Nebraska are very similar to the national trends (Figure 4 and Figure 5). Both Nebraska and the U.S. have seen a decrease in abuse and dependency for alcohol, but the percentage in Nebraska is consistently higher than the overall percentage for the U.S. (Figure 4). Notably, between 2015 and 2017, there has been an upward trend for dependency or alcohol abuse in young adults (18-25 years) in Nebraska (Figure 5), which reiterates the need to prioritize prevention and other services in this demographic.

Figure 4 NSDUH - Percentage of Respondents Classified as Dependent or Abusing Alcohol NE vs U.S 12 and older
Both of the aforementioned data sources, the NSDUH and BRFSS, provide evidence that demonstrates the need to prioritize prevention efforts targeting alcohol abuse/disorder and to put emphasis on underage and binge drinking among Nebraska youth and young adults. The continued need for alcohol-related services to youth and young adults is further corroborated in the Behavioral Health Barometer⁶ (p.12). In Nebraska, the trend for alcohol use disorder among individuals aged 12 and older is consistently higher than the national average at every point of measure.

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⁶ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Nebraska, Volume 4: Indicators as measured through the National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System. HHS Publication No. SMAQ-17-Baro-16-States-NE. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.
Evidence-Based Programs on Alcohol Use and Substance Use

As indicated in the Behavioral Health Barometer, alcohol appears to be the drug of choice as it is commonly combined with other drugs (Table 15) to make alcohol involved treatments account for more than two thirds of Nebraska’s substance use treatments in 2015. This situation further illustrates the need for multifaceted approaches in treatment strategies and processes.

Table 15 Drug Prevalence among Individuals Enrolled in Substance Use Treatments (Nebraska)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Problem Only</td>
<td>33.0%</td>
</tr>
<tr>
<td>Alcohol Problem Only</td>
<td>19.8%</td>
</tr>
<tr>
<td>Both Drug and Alcohol Problem</td>
<td>47.2%</td>
</tr>
<tr>
<td>Alcohol Involved Treatments</td>
<td>67.0%</td>
</tr>
</tbody>
</table>

As a requirement of the DBH’s annual Regional Budget Planning process, at least 60% of the Substance Abuse Block Grant (SABG) primary prevention dollars received by community coalitions is firmly allocated for community-based and environmental strategies. Emphasis is placed on using a multi-strategy approach where one or more environmental strategies are designed to impact the community and societal levels (of the social-ecological model) as well as impacting the individuals in their community’s target populations. In order to address the availability of substances as well as the community norms around these concerns, sub-recipients are expected to tailor their efforts to areas and strategies to areas highlighted by a local needs assessment and in tandem with community readiness and coalition capacity. Sub-recipients of the SABG are highly encouraged to utilize evidence-based practices and programs to address the identified needs in their catchment areas.

The percentage of Evidence-Based Programs implemented by prevention coalitions to reduce alcohol and substance use among individuals 9 to 20 years old are presented in
Figure 7. Prevention data entered into the Nebraska Prevention Information Reporting System (NPIRS) revealed evidence-based strategies peaked in FY2018 at 30.5% but have since decreased in FY2019 to 28.0% as described in Figure 7 and 8. The overall goal is to increase the use of Evidence-Based Programs during the upcoming Block Grant period FY2020-FY2021.

Figure 6  Evidence-Based Programs by Intervention Types (2016-2019)

![Evidence-Based Programs by Intervention Types](image)

Figure 7 Percentage of Evidence-Based Programs from 2016-2019

![Percentage of Evidence-Based Programs](image)
**Housing: Increase support for consumers to secure and maintain permanent housing.**

The lack of safe and affordable housing is a significant barrier to recovery from mental health and/or substance use disorders. (See DBH “Nebraska Supportive Housing Plan” http://dhhs.ne.gov/Reports/DBH-Nebraska%20Supportive%20Housing%20Plan%20-%20August%202016.pdf). Many adults with a serious mental illness live on Supplemental Security Income (SSI), a federal cash benefit program for those either 65 or older, blind, or disabled, and who have limited incomes. SSI provides a limited amount of cash; therefore, persons relying on SSI may have difficulty finding an affordable home.

In Nebraska, consumers discharge to stable living situations from community-based behavioral health services over 80% of the time on average. Consumers in residential services, however, discharge to stable living situations at a much lower rate. Figure 8 shows differences between the average discharge rates to stable living of consumers from all behavioral health services compared to the discharge rate for those consumers in residential services. As such, it is necessary to focus on the availability of affordable housing options for consumers discharging from the most intensive behavioral health services.
Plan Step 2 Identify unmet service needs & critical gaps w/in current system | Page 26 of 45

Figure 8 Quarterly Percent of Behavioral Health Consumers in Stable Living Arrangements at Discharge

**Employment: Increase support for consumers to sustain and acquire employment.**

Along with housing, consumers have much healthier and sustainable outcomes when they are able to obtain, and sustain, employment. Nebraska, as shown in Table 16 and Table 17, has a significant portion of its consumers who are receiving mental health services and are not in the labor force. Those who are not employed and have not actively sought in the past 30 days have made up over 40% of Nebraska’s consumers for a significant amount of time.
Table 16 Employment Status by Age Group (SAMHSA, 2015)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Employed</th>
<th>Unemployed</th>
<th>Not in Labor Force</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (Aged 18 or Older)</td>
<td>34.5%</td>
<td>21.2%</td>
<td>44.3%</td>
</tr>
<tr>
<td>18-20</td>
<td>37.0%</td>
<td>24.7%</td>
<td>38.3%</td>
</tr>
<tr>
<td>21-64</td>
<td>34.8%</td>
<td>21.3%</td>
<td>43.9%</td>
</tr>
</tbody>
</table>

Table 17 Employment Status by Age Group (URS Table, FY18)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Employed</th>
<th>Unemployed</th>
<th>Not in Labor Force</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (Aged 18 or Older)</td>
<td>34.3%</td>
<td>24.1%</td>
<td>41.6%</td>
</tr>
</tbody>
</table>

Even when consumers are able to enter the labor market, those discharging from behavioral health services often struggle to obtain employment by the end of service delivery. Figure 9 below shows how discharge rates from mental health and substance use disorder services, with noted exceptions, hover around 50% of consumers in the labor market who are discharging with employment statuses that qualify as employed; these include full and part time employment and full and part time armed forces. These figures highlight employment as a priority area for Nebraska to address moving forward.
Improvements in helping consumers gain employment can be made as demonstrated in Figure 10 which shows two-year quarterly trends for employment outcomes for those discharging from Supported Employment programs.
Increase access to community based services for priority populations

The DBH uses information from multiple sources to consider needs associated with access to mental health and substance abuse services: The Nebraska Annual Social Indicators Survey (NASIS)\textsuperscript{7}; Behavioral Health Barometer; Behavioral Health in Your Community Survey (BH provider survey) \textsuperscript{8}; and the National Survey of Substance Abuse Treatment Services (N-SSATS)\textsuperscript{9}.

The overarching theme in responses from the NASIS 2019 were that respondents were generally aware (60% to 69.5%) of the availability status of treatment for mental health, crisis, and substance use in their community (Figure 11). The substantial number of respondents who indicated that they were not certain about the availability of treatment in their community illustrates a need to increase awareness/visibility and potentially reduce barriers to accessing treatment. Figure 12 presents the likelihood that respondents would use the resources indicated to locate/identify potential services should the need arise for mental health, crisis, and/or substance abuse. The information in Figure 12 inadvertently indicates need, but more so, it highlights potential modes for communication.

\textsuperscript{7} NASIS is a multi-focused (inter-organizational) mailed in survey administered to a sample drawn from the general public. The 2019 administration had a historically low response rate (n=377); timing of the distribution was immediately before the catastrophic floods in March.

\textsuperscript{8} The Behavioral Health in Your Community Survey sampled 17 local Health Departments of various sizes in Nebraska (n=33).

\textsuperscript{9} N-SSATS is a survey directly soliciting feedback from state-approved facilities. In 2013, Nebraska’s response rate was 96.3% (107 respondents).
Figure 11 NASIS 2019: Treatment Availability in Nebraska

![Treatment Availability Chart]

Figure 12 Potential Resources to Identify/Locate Services

![Perceived Potential Resources for Treatment Chart]
As indicated in the Behavioral Health Barometer, mental health consumers in Nebraska and the USA report improved functioning from treatment, which is a positive credit to the effectiveness of services. For children and adolescents (17 and younger) in Nebraska, the percentage is lower than the national percentage by 9.2% (NE 62.4%; USA 71.6%). However, the percentage for adults (18 and older) is higher than the national percentage by 1.3% (NE 73.1%; USA 71.8%).

Additional survey work conducted in early 2019 captures the perspective of the respondents (employees) of local health departments across the state. The most apparent need is to get high quality care for either substance use disorders or mental health concerns across many areas of the state, and particularly in Western Nebraska. Low availability of choices and long wait times were prevalent, even in areas where higher numbers of providers are present. This report aligns with provider data at the county level, and speaks to the need to increase access to services. On the other hand, 69.7% of respondents reported that Behavioral Health is included as a priority in their department’s Community Health Improvement Plan.

Data in the CDS indicate that there is a decreasing trend in the wait times for services both in rural areas and in the state. However, the need persists to increase services to address the increasing number of consumers in priority populations, especially people who inject drugs, and in general.

**Increase access to community based services for priority populations – Need in Short Term Residential**

Nebraska Vital Records 2017 data as compared to data reported in 2015 and 2016 describes an increase in the number of deaths described as due to drug overdose for several drug types, with the exception of methadone and cocaine involved. The highest count of drug overdoses in 2017 were related to various types of opioid use (Table 18). A large portion of drug overdose deaths are due to an unspecified drug listed. The Division of Public Health has been working the past 2 years on a post-mortem toxicology program under the DOJ Comprehensive Opioid Abuse Program (COAP)
grant which can run additional labs and testing on suspected drug overdoses. This results in better data collection methods which can identify overdose deaths which would otherwise be listed as unspecified, as a true opioid overdose. So the upward trend of opioid overdoses could, in fact, be an increase in actual overdoses, an increase in media coverage and awareness which leads to an increase in reporting, or the increase in better toxicology testing methods.

Table 18 Number of All Drug Overdose Deaths and Selected Drug Involved Overdose Deaths by Year, Nebraska 2015-2017

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Total 2015-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Drug-involved Overdose</td>
<td>149</td>
<td>128</td>
<td>183</td>
<td>460</td>
</tr>
<tr>
<td>All Opioids (includes heroin, methadone, synthetic) T40.0-T40.4, T40.6</td>
<td>58</td>
<td>45</td>
<td>63</td>
<td>166</td>
</tr>
<tr>
<td>Opioid involved (not including heroin) T40.2-T40.4</td>
<td>54</td>
<td>38</td>
<td>59</td>
<td>151</td>
</tr>
<tr>
<td>Synthetic opioid involved (includes fentanyl and tramadol) T40.4</td>
<td>15</td>
<td>11</td>
<td>25</td>
<td>51</td>
</tr>
<tr>
<td>Methadone involved T40.3</td>
<td>12</td>
<td>7</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Benzodiazepine involved T42.4</td>
<td>24</td>
<td>26</td>
<td>32</td>
<td>82</td>
</tr>
<tr>
<td>Cocaine involved T40.5</td>
<td>5</td>
<td>10</td>
<td>*suppressed</td>
<td>15*</td>
</tr>
<tr>
<td>Psychostimulants with abuse potential (including methamphetamine) T43.6</td>
<td>36</td>
<td>19</td>
<td>50</td>
<td>105</td>
</tr>
<tr>
<td>Unspecified drug listed T50.9</td>
<td>81</td>
<td>75</td>
<td>96</td>
<td>252</td>
</tr>
</tbody>
</table>

*Note: Categories are not exclusive, because some deaths involve multiple drugs.*

*Cells with values less than 5 have been suppressed.

Data Source: Nebraska Vital Records, 2015-2017

Short Term Residential treatment is intended for adults with a primary substance use disorder requiring a more intensive treatment environment to obtain sobriety and engage in treatment. This service is highly structured and provides primary,
comprehensive substance use disorder treatment. Each year the DBH funds Short Term Residential treatment for approximately 1,200 to 1,300 individuals. Of those admitted into service in FY2018, the majority presented with a treatment need related to the use of methamphetamine/speed, alcohol, marijuana/hashish, or other opiates/synthetics. Table 19 describes the counts of each primary, secondary and tertiary substance type for those admitted in FY2018.

Table 19 Substances Reported for Individuals Admitting into Short Term Residential Treatment in FY2018

<table>
<thead>
<tr>
<th>Substance Used</th>
<th>Primary</th>
<th>Secondary</th>
<th>Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methamphetamine/Speed</td>
<td>568</td>
<td>152</td>
<td>67</td>
</tr>
<tr>
<td>Alcohol</td>
<td>490</td>
<td>144</td>
<td>90</td>
</tr>
<tr>
<td>Marijuana/Hashish</td>
<td>98</td>
<td>391</td>
<td>92</td>
</tr>
<tr>
<td>Other Opiates or Synthetics</td>
<td>41</td>
<td>36</td>
<td>23</td>
</tr>
<tr>
<td>Heroin</td>
<td>26</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Cocaine</td>
<td>21</td>
<td>38</td>
<td>19</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>14</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Alprazolam (Xanax)</td>
<td>9</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Hydrocodone (Vicodin)</td>
<td>9</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Oxycodone (Oxycontin)</td>
<td>8</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>482</td>
<td>961</td>
</tr>
<tr>
<td>Not Available</td>
<td>0</td>
<td>456</td>
<td>944</td>
</tr>
</tbody>
</table>

Total = 1296 Admissions in FY2018

Consumers across the six behavioral health regions required treatment in Short Term Residential programs during FY2018. Capacity data shows that Short Term Residential programs ran on average around 95% full capacity, requiring most individuals seeking treatment to have some duration of wait before admitting into treatment. Wait detail of each distinct encounter by the priority populations for those admitted into Short Term Residential services can be found in Table 20. Distinct encounter is defined as one
episode of care (starting with placement on a waitlist prior to admission) for one consumer, in one service, to one provider.

Table 20 Access to Short Term Residential Services (STR) for Substance Use Disorder (SUD) for Individuals Placed on Waitlist during FY2018

<table>
<thead>
<tr>
<th>Priority SUD Group</th>
<th>Service/Description</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant IV Drug User</td>
<td># of STR encounters FY18</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Average wait time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admitted within 14 days*</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Admitted within 30 days*</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>served for Mental Health FY18</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>served for Substance Use FY18</td>
<td>.2%</td>
</tr>
<tr>
<td>Pregnant Drug User</td>
<td># of STR encounters FY18</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Average wait time</td>
<td>7 days</td>
</tr>
<tr>
<td></td>
<td>Admitted within 14 days*</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td>Admitted within 30 days*</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>served for Mental Health FY18</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>served for Substance Use FY18</td>
<td>.3%</td>
</tr>
<tr>
<td>IV Drug User</td>
<td># of STR encounters FY18</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Average wait time</td>
<td>13 days</td>
</tr>
<tr>
<td></td>
<td>Admitted within 14 days*</td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td>Admitted within 30 days*</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td>served for Mental Health FY18</td>
<td>.2%</td>
</tr>
<tr>
<td></td>
<td>served for Substance Use FY18</td>
<td>7.9%</td>
</tr>
<tr>
<td>Women With Dependent Children</td>
<td># of STR encounters FY18</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Average wait time</td>
<td>14 days</td>
</tr>
<tr>
<td></td>
<td>Admitted within 14 days*</td>
<td>38%</td>
</tr>
<tr>
<td></td>
<td>Admitted within 30 days*</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td>served for Mental Health FY18</td>
<td>.1%</td>
</tr>
<tr>
<td></td>
<td>served for Substance Use FY18</td>
<td>4%</td>
</tr>
<tr>
<td>NEBRASKA DHHS-DBH TOTAL</td>
<td># of STR encounters FY18</td>
<td>1,283</td>
</tr>
<tr>
<td></td>
<td>total # unduplicated consumers FY18</td>
<td>32,579</td>
</tr>
<tr>
<td></td>
<td>Average wait time</td>
<td>9 days</td>
</tr>
<tr>
<td></td>
<td>Admitted within 14 days*</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td>Admitted within 30 days*</td>
<td>90%</td>
</tr>
</tbody>
</table>

When reviewing FY2018 wait data for those individuals seeking Short Term Residential services, the average wait time was found to be around 9 days and 79% of all consumers were admitted within 14 days. Priority for admission is expected to be granted to those meeting criteria for substance use priority populations; however, the
data also demonstrates that for IV Drug Users only 51% of those admitted into service within 14 days and for Women with Dependent Children only 38% admitted into service within 14 days.

**Coordinated specialty care for persons with first episode of psychosis**

Psychosis is treatable and recovery, particularly from related problematic symptoms, is possible. Research suggests early intervention can improve treatment outcomes; however, psychosis in the early stages may not be detected right away. Although the majority of services funded through the DBH are for adults, many youth and young adults benefit from the DBH substance use and mental health service array. The DBH has been working to address first episode of psychosis (FEP) over the past several years.

First Episode Psychosis Pilot Program eligibility criteria were changed in 2018 and have been revised as follows:

- Person is 14 to 35 years old
- Person has a diagnosis of: 295.90–Schizophrenia; 295.40–Schizophreniform Disorder; 295.70–Schizoaffective Disorder; 297.1-Delusional Disorder; 298.8-Brief Psychotic Disorder; and 298.9- Psychotic Disorder NOS
- Symptom Duration of a psychotic disorder for a period lasting more than one (1) week and no more than two (2) years.
- Exclusionary Criteria
  - Diagnosed with an Intellectual Disability
  - Psychotic Disorder Due to a General Medical Condition
  - Substance-Induced Psychotic Disorder (Substance Use Disorder as a secondary diagnosis is not excluded.)
  - Depressive and Bipolar Disorders
  - The Families of individuals age 18 and younger would have to agree to participate

A review of recent DBH treatment data for those meeting the age and diagnostic criteria necessary for program eligibility indicates a continuous and even growing need for treatment. As described in Table 21, data from FY2016, FY2017 and FY2018 shows a fairly consistent count for females and an increase for males between the ages of 14 to 35 who have a psychotic disorder diagnosis. In FY2018 there were 1,115 youth and
young adults meeting this criteria amongst those in behavioral health services funded by DBH across the state; 342 were female and 767 were male.

Table 21 First Episode Psychosis by Gender*, FY2016-2018

<table>
<thead>
<tr>
<th>Gender by Fiscal Year*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Not Available</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*Estimates based on those receiving services funded through DBH who meet revised eligibility criteria

The Nebraska FEP Coordinated Specialty Care (CSC) Pilot Programs were implemented in two of the six behavioral health service regions of the state. The two separate, independent FEP CSC Pilot Program teams are located in the Omaha metropolitan area (RBHA Region 6 Behavioral Healthcare; population 900,000) and in the Kearney micropolitan area (RBHA Region 3 Behavioral Health Services; population 150,000, from the two urban areas Grand Island and Kearney). The two teams are separated by 190 miles. These areas were selected because of a concentration of youth identified as experiencing FEP in addition to an existing concentration of specialty youth services. Data from FY2016, FY2017 and FY2018 shows that many of the youth and young adults meeting this criteria across the state (as were described in Table 21) reside in Regions which currently have a FEP Pilot Program (Table 22).

Table 22 First Episode Psychosis by FEP Pilot Program Catchment Areas*, FY2016-2018

<table>
<thead>
<tr>
<th>FEP Pilot Program Catchment Areas by Fiscal Year*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regions with FEP Pilot Programs</td>
</tr>
<tr>
<td>Region 3</td>
</tr>
<tr>
<td>Region 6</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*Estimates based on those receiving services in Region 3 and Region 6 funded through DBH who meet revised eligibility criteria
While the data indicates a much larger population who may potentially have a need for FEP treatment, admissions have been fairly small while the pilot programs have been getting established, training staff, and learning recruitment strategies. As shown in Table 23, there were 11 new admissions in FY2018 between the two programs which was consistent with enrollment in FY2017 and which showed an increase from the 7 new admissions in FY2016.

**Table 23 Statewide Count Total Enrolled FEP Pilot Programs**

<table>
<thead>
<tr>
<th>Year</th>
<th>New Admissions</th>
<th>Enrolled in Programs</th>
<th>Discharged</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2016</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>FY2017</td>
<td>11</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>FY2018</td>
<td>11</td>
<td>12</td>
<td>7</td>
</tr>
</tbody>
</table>

It is important during treatment of psychosis that areas of functioning are addressed. In a 2011 survey, NAMI asked the level of difficulty in managing aspects of daily life for individuals dealing with psychosis. Individuals who experienced psychosis rated social life as very difficult (51.1 percent) followed by work (47.5 percent) romantic relationships (47.4 percent), friendships (42.6 percent) and relationships with parents (39.2 percent).

Use of the Mental Illness Research, Education and Clinical Centers (MIRECC) version of the Global Assessment Functioning (GAF) Expanded scale has allowed providers in the FEP programs to measure and track improvements in functioning for the youth and young adults receiving treatment for first episodes of psychosis. MIRECC GAF Expanded measures individuals in occupational functioning, social functioning, and symptom severity on three subscales, in addition to offering a total functioning score. On average for the program enrollees, scores in each scale and as a whole assessment improved from the initial assessment (taken at the time of admission) to those taken
following FEP treatment. The first study offered a baseline average total score difference of 45.75 on the MIRECC GAF between admission and post-treatment. A second study the following year indicated even greater success with an average total score difference of 63.73. Review of pre and post treatment assessment scores have demonstrated improvement in functioning for the enrolled youth and young adults, indicating program success and readiness for enrollment expansion.

**Figure 13 MIRECC GAF**

![MIRECC GAF Expanded Pre- and Post-Treatment Outcome Scores](image)

**Baseline Average Total Score**
- Pre-test = 127.75
- Post-test = 173.50
- Average Baseline Total Score Difference = 45.75

**First Year Average Total Score**
- Pre-test = 123.77
- Post-test = 187.50
- Average First Year Total Score Difference = 63.73

**Additional Considerations**

**Requirements Regarding Tuberculosis**

Under the Substance Abuse Prevention and Treatment Block Grant (§96.127 Requirements Regarding Tuberculosis), the Single State Authority for Substance Abuse Services (SSA) must require programs receiving funds to treat substance abuse to routinely make Tuberculosis (TB) services available to each individual receiving...
treatment for substance abuse. The DBH is the SSA in Nebraska. While DBH has no specific financial set aside for TB services, partnership exists with the Nebraska Department of Health and Human Services - Division of Public Health which supports TB testing, education and treatment.

In 2018, Nebraska’s Health Departments reported 25 cases of active TB with a case rate of 1.30 per 100,000 (Source: Nebraska Department of Health and Human Services (DHHS) Tuberculosis Program Report 2018). This represents an increase in the number of cases and a higher case rate compared to 2017. In the United States, a total of 9,029 active TB cases were reported in 2018, with a case rate of 2.8 cases per 100,000, representing a decrease of 0.7% compared to 2017.

Figure 14 Reported Tuberculosis Cases in Nebraska by Year
The number of reported persons with TB in Nebraska for the last decade has been highest among racial and ethnic minorities who are foreign born.

**Figure 15 Reported Tuberculosis by Ethnicity, Nebraska**

**Figure 16 Reported Tuberculosis by Race, Nebraska**
Figure 17 Reported Tuberculosis Cases in Nebraska with High Risk Factors 2014-2018

The DBH contract applicable to each of the six RBHAs requires programs to have working relationships with local health departments and to screen for communicable diseases for all persons requesting substance use disorder treatment services. As such, TB screening is provided to all persons entering a substance use disorder treatment service. Additional services and/or referrals for services are made available to those individuals whose screening indicates “high risk” for TB. The Tuberculosis Program in the Nebraska Division of Public Health provides the overall coordination for the State of Nebraska. Therefore, the contract between the DBH and the RBHAs addresses the TB Screening and Services requirements. Pertinent language included in the DBH and RBHAs contract includes:

**Tuberculosis (TB) screening and services**

1. The RBHA will ensure that all providers receiving SAPTBG funds shall:
   a. Report active cases of TB to the Division of Public Health Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at: [http://dhhs.ne.gov/Pages/Title-173.aspx](http://dhhs.ne.gov/Pages/Title-173.aspx)
b. Maintain infection control procedures that are consistent with those established by the State’s infection control office.

c. Adhere to State and Federal confidentiality requirements when reporting such cases.

2. The RBHA will ensure that providers receiving SAPTBG funding will routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.

3. The RBHA shall establish procedures that ensure that the following (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
   a. Screening of all admissions for TB,
   b. Positive screenings shall receive test for TB,
   c. Counseling related to TB,
   d. Referral for appropriate medical evaluations or TB treatment,
   e. Case management for obtaining any TB services,
   f. Report any active cases of TB to state health officials, and
   g. Document screening, testing, referrals and/or any necessary follow-up information.

4. The RBHA is responsible for providing DBH with documentation which illustrates facilitation or provision of the above listed services and ensure that any changes are reported and on file with DBH.

It is expected that continuation of this priority area will help to protect Nebraskans, particularly those in priority populations.

**Services for HIV/AIDS**

As of December 31, 2017, there were 2,453 people living with Human Immunodeficiency Virus Infection / Acquired Immunodeficiency Syndrome (HIV/AIDS) in Nebraska. In 2017, there were 88 new HIV infections diagnosed among Nebraska residents. The Nebraska rate of new diagnoses for HIV/AIDS was approximately 5
cases per 100,000 individuals according to 2017 estimates. While there has been an increase (13%) of the number of new cases in 2017 (88) compared to 2016 (78), Nebraska remains a non-designated state and is thereby not required to include HIV/AIDS specific priorities for Block Grant planning purposes.

**Next Steps in Addressing Unmet Service Needs**

The DBH completed a comprehensive statewide needs assessment in 2016 which provided information on estimating burden of behavioral health in Nebraska, strengths and gaps in the system, the needs of special populations, the status of workforce, and a review of national and state level initiatives for integrated care. Key findings from the assessment, which included RBHA and other stakeholder input, guided the development of the DBH 2017-2020 Strategic Plan and work plan to address targeted needs. Progress in the work plan is monitored and shared with key stakeholders. In addition to ongoing assessment at the state and regional levels, a repeat of overall system assessment in 2020 is intended. An important recommendation, and one that drives ongoing assessment of service need, is DBH optimizing the use of the Nebraska Prevention Information Reporting System (NPIRS) and the Centralized Data System (CDS). The CDS supports service capacity assessment of both residential and outpatient settings, supports longitudinal follow up to assess outcomes and accommodates formal data sharing to coordinate and assess services and outcomes across systems. The DBH works with RBHAs to address unmet needs in a variety of ways. It should be noted that unmet needs may be based on lack of training for providers, lack of funding within the system, or lack of providers in the system with certain expertise.

Upon assessment of unmet needs such as co-occurring services and trauma-informed care, where provider training is an issue, plans were developed by each provider based on a baseline assessment using a standardized tool, to increase the competencies in those areas for that provider. The DBH asks providers to reassess, and RBHAs submit
assessment scores once every 2 years. The DBH then reviews and looks to provide training and or technical assistance in unmet needs. At some point, value-based contracting may be considered to support quality service delivery in these areas.

The DBH asks RBHAs to conduct local community needs assessments to better designate regional allocated funding for areas where the unmet needs exist, shifting funding away from areas where needs are adequately met by Medicaid or where funding was unexpended within their contract. The DBH has contracted for consultation in maximizing the use of behavioral health dollars, with consideration going to allocation of funding and other strategies to use dollars efficiently.

The Behavioral Health Education Center of Nebraska (BHECN) provides training and incentives for professionals to practice in areas of provider healthcare shortage, to increase access for consumers in rural and frontier areas, or in professions with a severe shortage within the state (psychiatry). The DBH is also working cooperatively with BHECN and other entities to increase the peer workforce in the system.

Within the Prevention system, the DBH continues to work with RBHAs to support community coalitions in using funding for areas of need for Substance Abuse prevention. Using data from the NPIRS, in addition to a variety of surveys regarding alcohol and drug use, communities are able to evaluate the effectiveness of current prevention efforts and redirect dollars to areas of need when appropriate.
Summary of System Needs and Priorities

Through a comprehensive review of data sources and reports, followed by discussion and review with stakeholder and advisory groups, the DBH has identified seven priority areas. Each identified priority area has been determined as necessary to best address priority and target population needs. Concentration on identified priority areas throughout FY20/FY21 is expected to bring about overall behavioral health system improvements to support the treatment and recovery needs of consumers while working to prevent harmful substance use behaviors. In summary, the DBH has selected the following seven priority areas for FY20/FY21:

1. Prevention of binge drinking among youth and young adults
2. Increase the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use
3. Increase support for consumers to secure and maintain permanent housing
4. Increase support for consumers to sustain and acquire employment
5. Increased access to community-based services for priority populations
6. Increase the number of persons admitted into treatment for first-episode psychosis
7. Referral to services for persons with tuberculosis
Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA’s success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA’s centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA’s state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities’ movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state’s data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state’s current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?  
   Please indicate areas of technical assistance needed related to this section.
Planning Steps
Quality and Data Collection Readiness
States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

The Division of Behavioral Health (DBH) Centralized Data System (CDS) allows for collection of treatment utilization and outcome data from contracted behavioral health providers and offers reporting capability at the client, program, provider location, provider agency, regional, and state levels. Data is only available for individuals not eligible for or funded through Medicaid, private insurance or other payer sources. The system is focused on TEDS type of client level reporting for both mental health and substance use disorder services.

The Nebraska Prevention Information Reporting System (NPIRS) currently collects information about prevention interventions funded by the Substance Abuse Prevention and Treatment Block Grant as well as other federal discretionary grants. NPIRS provides summary data by county, region or state level. Data can be further broken out by individual vs population level, specific IOM population as well as federal strategy level. Demographics and total number of individuals impacted by the intervention are also required reporting fields.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

Data collection and reporting is limited to data for substance use disorder and mental health treatment services funded through the DBH; it does not include treatment data for those funded through Medicaid, private insurance, self-pay, child welfare systems or other state or federally funded sources such as Veterans or Medicare. Prevention data collection is primarily at a population and/or strategy level, does not include client level data, and does not capture the prevention related draft measures proposed. Prevention data collected through NPIRS is primarily for substance abuse prevention, however, organizations can list mental health concerns as a secondary priority problem in the NPIRS system. NPIRS is a stand-alone web based database maintained by DHHS / DBH. NPIRS does not interface with any state operated database at this time; however, exploration of integration with the DBH Electronic Billing System (EBS) is under review and being considered for future use.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

The CDS captures client level information which allows for CLD reporting for both mental health
and substance use disorder services funded through the DBH; data for mental health and substance use disorders is now submitted in separate files to TEDS quarterly. None of the proposed measures are currently collected at the individual level for both treatment and prevention. A limited number are available from individuals in treatment; however, we are uncertain if the question and response wording is an exact match which could require significant work to change across our treatment provider network. We also do not have a claims system that can track proposed measures through this type of system. Most existing systems do not capture primary health measures such as alcohol or blood pressure screening, nor are many treatment centers licensed to do such care. Other than basic demographic information such as age, race, ethnicity when available, prevention data collected through NPIRS is not collected at the individual client level.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

See above. In addition, there are significant challenges in collecting data from Medicaid and commercial adult populations within our state system. There would also be significant costs to add the measures not currently collected. There are significant barriers for any type of post discharge data collection due to having to "track" down clients, potential confidentiality barriers as well as increased staffing needs to perform these functions. Providers are already burdened by data collection and varying requirements for data reporting and billing, and this will only add to the burden unnecessarily and likely negatively impact overall data integrity. Similar to the reasons stated earlier it would be cost prohibitive to include and/or collect individual client level information for prevention activities through NPIRS; and being that several activities are at the population level, it would not be possible to track this level of information in the NPIRS system.

*Please indicate areas of technical assistance needed related to this section.*
There is no area of technical assistance need identified at this time.

#END BG 2018/19 Quality and Data Collection Readiness
# Planning Tables

## Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area</td>
<td>Alcohol Use among Youth and Young Adults</td>
</tr>
<tr>
<td>Priority Type</td>
<td>SAP</td>
</tr>
<tr>
<td>Population(s)</td>
<td>PP, Other (Adolescents w/SA and/or MH, Students in College, Rural, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)</td>
</tr>
</tbody>
</table>

**Goal of the priority area:**

Reduce harmful alcohol use among youth and young adults.

**Objective:**

Reduce the prevalence of binge drinking by youth and young adults.

**Strategies to attain the objective:**

Work with prevention coalitions across state to continue engaging in partnerships with local schools, colleges and community groups to facilitate trainings and educational activities which aim to enhance awareness of the risks associated with alcohol use, particularly those associated with binge drinking.

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Prevalence of binge drinking reported by youth and young adults, ages 18 to 24</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>31.8%</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>30.0%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>28.0%</td>
</tr>
</tbody>
</table>

**Data Source:**

Behavioral Risk Factor Surveillance Survey (BRFSS)

**Description of Data:**

The Behavioral Risk Factor Surveillance System (BRFSS) is a survey which collects state data about residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. The BRFSS is a cross-sectional survey conducted by states with technical and methodological assistance provided by the Centers for Disease Control and Prevention (CDC). States use a standardized core questionnaire, optional modules, and state-added questions to ask a variety of important health-related topics of which DBH contributes recommendations on question content. It is administered every year and targeted at non-institutionalized adults 18 years of age and older. The Nebraska Department of Health and Human Services (DHHS) Division of Public Health (DPH) contracts with the University of Nebraska-Lincoln, Bureau of Sociological Research (BOSR) to manage BRFSS data collection.

**Data issues/caveats that affect outcome measures:**

Although this survey has historically been implemented every year, the Division of Behavioral Health does not directly coordinate and is thereby dependent on availability of survey results through coordination with DPH and CDC.

<table>
<thead>
<tr>
<th>Priority #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area</td>
<td>Increase Use of Evidence-based Strategies</td>
</tr>
<tr>
<td>Priority Type</td>
<td>SAP</td>
</tr>
<tr>
<td>Population(s)</td>
<td>PP, Other (Adolescents w/SA and/or MH, Students in College, Rural, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)</td>
</tr>
</tbody>
</table>
Goal of the priority area:

Increasing the use of evidence-based strategies supported through Block Grant funding.

Objective:

Increase the use of evidence-based strategies employed by prevention coalitions to reduce alcohol and substance use.

Strategies to attain the objective:

Support increased use of evidence-based interventions in prevention practices. Use evidence-based public education and awareness strategies, campaigns, and engagement activities to increase awareness of binge drinking and reduce binge drinking rate. Offer technical assistance to enhance program staff understanding on identification and use of evidence-based strategies in addition to continued training on data collection and entry into the state prevention reporting system related to prevention activities.

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Percentage of Block Grant funded evidence-based strategies</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>28.0%</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>31.5%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>34.0%</td>
</tr>
</tbody>
</table>

Data Source:

Nebraska Prevention Information Reporting System (NPIRS)

Description of Data:

The NPIRS is an internet-based reporting system designed to collect and report prevention activity data in Nebraska. The system collects community, regional, and state level data from recipients of federal and state prevention funds administered by the Division of Behavioral Health. NPIRS provides the reporting capabilities for components of the Federal Block Grant. The reports provide number served by individual-based programs or population-based programs and strategies, numbers served by intervention type, and use of evidence-based programs and strategies.

Data issues/caveats that affect outcome measures:

During August 2018, DBH implemented a new NPIRS system. System users have received numerous training opportunities and work continues to improve consistency and accuracy in reporting into the NPIRS.

Priority #: 3
Priority Area: Consumers in Stable Living Arrangements
Priority Type: SAT, MHS
Population(s): SMI, SED, PWWDC, ESMI, PWID, EIS/HIV, TB, Other (Rural, Homeless)

Goal of the priority area:

Consumers have permanent and stable housing.

Objective:

Increasing support for consumers to secure and maintain permanent housing.

Strategies to attain the objective:

Increase system and community-level planning efforts to focus on targeted resources for priority populations. Work with providers and community partners to understand local housing needs and help support response efforts.

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
</table>
Indicator: Percentage of consumers in stable living arrangements at discharge from residential services

Baseline Measurement: 58%
First-year target/outcome measurement: 60%
Second-year target/outcome measurement: 62%

Data Source:
Nebraska DHHS Division of Behavioral Health Centralized Data System (CDS).

Description of Data:
Consumer treatment data from CDS. CDS collects consumer level information to report to the Treatment Episode Date Set (TEDS) of MH and SU Disorders consumers receiving DBH funded services, either directly or through regional contracts. CDS warehouses all the data entered so that it can be analyzed at any time.

Data issues/caveats that affect outcome measures:
Information is provided by consumer who may not wish to disclose they are or are at risk of experiencing homelessness. Residential services include: Dual Disorder Residential – MH + SUD, Halfway House – SUD, Intermediate Residential – SUD, Psychiatric Residential Rehabilitation – MH, Secure Residential – MH, Short Term Residential – SUD, Therapeutic Community – SUD, Mental Health Respite – MH + SUD.

Priority #: 4
Priority Area: Consumer Employment
Priority Type: SAT, MHS
Population(s): SMI, SED, PWDC, ESMI, PWID, EIS/HIV, TB, Other (Rural, Military Families, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:
Consumers in the labor market have competitive employment.

Objective:
Increasing support for consumers to sustain and acquire competitive employment.

Strategies to attain the objective:
Work with providers and community partners to understand local employment opportunities and help support efforts to connect consumers with employers.

Annual Performance Indicators to measure goal success

Indicator #:

Indicator: Percentage of consumers in the labor market who are employed at discharge from any DBH funded service

Baseline Measurement: 51%
First-year target/outcome measurement: 53%
Second-year target/outcome measurement: 55%

Data Source:
Nebraska DHHS Division of Behavioral Health Centralized Data System (CDS).

Description of Data:
Consumer treatment data from CDS. CDS collects consumer-level information to report to the Treatment Episode Date Set (TEDS) of MH and SU Disorders consumers receiving Division funded services, either directly or through regional contracts. CDS warehouses all the data entered so that it can be analyzed at any time.

Data issues/caveats that affect outcome measures:
Information is provided by consumers who may not wish to disclose employment and thus would be excluded from calculation. The labor market consists of those who are employed (employment status is 'Active/Armed Forces ( < 35 Hrs)', 'Active/Armed Forces (35+ Hrs)', 'Employed Full Time (35+ Hrs)', or 'Employed Part Time ( < 35 Hrs)') and those who are unemployed but have been actively looking for employment in the past 30 days.

Priority #: 5
Priority Area: Access for Priority Populations to Substance Use Disorder Services
Priority Type: SAT
Population(s): PWID, EIS/HIV, TB, Other (Rural, Criminal/Juvenile Justice, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:
Priority populations are admitting into substance use disorder services in a timely manner.

Objective:
Improve wait times into Short Term Residential services for persons who inject drugs.

Strategies to attain the objective:
As required through the contracts with the Regional Behavioral Health Authorities (RBHAs), priority populations are expected to receive priority status according to priority type when waiting to enter a substance abuse treatment service. Educational trainings with RBHAs and providers to ensure priority status is understood and Federal requirements are followed. Monitoring and assessment of Short Term Residential capacity to determine if additional service locations are necessary to meet the needs of all priority populations seeking treatment.

Annual Performance Indicators to measure goal success

Indicator #:
1

Indicator:
Percentage of persons reported as injecting drugs who are admitted into Short Term Residential services within 14 days of seeking treatment

Baseline Measurement:
51%

First-year target/outcome measurement:
53%

Second-year target/outcome measurement:
55%

Data Source:
Nebraska DHHS Division of Behavioral Health Centralized Data System (CDS).

Description of Data:
Consumer wait and admission data from CDS. CDS collects consumer level information for all consumers placed on a waiting list for MH and SU Disorders receiving DBH funded services, either directly or through regional contracts. CDS warehouses all the data entered so that it can be analyzed at any time.

Data issues/caveats that affect outcome measures:
Access reporting is a new function available within the CDS and remains under review for completeness and accuracy.

Priority #: 6
Priority Area: First Episode Psychosis (FEP)
Priority Type: MHS
Population(s): SMI, SED, ESMI

Goal of the priority area:
Improve the system such that more people are being provided the behavioral health services they need earlier and in a voluntary capacity through self-entry into the service system.
Objective:

Improve access to FEP Coordinated Specialty Care (CSC) treatment for youth and young adults who have experienced a first episode of psychosis.

Strategies to attain the objective:

Continue to develop recovery-oriented services and increase use of evidence-based practices which help individuals stabilize and maintain stabilization in community settings. Support Mental Health trainings to improve early intervention and support, particularly for youth having a first episode of psychosis (FEP). Emphasis will be placed on enhancing recruitment strategies and increasing community awareness on FEP services available.

Annual Performance Indicators to measure goal success

| Indicator #: | 1 |
| Indicator: | Number of statewide admissions into FEP programs |
| Baseline Measurement: | 11 admissions |
| First-year target/outcome measurement: | 14 admissions |
| Second-year target/outcome measurement: | 16 admissions |

Data Source:

FEP programs funded by DBH.

Description of Data:

FEP programs record admission, service utilization, outcome measures, and discharge data for all FEP participants. This information is available to DBH as requested.

Data issues/caveats that affect outcome measures:

DBH is currently dependent on receipt of admission data directly from the FEP programs.

Priority #: 7

Priority Area: Tuberculosis

Priority Type: SAT

Population(s): TB, Other (Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Tuberculosis screening is provided to all persons entering substance abuse treatment service and meets federal requirements regarding screening for Tuberculosis.

Objective:

As required through the contracts with the Regional Behavioral Health Authorities, Tuberculosis screening is provided to all persons entering a substance abuse treatment service. Additional services and/or referrals for services are made available to those individuals whose screening indicates “high risk” for TB. The Tuberculosis Program in the Nebraska Division of Public Health provides the overall coordination for the State of Nebraska.

Strategies to attain the objective:

Regional Behavioral Health Authorities will comply with contract requirements for tuberculosis screening to be provided to all persons entering a substance abuse treatment service.

Annual Performance Indicators to measure goal success

| Indicator #: | 1 |
| Indicator: | Tuberculosis (TB) |
| Baseline Measurement: | Maintain the contract requirement with the Regional Behavioral Health Authorities for Tuberculosis screening provided to all persons entering a substance abuse treatment service. |
| First-year target/outcome measurement: | The contract requirement will be maintained with the Regional Behavioral Health Authorities for Tuberculosis screening provided to all persons entering a substance abuse treatment service. |
Second-year target/outcome measurement: The contract requirement will be maintained with the Regional Behavioral Health Authorities for Tuberculosis screening provided to all persons entering a substance abuse treatment service.

Data Source:
The Nebraska Department of Health and Human Services - Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities.

Description of Data:
Signed contracts between the Nebraska Department of Health and Human Services - Division of Behavioral Health and the six Regional Behavioral Health Authorities.

Data issues/caveats that affect outcome measures:
This contract requirement is connected to the Federal requirements under the Substance Abuse Prevention and Treatment Block Grant.

Footnotes:
### Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021.

**ONLY include funds expended by the executive branch agency administering the SABG**

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$11,155,494</td>
<td>$2,800,000</td>
<td>$11,236,596</td>
<td>$55,274,340</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children*</td>
<td>$1,279,974</td>
<td></td>
<td>$4,175,644</td>
<td>$4,175,644</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. All Other</td>
<td>$9,875,520</td>
<td>$2,800,000</td>
<td>$7,060,952</td>
<td>$51,098,696</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$3,361,116</td>
<td></td>
<td>$2,550,000</td>
<td>$394,534</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$382,016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$382,016</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$14,898,626</td>
<td>$0</td>
<td>$2,800,000</td>
<td>$13,786,596</td>
<td>$55,668,874</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.
Table 2 State Agency Planned Expenditures [MH]
States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019  Planning Period End Date: 6/30/2021

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>Activity</th>
<th>Activity</th>
<th>Activity</th>
<th>Activity</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse and Treatment</td>
<td>A. Substance Abuse Block Grant</td>
<td>B. Mental Health Block Grant</td>
<td>C. Medicaid (Federal, State, and Local)</td>
<td>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</td>
<td>E. State Funds</td>
</tr>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention*</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$95,962</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**</td>
<td></td>
<td>$613,750</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td>$0</td>
<td>$9,620,006</td>
<td>$128,040,041</td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td>$419,078</td>
<td>$0</td>
<td>$0</td>
<td>$26,185,202</td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td>$4,797,801</td>
<td>$13,600,000</td>
<td>$5,703,987</td>
<td>$93,833,759</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)***</td>
<td></td>
<td>$306,875</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$0</td>
<td>$6,137,504</td>
<td>$13,600,000</td>
<td>$15,323,993</td>
<td>$248,154,964</td>
</tr>
</tbody>
</table>

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.
## Planning Tables

### Table 3 SABG Persons in need/receipt of SUD treatment

<table>
<thead>
<tr>
<th></th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>356</td>
<td>38</td>
</tr>
<tr>
<td>2. Women with Dependent Children</td>
<td>10000</td>
<td>443</td>
</tr>
<tr>
<td>3. Individuals with a co-occurring M/SUD</td>
<td>58000</td>
<td>6450</td>
</tr>
<tr>
<td>4. Persons who inject drugs</td>
<td>2000</td>
<td>701</td>
</tr>
<tr>
<td>5. Persons experiencing homelessness</td>
<td>519</td>
<td>379</td>
</tr>
</tbody>
</table>

Please provide an explanation for any data cells for which the state does not have a data source.

Column B Estimates of “Aggregate Number of Estimated in Need”: Source Row 1-PW: Estimate obtained by multiplying 2017 ACS estimated count of Nebraska women between ages 15 to 49, 423,817, by 2017 BRFSS estimated percent of pregnant Nebraska women, 1.04, by 2016-2017 NSDUH (table 23) estimated percent 18+ SUD, 8.08. – Source Row 2-WWDC: SAMHSA/CBHSQ Data Tables in “ASC_AdHoc091-08-18-17” released to SABG Coordinators on August 24, 2017. Table used: “Co-Occurring Need for Treatment at a Specialty Facility for a Substance Use Problem and Characteristic of Interest in the Past Year among Persons Aged 18 or Older, 2012-2014-Women Living with Children”. – Source Row 3-Individuals with a co-occurring M/SUD: SAMHSA/CBHSQ Data Tables in “ASC_AdHoc091-08-18-17” released to SABG Coordinators on August 24, 2017. Table used: Co-Occurring Need for Treatment at a Specialty Facility for a Substance Use Problem and Characteristic of Interest in the Past Year among Persons Aged 18 or Older, 2012-2014-Any Many Illness in the Past Year”. – Source Row 4-PWIDs: Data Tables in “ASC_AdHoc091-08-18-17” released to SABG Coordinators on August 24, 2017. Table used: Co-Occurring Need for Treatment at a Specialty Facility for a Substance Use Problem and Characteristic of Interest in the Past Year among Persons Aged 18 or Older, 2012-2014-Needle Use in Past Year.” – Source Row 5-Persons experiencing homelessness: Need estimated based on HUD 2018 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations with a chronic SUD 2018 Point-in-Time Count (PIT). The PIT Count is conducted on a single day across the state and SUD is self-reported. Column C counts of “Aggregate Number in Treatment” Counts reported in Column C are persons served in the DBH Network of Services and do not include individuals served through Medicaid and other funding. Counts are from FY 2018 TEDS Planning Tables.
and as reported into the Division of Behavioral Health Centralized Data System by treatment providers for individuals in service during FY 2018. Homeless number in treatment is a point in time of those experiencing homelessness and in treatment for SUD on 8/28/19.

Footnotes:
# Planning Tables

## Table 4 SABG Planned Expenditures

**Planning Period Start Date:** 10/1/2019  
**Planning Period End Date:** 9/30/2021

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment*</td>
<td>$5,577,747</td>
</tr>
<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$1,680,558</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV**</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$382,016</td>
</tr>
<tr>
<td><strong>6. Total</strong></td>
<td><strong>$7,640,321</strong></td>
</tr>
</tbody>
</table>

* Prevention other than Primary Prevention  
** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case...
rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:
### Table 5a SABG Primary Prevention Planned Expenditures

**Planning Period Start Date:** 10/1/2019  
**Planning Period End Date:** 9/30/2021

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FFY 2020</th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Universal</td>
<td></td>
<td></td>
<td>$57,541</td>
</tr>
<tr>
<td>1. Information Dissemination</td>
<td>Selective</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$57,541</strong></td>
</tr>
<tr>
<td>2. Education</td>
<td>Universal</td>
<td></td>
<td>$393,247</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td>$79,411</td>
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</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td>$3,229</td>
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</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$475,887</strong></td>
</tr>
<tr>
<td>3. Alternatives</td>
<td>Universal</td>
<td></td>
<td>$54,032</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$54,032</strong></td>
</tr>
<tr>
<td>4. Problem Identification and Referral</td>
<td>Universal</td>
<td></td>
<td>$1,053</td>
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</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td>$132,045</td>
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<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td>$26,075</td>
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</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td></td>
<td><strong>$159,173</strong></td>
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**Approved:** 04/19/2019  
**Expires:** 04/30/2022  
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<table>
<thead>
<tr>
<th>Category</th>
<th>Selective</th>
<th>Indicated</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Community-Based Process</td>
<td></td>
<td></td>
<td></td>
<td>$288,959</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Environmental</td>
<td>Universal</td>
<td></td>
<td></td>
<td>$606,468</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>$606,468</td>
</tr>
<tr>
<td>7. Section 1926 Tobacco</td>
<td>Universal</td>
<td></td>
<td></td>
<td>$38,498</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>$38,498</td>
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<tr>
<td>8. Other</td>
<td>Universal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

**Total Prevention Expenditures**  
$1,680,558

**Total SABG Award**  
$7,640,321

**Planned Primary Prevention Percentage**  
22.00%

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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**Footnotes:**
# Planning Tables

## Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019    Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$272,944</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$1,166,854</td>
</tr>
<tr>
<td>Selective</td>
<td>$211,456</td>
</tr>
<tr>
<td>Indicated</td>
<td>$29,304</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$1,680,558</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong>*</td>
<td><strong>$7,640,321</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>22.00 %</strong></td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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**Footnotes:**
# Planning Tables

## Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

**Planning Period Start Date:** 10/1/2019       **Planning Period End Date:** 9/30/2021

### Targeted Substances

<table>
<thead>
<tr>
<th>Substances</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>✓</td>
</tr>
<tr>
<td>Tobacco</td>
<td>✓</td>
</tr>
<tr>
<td>Marijuana</td>
<td>✓</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>✓</td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>✓</td>
</tr>
<tr>
<td>Inhalants</td>
<td></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td></td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
<td></td>
</tr>
</tbody>
</table>

### Targeted Populations

<table>
<thead>
<tr>
<th>Populations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
<td>✓</td>
</tr>
<tr>
<td>Military Families</td>
<td></td>
</tr>
<tr>
<td>LGBTQ</td>
<td></td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>✓</td>
</tr>
<tr>
<td>African American</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>✓</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
<td></td>
</tr>
</tbody>
</table>

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## Planning Tables

### Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019  
Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. SABG Treatment</th>
<th>B. SABG Prevention</th>
<th>C. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
<td>$17,773</td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$154,489</td>
<td>$17,773</td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$154,489</strong></td>
<td><strong>$35,546</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

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**Footnotes:**

Amount of SABG Primary Prevention funds (from Table 4, Row 2) to be used for Non-Direct Services/System Development activities for SABG Prevention, column B, and/or SABG combined, Column C = $35,546.

Amount of SABG Administration funds from (from Table 4, Row 5) to be used for Non-DIrect-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = $0.
### Table 6 Non-Direct-Services/System Development [MH]

**MHBG Planning Period Start Date:** 10/01/2019  
**MHBG Planning Period End Date:** 09/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

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**Footnotes:**  
Nebraska does not use MHBG funding for these activities.
Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs. Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care. Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with
partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.


Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

   The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health is engaged in multiple strategies and activities that have at their core, integration. The Director of the Division of Behavioral Health (DBH) is the designated Single State Authority (SSA) and State Mental Health Authority (SMHA) for the state. As the SSA and SMHA, DBH oversees the SAPTBG and MHBG and provides leadership in funding for substance use disorder programs and mental health programs in the state. DBH provides substance use and mental health disorder services to non-Medical eligible consumers using a combination of SAPTBG and MHBG and state funding. DBH collaborates with other state agencies providing behavioral health services.

   Medicaid eligible individuals receive behavioral health services provided by the DHHS Division of Medicaid and Long Term Care (MLTC). These services are delivered through MLTC contracted plans, many of which are also contracted for by DBH. Information about the behavioral health services provided by Medicaid is available at these web sites:
   http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx
   http://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx

   MLTC implemented a new integrated managed care program, Heritage Health, with the signing of three contracts in April 2016. Whereas previously behavioral health was a carve out, the three health plans now coordinate a full range of services, including physical health, behavioral health and pharmacy services including services for individuals with co-occurring mental and substance use disorders in primary care settings and community-based mental and substance use disorder treatment settings. The care of behavioral health clients is delivered through a network of providers who contract directly with the plans. This system went live January 2017.

   Cross-Agency integration activities of DBH include the sharing of a chief behavioral health clinical officer with MLTC and the participation of key staff on quality improvement, service definition/delivery, and administrative processes that support the integration of primary care and behavioral health with the MLTC / Heritage Health vendors. Further opportunities for integration include increased use of data sharing and collection to allow for valid comparisons across systems and reporting periods and utilization of Extension for Community Healthcare Outcomes (Project ECHO) to expand access to high quality and effective medical and behavioral treatment. Project ECHO, considered a revolution in medical education and care delivery, was implemented in Nebraska in 2018. This extension for community healthcare outcomes hub and spoke model increases workforce capacity to provide best practice in specialty care and better equips primary care practitioners in rural areas to better serve the behavioral health population.
System integration through managed care policy and practice includes improved health outcomes based on the social determinants of health, enhanced integration of services and quality of care, care management and preventive services, reduced costly and avoidable care, improved financial sustainability and a quality public system of primary and behavioral health care that is seamless and inclusive of all individuals eligible for services. The MLTC plans are financially and contractually incentivized to invest in prevention case management and care/treatment. At an administrative level, MLTC, the three Heritage Health Managed Care Organizations (MCOs) and DBH meet twice a month.

With the MLTC expansion on the horizon in Nebraska, the opportunity for improved integration efforts and results in all areas, including governance, data sharing, health prevention and promotion, defining and sharing performance outcomes is expected.

Integration work has required enhanced partnerships with the sister Divisions, including the DBH, to implement a program that is seamless and inclusive of all individuals eligible for service. Key contract features include performance measures specific to population served, establishment of Quality and Integration Committees, early identification of care management needs, inclusion of social determinants of health in health risk assessment and care management strategy and referrals to community resources. Other features include preventive and specialty care, recovery-oriented services and expanded access to primary care. The requirements for the provider network include many shared mental health and substance use disorder treatment providers as well as consistency in service definitions and services packages. At this time there are 55 known Integrated Behavioral Health Clinics with 20 located in rural areas, 33 in urban area and 2 pending. Targeted strategies across Divisions are directed toward setting baselines and increasing the number of primary care practices offering behavioral health services within the practice.

An integration advisory committee provides a platform for behavioral health providers and advocates to address integration-related recommendations, questions, and concerns directly with the vendors and State program administrations, including the DBH.

DBH monitors federal parity regulations and has established a Parity System of Care workgroup whose participants include representatives from MLTC, DHHS Division of Public Health (DPH), and the Department of Insurance (DOI). This group has provided feedback and guidance on parity implementation and communication for consumers. Qualified Health Plans (QHPs) in Nebraska provided through the Federal Marketplace have been reduced however must meet the ten required Essential Health Benefits, including mental and substance use disorders treatment. In addition to covering physical health needs, the plans must cover hospitalization, medication management and outpatient services for behavioral health disorders when they determined to be medically necessary. QHPs do not have to cover services such as case management, housing, peer support or other recovery based services. Payment for rehabilitative behavioral health services such as residential treatment programs is limited and subject to reduced length of stay.

The DBH, in partnership with the Behavioral Health Education Center of Nebraska (BHECN), promotes activities in research and education to improve the quality of services, recruitment and retention of behavioral health professionals and access to programs and services. The DBH and BHECN are engaged in shared workforce strategic planning focusing on access to healthcare data, integration efforts, and reciprocity in relationships, needs assessment, workforce plan and metrics and shared conferences. Last year, BHECN was also contracted to serve as the Region VII Mental Health ATTC. This work will continue to build upon and enhance efforts in integration and workforce development.

Through planning efforts and State Targeted Response / State Opioid Response grant funding, the DBH and the University of Nebraska Medical Center (UNMC) have implemented an Executive Fellowship and an Addiction Medicine Fellowship approved for UNMC. The Fellowship will be located within Family Practice medicine which further supports integration initiatives.

The DBH, UNMC, the College of Public Health and BHECN are supporting research projects to expand the utilization of telehealth or telemental health in the State. The UNMC Department of Psychiatry has created a telepsychiatry consultation service to provide psychiatric care to rural communities. Services are provided to underserved areas with the use of HIPAA compliant teleconferencing platforms. E-Psychiatry provides access to an online psychiatrist using telepsychiatry. UNMC's telehealth services health fill the state's shortage of mental health physicians by having its psychiatric team conduct virtual visits via computer link to nursing homes and some assisted-living facilities and community sites.

Project ECHO, as described earlier, is operational with UNMC. This peer consultation provides condition specific consultation (currently pain management and substance use disorder focused) and case review by treatment experts through the use of telehealth technology. Training and case consultation is provided to general practitioners, which builds competencies and extends the workforce.

Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

2. Describing how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Funding from the block grant, along with state dollars, pass through from DBH to Regional Behavioral Health Authorities (RBHAs) and are distributed via Sub grants to local providers. The DBH works with the RBHAs and the Nebraska Association of Behavioral Health Organizations (NABHO) to identify needs and develop plans for service delivery. In addition, the DBH has urged RBHAs to work collaboratively with Federally Qualified Health Centers (FQHCs) in their catchment areas to provide integrated opportunities.
Services are provided by the SSA/SMHA to non-Medicaid eligible consumers in the state and are paid for with a combination of SAPTBG, MHBG and state funding. MLTC contracted health plans provide mental health and substance use disorder services for behavioral health consumers. MLTC and DBH share services and service definitions. Most providers contracted to provide services contract with MLT and the SSA/SMHA.

http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx
http://dhhs.ne.gov/Pages/Heritage-Health-Contacts.aspx

DBH is in year 3 of a children’s system of care grant directed at improving integration of services across child caring systems. Work teams are addressing service packages, policies, blended funding and payment strategies. DBH is employing a system of care approach toward targeted Strategic Plan areas.

A collaborative effort to help identify issues early and connect children and teens with services was created by the Nebraska Legislature through passage of legislation creating a pilot children’s behavioral health screening and referral program in three primary care clinics. The pilot program provides for a unique combination of primary care, on-site behavioral health, and specialty behavioral health care and education from experts at UNMC. This is achieved via: integration – convenient assessment and treatment for children in their medical home via integrated clinics; screening – early identification of childhood behavioral health problems; and, optimization – consultation, referral, and education from specialty behavioral health providers at UNMC using distance technologies. Children are screened for common behavioral health challenges and referred to behavioral health specialists for treatment. Behavioral health services will be delivered within the primary care practice setting. The program began with three pilot primary care sites in 2013 and expanded to ten pilot sites in 2015. This work is being spearheaded by the Behavioral Health Education Center of Nebraska. See Section 10 for more information.

The DBH supports and encourages local partnerships with FQHCs and other collaborative efforts with primary care and publicly funded systems.

In addition, the Munroe-Meyer Institute is conducting a project to improve access to pediatric mental health services in Nebraska, working as a sub-recipient in a $2.2 million five-year grant awarded to the Nebraska DHHS Title V Maternal and Child Health program. Please see link for more information: https://www.unmc.edu/news.cfm?match=23059

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? [ ] Yes [ ] No

b) and Medicaid? [ ] Yes [ ] No

4. Who is responsible for monitoring access to M/SUD services by the QHP? The Nebraska Department of Insurance (DOI) is responsible for monitoring access to Mental Health/Substance Use Disorder services by the Qualified Health Plans. The DOI is responsible for evaluating, approving or disapproving life, health, and annuity products marketed to Nebraska residents, as well as reviewing rate filings.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? [ ] Yes [ ] No

6. Do the M/SUD providers screen and refer for:

   a) Prevention and wellness education [ ] Yes [ ] No

   b) Health risks such as

      ii) heart disease [ ] Yes [ ] No

      iii) hypertension [ ] Yes [ ] No

      iv) high cholesterol [ ] Yes [ ] No

      v) diabetes [ ] Yes [ ] No

   c) Recovery supports [ ] Yes [ ] No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? [ ] Yes [ ] No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? [ ] Yes [ ] No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions? Qualified Health Plans (QHPs) in Nebraska provided through the Federal Marketplace have been reduced in number however must meet the ten required Essential Health Benefits, including mental and substance use disorder services treatment. In addition to covering physical health needs, the plans must cover hospitalization, medication management and outpatient services for behavioral health disorders when they determined to be medically necessary. QHPs do not have to cover services such as case management, housing, peer support or other recovery based services. Authorization and payment for rehabilitative behavioral health services
such as residential treatment programs is limited and the Parity Team has reviewed parity provisions and identified areas requiring plans of corrections. The Parity Team identified additional issues including challenges to network adequacy for mental health and substance use disorder, lack of resources particularly in rural areas, aging workforce, low reimbursement rates, lack of clarity or standardization in assessment and assessment tools for “parity” and a lack of access to projected claims for comparison analytics. The DOI performs annual focus groups around the state and the workgroup helps to identify questions and interpret feedback received. Additional barriers include lack of clarity / direction on the application and monitoring of parity measures.

10. Does the state have any activities related to this section that you would like to highlight?
As a result of the Parity team learning collaboration, the DOI members drafted a Mental Health Parity-related Guidance adopted by the Market Conduct Exam Standards Working Group in December 2018.

The group also participated in plan parity review of the Medicaid Heritage Health vendor plans.

Please indicate areas of technical assistance needed related to this section

None at this time.

Footnotes:
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, Healthy People, 2020, National Stakeholder Strategy for Achieving Health Equity, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary’s top priority in the Action Plan is to “assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.”

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

44 http://www.minorityhealth.hhs.gov/npha/files/Plans/NSS/NSS_07_Section3.pdf
45 http://www.ThinkCulturalHealth.hhs.gov
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
   - a) Race
   - b) Ethnicity
   - c) Gender
   - d) Sexual orientation
   - e) Gender identity
   - f) Age

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?

7. Does the state have any activities related to this section that you would like to highlight?
   DBH completed a survey of behavioral health providers during the spring of 2019. Providers were asked about their capacity to meet linguistic and cultural needs of individuals seeking treatment. 75.0% of providers reported consumers have access to translation services or an interpreter if one is required; 73.4% reported they were able to effectively respond to the cultural needs of consumers within their local community; and 54.7% reported they were able to effectively respond and provide high quality care to consumers with disabilities.
   Please indicate areas of technical assistance needed related to this section
   None at this time.

Footnotes:

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Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

\[
\text{Health Care Value} = \frac{\text{Quality}}{\text{Cost}}, \quad (V = \frac{Q}{C})
\]

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General, \(^{49}\) The New Freedom Commission on Mental Health, \(^{50}\) the IOM, \(^{51}\) NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). \(^{52}\) The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online." \(^{53}\) SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS) \(^{54}\) are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT) \(^{55}\) was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.
SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers’ decisions regarding M/SUD services.

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  
   - [ ] Yes  - [ ] No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   a) [ ] Leadership support, including investment of human and financial resources.
   b) [ ] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) [ ] Use of financial and non-financial incentives for providers or consumers.
   d) [ ] Provider involvement in planning value-based purchasing.
   e) [ ] Use of accurate and reliable measures of quality in payment arrangements.
   f) [ ] Quality measures focus on consumer outcomes rather than care processes.
   g) [ ] Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h) [ ] The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

   The DBH Centralized Data System (CDS) is a DHHS hosted web-based system that utilizes Compass software to collect information from behavioral health providers for service authorization approval for higher levels of care, at admission into service, during the course of treatment and at the time of discharge from behavioral health services. Waitlist and capacity functionality exists in the CDS. Providers enter a variety of demographic, health status and presenting symptoms, trauma history, substance use and treatment progress related data. We believe that this will allow the use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   In 2017, the DBH implemented an Electronic Billing System (EBS). The EBS is a DHHS hosted web-based system developed to streamline the billing processes by moving billing for recovery, treatment and prevention efforts from paper to electronic submission. The system provides system-wide consistency in tracking and reporting all DBH Community-Based Services funded mental health and substance abuse services.

   The EBS integrates with the CDS to connect consumer services to funds requested. This provides greater flexibility than rekeyed paper based information to analyze purchased services across providers, areas of the state and by service.

   The EBS and CDS is the primary vehicle used to evaluate service utilization at the State, region and provider level and to make data informed decisions through the DBH’s management and quality assurance initiatives. Standard reports for individual providers as well as each RBHA can be used for planning, controlling, and monitoring operations. Statewide reports allow for this oversight on a larger scale and for reports to be aggregated for the state as well as at a very granular level. The result will be more data informed decisions to ensure overall efficiency and cost effectiveness.

   Also, Nebraska is currently working with OPEN MINDS to explore approaches to design and development of value based reimbursement models. Education regarding different types of models and the benefits/challenges of use of each model was...
presented to DBH senior leadership and sister agency leadership, the MCO's, the Administrative Office of Probation and the Courts and RBHA Partners. This work will continue to identify state trends and best practices in value based contracting for behavioral health services.

Please indicate areas of technical assistance needed related to this section.

None needed at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA’s working definition of an Early Serious Mental Illness is “An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset.”

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?
   - [ ] Yes
   - [X] No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
   - [X] Yes
   - [ ] No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   In addition to the state appropriation for Mental Health First Aid (MHFA), DBH is a key partner on Nebraska’s Project AWARE grant. This grant, awarded to the Nebraska Department of Education, aims to improve prevention, early identification and treatment response for students with or at risk of having behavioral health conditions. There are targeted efforts to expand the instructor network for Youth Mental Health First Aid in the next year.

   The Nebraska First Episode Psychosis Coordinated Specialty Care (FEP CSC) Pilot Program is utilizing the evidence-based practice Coordinated Specialty Care model developed by OnTrackNY and supported by The Center for Practice Innovations at Columbia Psychiatry. The OnTrackNY program is modeled after the Coordinated Specialty Care Team model that was developed through the National Institute of Mental Health’s research program Recovery After an Initial Schizophrenia Episode (RAISE) which was designed to develop and test interventions to improve the clinical outcomes of young adults who are diagnosed with schizophrenia. Nebraska is currently exploring the use of the RAISE Navigate Model as possibly better suited to address the needs of programs in rural areas. We have consulted with the RAISE consultants and are
currently working with both programs to differentiate and better determine which model would best meet their needs.

The goals of the FEP CSC Pilot Program continue to be to develop and implement an individualized, person-centered plan that will help the consumer manage symptoms, identify any co-morbid conditions that should be treated, provide for ongoing risk assessment, provide education so clients and families can learn to manage the illness and develop coping skills, and focus on consumer goals and recovery. Prior to this pilot there were no existing first episode psychosis-focused teams in Nebraska. Initial focus was on building teams involving inter-agency collaborations to bring together expertise for integrated FEP specialty care and develop a network to coordinate intentional interaction and formation of a coordinated working FEP Team. Nebraska uses block grant funds for targeted investments to build core capacities and regional collaborations to develop FEP expertise as the programs develop.

The FEP CSC Pilot Program continues to serve two of the six behavioral health service regions of the state. The two separate, independent FEP CSC Pilot Program teams are located in the Omaha metropolitan area (RBHA Region 6 Behavioral Healthcare; population 900,000) and in the Kearney micropolitan area (RBHA Region 3 Behavioral Health Services; population 150,000). The two teams are separated by 190 miles. These areas were selected because of concentration of youth identified as experiencing FEP as well an existing concentration of specialty youth services.

The FEP pilot program is designed to help consumers navigate the road to recovery from an episode of psychosis, including supporting efforts to function well at home, on the job, at school, and in the social world. This comprehensive program includes four different treatment components that work collaboratively as a team with the consumer. These components include: Medication Management, Supported Employment and Education, Individual Psychotherapy, and Family Psychotherapy/Education.

Additionally, the Nebraska FEP CSC teams have been provided and are utilizing resource materials from the Center for Practice Innovations “Learning Management System.” These resources include Handbooks, guides, PowerPoints, as well as many trainings and tools.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Increasing behavioral health providers in integrated settings is an objective in the DBH’s Strategic Plan. DBH is working with the Behavioral Health Education Center of Nebraska (BHECN) and the Division of Public Health (DPH) in reviewing information and revising survey questions to capture responses via the Health Profession Tracking System. This data demonstrates change in professions that are working in integrated (primary care and behavioral health) settings and provides data to inform future training and education of the workforce. There are four Federally Qualified Health in Nebraska that afford opportunities for individuals seeking physical care to access behavioral health care when recommended. DBH, through a Parity team comprised of Medicaid (MLTC), DPH, Legal Office of Consumer Affairs, and Department of Insurance personnel, works to review and address parity analysis issues within the Medicaid and other marketplace plans in Nebraska. Comprehensive, individualized and integrated service delivery is an expectation across public and private systems. Complimentary to these activities, DBH, in its work with MLTC on Medicaid expansion, will be defining a vision/model, incorporating overall health measures across Medicaid managed care plans, and implementing integration activities by site, profession, location and co-location.. The training and best practices described in Question 2 are anticipated to be sustained.

In addition to the Coordinated Specialty Care model currently in operation, other evidence-based practices that are available to consumers with Early Serious Mental Illness (ESMI) include services such as Assertive Community Treatment, Supported Employment, Supported Housing and high fidelity wrap around.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?  
   - Yes ☑️  No  

5. Does the state collect data specifically related to ESMI?  
   - Yes ☑️  No  

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?  
   - Yes ☑️  No  

7. Please provide an updated description of the state’s chosen EBPs for the 10 percent set-aside for ESMI.
   Nebraska’s chosen Evidence-based Practice (EBP) for the 10 percent set aside for ESMI is described above under Question 2, coordination specialty care currently following the OnTrackNY model.

   Nebraska is continuing to explore the use of RAISE or continuation of ON TRACK to determine which model will best meet our needs. Following that determination, it is anticipated that we will seek training from the selected vendor to train/retrain FEP staff.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state’s ESMI programs including psychosis?
   Nebraska will determine which model (ON TRACK or RAISE) to use for our pilots and seek training for FEP staff. Given low utilization within the FEP programs continues, Nebraska will continue to assess the referral patterns and identified access barriers to identify any program modifications that may need to be considered to increase utilization. Nebraska recently expanded the entry criteria to the program to adjust the age to 14 to 35 (from 15 to 25) and change the symptom Criteria/History of Psychotropic Medications to “symptoms of a psychotic disorder for a period lasting more than 1 week and no more than 2 years” from the previous criteria of First psychotic episode of any duration so long as the individual has taken antipsychotic medication for a
cumulative period no longer than six months. We believe this change will allow access to more youth/young adults that will benefit from the service. In addition, the FEP teams have requested consideration of additional funding for recruitment activities and peer support services within the FEP programs. DBH is reviewing the degree to which both of these are or should be included in the FEP service expectations and what additional payment structure could be appropriately considered to support these critical interventions within the FEP model. Once criteria modification recommendations and/or any other program enhancements are identified, the DBH will seek approval by SAMHSA to implement.

9. Please explain the state’s provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The Nebraska FEP CSC Pilot Programs collect and report as requested on outcomes measures and fidelity measures to answer key questions around program implementation. Fidelity and outcome information includes CSC components of team structure and functioning, psychopharmacology, individual psychotherapy, family intervention, and supported employment/education.

The Nebraska FEP CSC pilot programs enter an admission form as well as the assessment set identified below into an Access Database form for collection and submission as requested to DHHS.

FEP CSC Pilot Program Outcome and Assessment Set - Items to be Used at Specific Time Points

FEP CSC TEAM

Tool: Columbia Suicide Severity Rating Scale (C+SSRS)-Risk Assessment Time Frame: Admission* / q6mos / Discharge / As Indicated
Tool: MIRECC GAF-Expanded Time Frame: Admission* / q6mos / Discharge / As Indicated*Admission: Completed at first FEP CSC Team meeting after everyone has seen the participant.

Individual Participant

Tool: OnTrackNY Modified Colorado Symptom Index Time Frame: Admission / q3mos / Discharge
Tool: OnTrackNY Quality of Life Time Frame: Admission / q3mos / Discharge
Tool: OnTrackNY Experience Time Frame: q6mos / Discharge

10. Please list the diagnostic categories identified for your state’s ESMI programs.

Nebraska First Episode Psychosis Coordinate Specialty Care (FEP CSC) Pilot Program

FEP CSC Pilot Program Enrollment Criteria

a. Age: Male/Female age 14 through 35

b. Diagnostic Criteria: 295.90–Schizophrenia; 295.40–Schizophreniform Disorder; 295.70–Schizoaffective Disorder; 297.1-Delusional Disorder; 298.8-Brief Psychotic Disorder; and 298.9- Psychotic Disorder NOS

c. Symptom Duration: Symptoms of a psychotic disorder for a period lasting more than one (1) week and no more than two (2) years.

d. Exclusionary Criteria-- Diagnosed with an Intellectual Disability;-- Other diagnoses excluded are Psychotic Disorder due to a General Medical Condition and Substance-induced Psychotic Disorder, as well as the Depressive and Bipolar Disorders.-- The Families of individuals age 18 and younger would have to agree to participate, but individuals age 19 and older who do not want their families involved could still be enrolled in the program.

Please indicate areas of technical assistance needed related to this section.

None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
### 5. Person Centered Planning (PCP) - Required MHBG

**Narrative Question**

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person?s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person?s needs and desires.

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<tr>
<td>1.</td>
<td>Does your state have policies related to person centered planning?</td>
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<td>Yes</td>
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<td>2.</td>
<td>If no, describe any action steps planned by the state in developing PCP initiatives in the future.</td>
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<td>Not applicable.</td>
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<td>3.</td>
<td>Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.</td>
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<td>The Nebraska Division of Behavioral Health (DBH) supports and promotes the use of person-centered service delivery and participant directed care within the state hospitals, regional and community based provider systems. Nebraska’s public behavioral health system governing regulations “Standards of Care” (NAC 206, Chapter 6) identifies the right of each consumer to receive behavioral health services in the most integrated setting appropriate based on an individualized and person-centered assessment, and actively and directly participate in decisions which incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment. This is evidenced by person-centered planning policies within the state hospitals (e.g. Regional Centers), regional and community based provider program fidelity audits, the work of the Office of Consumers Affairs related to consumer voice and choice, and Consumer Specialist peer-related empowerment activities occurring within the Regional Behavioral Health Authorities (RBHAs). It is the shared vision and expectation to enable individuals and their treatment team to create a plan of care that addresses each person’s needs, strengths, choices and goals, and is sensitive to each person’s experiences, traumas, and cultural background.</td>
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<td>DBH requires via its Network Operations Manual, incorporated into the RBHA contracts by reference, for behavioral health RBHAs and their contracted providers to build a recovery oriented system of care (ROSC). This is defined as a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for persons with behavioral health disorders.</td>
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<td>A ROSC encompasses a menu of individualized, person-centered, and strength-based services within a self-defined network. By design, a ROSC provides individuals and families with more options with which to make informed decisions regarding their care. Services are designed to be accessible, welcoming, and easy to navigate. A fundamental value of a ROSC is the involvement of people in recovery, their families, and the community to continually improve access to and quality of services.</td>
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<td>The DBH is in year 3 of a children and families Nebraska System of Care initiative. Under that framework, the service system is working to:</td>
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<td>1. Ensure that families, other caregivers, young adults and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.</td>
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<td>2. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services that build on the family’s natural and informal supports system.</td>
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<td>3. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, individualized service planning process developed in true partnership with the child, family and/or young adult.</td>
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<td>4. Ensure availability of services and supports that are evidence-informed and promising practices, as well as interventions supported by practice-based evidence, and monitor the utilization and effectiveness of these services to improve outcomes for children and their families.</td>
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<tr>
<td></td>
<td>5. Ensure the delivery services and supports are available, utilized and accessible within the least restrictive, most normative environments that are clinically appropriate.</td>
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Under contract with MLTC, the MCOs are required to develop a care management program that focuses on collaboration between

6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs with
mechanisms for administrative and system-level management, in planning, developing and coordinating services and funding
boundaries through an integrated care management process.

7. Provide care management, wraparound service planning or similar mechanisms at the practice level to ensure that multiple
services are delivered in a coordinated and therapeutic manner and that children, young adults and their families can move
through the system of services in accordance with their changing needs.

8. Provide developmentally appropriate behavioral health services and supports that promote protective factors, resiliency, trauma-
informed care, and optimal social-emotional outcomes for young children and their families in their homes and community
settings.

9. Provide developmentally, socially appropriate and trauma-informed services and supports to facilitate the transition of youth to
adulthood and to the adult service system as needed.

10. Incorporate or link with behavioral health promotion, prevention, and early identification and intervention programs and
initiatives to improve long-term outcomes, and to identify needs at an earlier stage and ensure behavioral health promotion and
prevention activities are directed at all children and adolescents.

11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement
of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level,
practice level, and child and family level.

12. Protect the rights of children and families and promote and support effective advocacy efforts. 13. Provide services and
supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, disability, socioeconomic
status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive
and responsive to the individual.

The Nebraska System of Care is instituting mechanisms to support person centered planning, through a system of care family
liaison who is responsible for working with family-run organizations; working in partnership with DBH staff and system partners
in all levels of decision-making, including the development, implementation and evaluation of the Nebraska System of Care
(NeSOC) and coordinating feedback regarding involvement of youth and families in all layers of decision making for families
receiving services through the System of Care. The liaison coordinates appropriate family and youth support activities with the
NeSOC Project Director and Task Lead Coordinator. While youth and family representatives participate in all layers of the
governance structure, there are dedicated Youth and Family Advisory Councils operating to ensure youth and families are fully
engaged in the decision making process

DBH contracts for the Nebraska Network of Care, an online resource for people with living with behavioral health disorders, their
caregivers, and service providers that lets people access information about issues such as treatments, resources and diagnoses,
and wellness recovery action plans. Consumers can choose to communicate directly with other participants and to organize and
store their own personal health information.

Consumer Peer Specialists are using the Living Well curriculum to educate consumers on chronic disease self-management.
Trained as facilitators of this curriculum, Consumer Peer Specialists are providing this education through day programs, county
hospitals, shelters, Regional Center programming, jails, churches and community settings. Living Well is a self-directed program
for self-management through the Nebraska Chronic Disease Prevention and Control Program in the Division of Public Health. This
program enables Nebraska to build additional capacity and increase programming for the chronic disease self-management
program. A mental health diagnosis is a chronic condition. Consumers with a mental health diagnosis may also have chronic
physical health issues. This curriculum is driven by self-regulation and self-direction and building resiliency.

The state conducts activities to promote consumer involvement in the service system and recovery process. Individual consumers
and their families are engaged on a statewide and regional level. The DBH 36-member Joint Advisory Committee (State Advisory
Committees on Mental Health and Substance Use Disorder Services) advise, assist, support and advocate for mental health and
substance use disorder services. Committee members bring unique skills and knowledge to the table to advise the work of DBH.
The Office of Consumer Affairs (OCA) facilitates community forums for consumers to give feedback on the quality of service and to
identify gaps in these services and facilitates the OCA’s People’s Council. The OCA Peoples Council is designed to advise DBH
around consumer involvement; members are former or current consumers of behavioral health services and caregiver/family
members of a person receiving services utilizing personal lived experience to advocate for systems transformation as well as
identify and advocate for a ROSC. The DBH Prevention Advisory Committee members represent state, regional and community level
partnerships to provide state and regional system leadership in substance abuse and mental health prevention to Nebraska’s
behavioral health system.

The Heritage Health MCOs are also under this requirement for implementing person centered planning practices as part of a
recovery oriented system of care. The Nebraska Division of Medicaid & Long-Term Care (MLTC) began operations of Heritage
Health on January 1, 2017, a managed care system in which the State contracts with three managed care organizations (MCO) to
provide health care benefits and services to Medicaid enrollees. MLTC developed Heritage Health to create a health care delivery
system in which all of a Medicaid member’s behavioral health, physical health, and pharmacy services are provided by one of three
statewide health plan. Each of the three MCOs operates statewide. The three MCOs are Nebraska Total Care, UnitedHealthcare
Community Plan of Nebraska, and WellCare of Nebraska.

Under contract with MLTC, the MCOs are required to develop a care management program that focuses on collaboration between
the MCO and (as appropriate) the member, his/her family, providers, and others providing services to the member, including HCBS service coordinators. They assist members in the coordination of services using person-centered strategies, manage co-morbidities, and not focus solely on the member’s primary condition. They incorporate interventions that focus on the whole person and empower the member (in concert with the medical home, any specialists, and other care providers), to effectively manage conditions and prevent complications through adherence to medication regimens; regular monitoring of vital signs; and, an emphasis on a healthful diet, exercise, and other lifestyle choices. They engage members in self-management strategies to monitor their disease processes and improve their health, as appropriate. They must work with providers to ensure a patient-centered approach that addresses a member’s medical and behavioral health care needs in tandem.

To promote a collaborative effort to enhance patient centered delivery system, the MCOs have established and maintained a member advisory committee that is accountable to the MCO’s governing body to provide input and advice regarding program and policies. Membership of the Advisory Committee must include members, members’ representatives, providers, and advocates that reflect the MCO’s population and communities served. The Member Advisory Committee must represent the geographic, cultural, and racial diversity of the MCO’s membership.

4. Describe the person-centered planning process in your state.

Nebraska’s Adult System of Care (ASOC) is recovery-oriented system of care that is recovery focused, person-centered, strength-based, culturally responsive, individualized, integrated, outcomes-driven, research-based and adequately and flexibly financed. Nebraska’s ASOC incorporates this framework and associated system of care guiding principles and core values into a spectrum of community-based services and supports that is organized within a coordinated system of care network. It is designed to assist consumers in achieving their optimal level of self-sufficiency and independence by providing mental health and substance use prevention, treatment, recovery and support services at the right time, in the right amount and in the right place.

The DBH works with consumer specialists (peers) in each of the RBHAs to provide Wellness Recovery Action Planning (WRAP) for consumers of behavioral health services. Individuals who participate in WRAP will create a plan for themselves that includes a wellness toolbox, a daily maintenance plan, identification of triggers and actions to avoid them, a plan for what to do when things break down and an action plan to address crisis, and a post crisis plan. These sessions are available for individuals served in the state hospitals and community based services across the state.

The NeSOC framework incorporates three Core Values: Family driven and youth; Community based; and, culturally and linguistically competent. In this framework family driven means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state and tribe. This includes: choosing supports, services, and provider; setting goals; designing and implementing programs; monitoring outcomes; and determining the effectiveness of all efforts to promote the mental health of children and youth. Likewise, youth guided means that youth are included in every level of the system, too, from their own care to policies and procedures. Youth are seen as experts in their own lives and receive training, support and mentoring to better equip them to take on active leadership roles.

Family and youth involvement occurs at all levels: Service Delivery as peer mentors and system navigators; Administration involvement with evaluation, personnel, and training; and Policy involved in work groups and advisory bodies.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:
Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: [http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf](http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf). States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☐ Yes ☐ No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ☐ Yes ☐ No

3. Does the state have any activities related to this section that you would like to highlight?

The state sets a standard for quality prior to accepting providers into the Nebraska Behavioral Health System. The Division of Behavioral Health (DBH) contracts with six Regional Behavioral Health Authorities (RBHAs) to enroll providers in their regional networks. Each RBHA requires providers to meet minimum standards as outlined in the Network Operations Manual developed by the DBH. With rare exception, contracts require providers to be/become Medicaid enrolled, which adds additional quality control and oversight mechanisms. The Centralized Data System further aids providers in determining if clients are enrolled in Medicaid as the system crosschecks against a Medicaid eligibility file. RBHAs, with review and approval of DBH, issue proposals for bidding for new services or capacity needed in the network. RBHA staff, DBH staff, and consumers evaluate proposals for quality based on bid requirements and best practices.

DBH relays its standards of care through Service Definitions as well as within regulations. The service definitions detail the basic definition, service expectations, staffing, hours of operations and desired outcomes related to each particular level of care and are an incorporated by reference into the contracts/subawards. The regulations (NAC 206 Chapter 6) defines consumer rights, consumer grievances, expectations for trauma informed services, consumer eligibility and payments for services, records content, access, and retention, clinical documentation requirements, discharge planning, and requirements for individualized treatment, rehabilitation, and recovery planning with consumers.
Once in the network, RBHA and DBH staff members provide technical assistance to the providers in the provision of quality recovery oriented services and supports. Annual training and technical assistance, along with Program Fidelity and Unit Audit Reviews, allow providers ample opportunity for improvement in service delivery and to receive technical assistance. The State requires most providers to hold National Accreditation to ensure quality and safety infrastructure within provider organizations. DBH works to ensure that RBHAs are using the Federal Block Grant Program Fidelity Tool during site visits to ensure that SAPTBG requirements are met.

The Division of Behavioral Health also partners with other sister Divisions, such as Medicaid and Long Term Care and Public Health when quality of care concerns are identified.

Please indicate areas of technical assistance needed related to this section

None at this time.

Footnotes:
Environmental Factors and Plan

7. Tribes - Requested

Narrative Question
The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state’s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   The Division of Behavioral Health (DBH) has met with all four federally recognized tribes in Nebraska in FY19; meeting twice with the Omaha Nation and Winnebago tribes and once with the Santee Sioux and Ponca tribes. Technical Assistance is provided to all four tribes throughout the year. DBH and each of the tribes are in regular communication by phone or email.

   Every fiscal year each of the tribes provides DBH with their Mental Health/Substance Use Disorder (MH/SUD) program plan. These plans identify the services most beneficial to their respective members and for which DBH funding is requested to support. The MH/SUD program plan demonstrates what services the tribe will provide in the fiscal year. The MH/SUD program plan is then incorporated into the tribe’s contract with DBH. The services performed must meet either standards of the Indian Health Services (IHS) service definitions criteria or the DBH service definitions. Each tribe can select which service provision standards they will utilize. As with all contracts for services from DBH, audits and site visits are conducted to ensure service provision is occurring as planned. If the program is using IHS standards, the IHS review is accepted as the program review. However, auditing to ensure the service is being performed as billed is still completed.

   During these consultations, DBH reviews the tribe’s MH/SUD program plan and verifies that the services are being provided to Nebraskan tribal members. Conversations and findings from the review are discussed with the tribes’ Program Directors and Clinical Directors. This is also a further opportunity to meet with tribal representatives about other items needing discussion.

2. What specific concerns were raised during the consultation session(s) noted above?

   The Omaha Nation tribe is struggling with electronic health records in their MH/SUD programs. DBH has asked the other tribes about the computer software they use and how it worked for them as a means of comparison. DBH has forwarded this information to the Omaha Nation M/SUD programs. The Omaha Nation has internal infrastructure struggles with billing. DBH has had an in person meeting and set up monthly calls with the Omaha Nation M/SUD program, billing department and...
administrative staff. These meetings have opened the line of communication within the Cart T. Curtis clinic.

The Winnebago Tribe SUD program is struggling with billing 3rd party (i.e. Medicaid, private insurance). DBH is currently working with their program to correct problem areas. All other tribes are currently billing 3rd party payers.

3. Does the state have any activities related to this section that you would like to highlight?

The State of Nebraska recognizes that the four federally recognized tribes headquartered in Nebraska have a unique status that sets them apart from other groups and interests in Nebraska. The DBH provides state funding directly to those four tribes – the Omaha Tribe of Nebraska, the Ponca Tribe of Nebraska, the Santee Sioux Nation, and the Winnebago Tribe of Nebraska.

The four federally recognized tribes with whom the DBH allocates $1.6 million of state general funds in contracts, are invited to participate in advisory committees, local and statewide meetings regarding services, trainings on behavioral health topics, and other state activities and initiatives.

The DBH is in active discussion with other DHHS Divisions such as Division of Medicaid and Long Term care and the three contracted MCOs and with the Division of Children and Family Services, all of whom also have contractual relationships with the Tribes, to understand what, if any, contract management, meeting or other communication efficiencies should be considered to reduce administrative burden on Tribal partners. The DBH will continue its efforts to engage tribal representatives in planning, trainings, and initiatives, as well as support the culturally appropriate provision of services to their tribal members.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:
Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

**Assessment**

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?
   - Yes ☑ No ☐

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)
   - [☑] Data on consequences of substance-using behaviors
   - [☑] Substance-using behaviors
   - [☑] Intervening variables (including risk and protective factors)
   - [☑] Other (please list)
   - d) Other: Perceptions about underage substance use and abuse.

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
   - ☐ Children (under age 12)
   - ☑ Youth (ages 12-17)
   - ☑ Young adults/college age (ages 18-26)
   - ☑ Adults (ages 27-54)
   - ☑ Older adults (age 55 and above)
   - ☑ Cultural/ethnic minorities
   - ☐ Sexual/gender minorities
   - ☑ Rural communities
   - ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)
Archival indicators (Please list)

- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

Others - List:
- Nebraska Young Adult Alcohol Opinion Survey (NYAAOS)
- Nebraska Risk and Protective Factor Student Survey (NRPFSS)
- Youth Tobacco Survey (YTS)

5. Does your state use needs assessment data to make decisions about the allocation of SABG primary prevention funds?

- Yes
- No

If yes, (please explain)

As a requirement of the Division of Behavioral Health’s (DBH) annual Regional Behavioral Health Authority (RBHA) Regional Budget Planning process, at least 60 percent of the SABG Primary Prevention dollars received by community coalitions should be used to fund evidence-based strategies. Emphasis is placed on using a multi-strategy approach where one or more environmental strategies are designed to impact the community and societal levels (of the social-ecological model) as well as impacting the individuals in their community’s target populations. In order to address the availability of substances and community norms around these concerns, sub-recipients are expected to familiarize themselves with the wealth of approaches that can be used, and pick those that best fit their assessed needs, as balanced against community readiness and coalition capacity. Beyond this, sub-recipients of the SABG have the flexibility to implement a variety of evidence-based programs, policies, and substance abuse prevention practices in their community as long as the interventions are supported by a local need assessment and driven by a planning process using the Strategic Planning Framework.

If no, (please explain) how SABG funds are allocated:
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?

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   If yes, please describe

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?

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   If yes, please describe mechanism used

   Each of the six RBHAs has a designated Regional Prevention Coordinator (RPC) responsible for the coordination of prevention activities across their region. Through leadership and contractual requirements with DBH, the RPC and their staff comprise the Regional Prevention Coordination System and provide training and technical assistance to area coalitions in implementing data-driven evidence-based policies, programs, and practices. In turn, this system is readily available to develop and deliver training opportunities for community coalitions in response to training and technical assistance (T/TA) needs. RPC’s are knowledgeable in the Strategic Prevention Framework process and use a variety of methods to deliver T/TA, including traditional instructional methods, web-based conference calls, webcasts and coaching. Additionally, submission of an annual work plan and training plan outline from each of the RPCs is reviewed and discussed on a quarterly basis. It is the expectation that RBHA work plans be designed to address the T/TA needs identified in their catchment area and that progress in these areas are monitored on an ongoing basis. RPCs continue to build on existing success by further providing extensive community-based training and technical assistance to assess community readiness, identify outcomes and prioritize the most effective interventions in the development of local sustainability plans. The diagram below captures the flow of communication at the local, regional, and state level to address T/TA requests.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

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   If yes, please describe mechanism used

   Coalitions have been trained to review existing resources in their community utilizing an asset-based approach to prevention planning, rather than focusing on deficits and gaps. Using this approach allows for careful evaluation of how ready a community is to accept that a substance abuse problem needs to change and take action to change the problem.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

**Planning**

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No
   
   If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan.

   Please see attachment labeled "NE_DBH_Behavioral-Health-Strategic-Plan-2017-2020."

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)
   - Yes
   - No
   - N/A

3. Does your state’s prevention strategic plan include the following components? (check all that apply):
   - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   - b) Timelines
   - c) Roles and responsibilities
   - d) Process indicators
   - e) Outcome indicators
   - f) Cultural competence component
   - g) Sustainability component
   - h) Other (please list):
   - i) Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?
   - Yes
   - No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?
   - Yes
   - No

   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based.

State prevention staff, in collaboration with the Prevention Advisory Council, serve as the evidence-based workgroup for the State of Nebraska. A decision making process has been developed to review and select appropriate programming. This involves completion of an assessment of available evidence of effectiveness, consideration of the overarching state and local level prevention strategy, and an understanding of the local level climate and capacity to implement. Nebraska has a small paid prevention workforce statewide that would overlap substantially with the Prevention Advisory Council if an additional committee were to be formed. We have found that the process of reviewing concerns related to evidence-based prevention is best done in conjunction with other advisory efforts.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
   - a) ☐ SSA staff directly implements primary prevention programs and strategies.
   - b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   - c) ☒ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   - d) ☒ The SSA funds regional entities that provide training and technical assistance.
   - e) ☒ The SSA funds regional entities to provide prevention services.
   - f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.
   - g) ☐ The SSA funds community coalitions to provide prevention services.
   - h) ☒ The SSA funds individual programs that are not part of a larger community effort.
   - i) ☐ The SSA directly funds other state agency prevention programs.
   - j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
   - a) **Information Dissemination**: DBH funds community coalitions to develop products for information dissemination that provide and promote awareness, knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities. Many of our community coalitions showcase their products via brochures, flyers, public service (radio) announcements, billboards, newspapers inserts and during speak engagements, public health fairs, and parent teacher conferences. Visibility and reach of social norming campaigns have also expanded by use of social media as well as screen messaging at movie theaters and signage at sports arenas.
   - b) **Education**: DBH funds educational programs and curriculums aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities. State staff, Regional Prevention Coordinators and coalition leaders present to various advisory committees, board groups, schools, youth groups, community and public interest groups upon request. Examples of these primary prevention programs include but are not limited to the following:
     - Across Ages
     - Alcohol: True Stories
c) Alternatives:

DBH sponsors a variety of alternative activities such as youth trainings and/or summits throughout the school year and summer breaks designed to develop youth leadership within their home communities. Another frequently used strategy is partnerships with law enforcement to coordinate promotional letters sent to students to encourage safer and wise choices during prom and graduation season. Nebraska also has many successful mentoring programs, namely Teammates and the Big Brothers Big Sisters Mentoring Program that provide positive alternatives to our youth. Other strategies include the Health Rocks Teen program, Girls on the Run, Community drop-in centers and drug free dances/parties.

d) Problem Identification and Referral:

DBH has one direct prevention provider, Lincoln Medical Education Partnership’s School Community Intervention and Prevention (SCIP) program, which provides statewide problem identification and referral services. SCIP provides prevention, education, and early intervention services and trains teams within schools to help recognize a child’s behavioral health needs at early on-set, rather than waiting until they have progressed to a more critical level and are more difficult to address. Following a student’s referral to SCIP, the team assesses the need for further action, coordinating an intervention with the student and/or their parent/guardian when necessary. A plan is developed to address the concerns and increase the student’s opportunity to succeed in school. This plan may include a referral to a school resource or to partnering behavioral health agencies who can provide a screening for the student, at no cost to the family. A number of contracted prevention providers offer DUI/DWI Education Programs as well as Parent and Family Skills Training throughout the year to selective and indicated populations. Several institutes of higher learning also fund Brief Alcohol Screening Intervention of College Students (BASICS).

e) Community-Based Processes:

Much of the SABG is dedicated to the support of community-based processes that include organizing, planning, evaluating and enhancing the effectiveness of funded programs, policies, and practice implementation, interagency collaboration, coalition building, and networking. Regional Prevention Coordinators and coalition leads are specifically funded to provide training, technical assistance, systematic planning, multi-agency coordination and guidance for community teambuilding activities. Funding through this strategy for coordination of local coalitions and other community activities is intended to ensure prevention services are available, accessible and that duplication of efforts is minimized.

f) Environmental:

Environmental strategies represent over half of funding efforts to establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. The primary programs used for this strategy is Communities Mobilizing for Change on Alcohol (CMCA) and Challenging College Alcohol Abuse. Other environmental strategies implemented throughout the year include compliance checks for alcohol and tobacco, sobriety checkpoints and party patrols. In support of the State’s social norms campaign to prevent underage drinking, the prevention system continues to focus on preventing the sale and use of alcoholic beverages products to minors. This includes implementation of social host ordinances at the local level, regular provision of Responsible Beverage Server Training (RBST) and Training for Intervention Procedures (TIPS).

Concentrated review of use policies and procedures is active in every region of the state via the Life of An Athlete Program. Specific program activities include: revision of student codes of conduct to support healthy lifestyle choices; policy changes that encourage positive behavior among the athletic community; youth leadership training to develop team unity; and student athlete, coach, parent, and community education on the impact of lifestyle choices and how to make healthier ones.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?

   Yes  ☐  No

If yes, please describe

DBH updates and provides annual budgetary guidance for use of SABG dollars through a number of methods. The first has been to ensure the language within our State to RBHA contract is consistent with the federal register and SABG application.
instructions. Thus, it is a standard contractual requirement that SABG dollars can only be used to fund primary substance abuse prevention services. These requirements are also outlined in the RBHA Budget Guidelines published each year as part of community RFP process. Additionally, DBH performs a variety of audits with their providers, including a Programmatic Activity Review for an entity receiving SABG dollars for prevention. The programmatic review is required for all community coalitions funded by the SABG and is conducted annually in partnership with Regional Prevention Coordinators.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? 
   - ![Yes](Yes) ![No](No)
   - If yes, please attach the plan in BGAS by going to the [Attachments Page](Attachments Page) and upload the plan.
   - Please see attachment labeled “State Evaluation Plan 2019.”

2. Does your state’s prevention evaluation plan include the following components? (check all that apply):
   - a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   - b) Includes evaluation information from sub-recipients
   - c) Includes SAMHSA National Outcome Measurement (NOMs) requirements
   - d) Establishes a process for providing timely evaluation information to stakeholders
   - e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   - f) Other (please list:)
   - g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:
   - a) Numbers served
   - b) Implementation fidelity
   - c) Participant satisfaction
   - d) Number of evidence based programs/practices/policies implemented
   - e) Attendance
   - f) Demographic information
   - g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
   - a) 30-day use of alcohol, tobacco, prescription drugs, etc
   - b) Heavy use
   - ![Binge use](Check)
   - ![Perception of harm](Check)
c) ☑ Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):
ONE NEBRASKA! ONE PLAN!

Division of Behavioral Health
Strategic Plan
2017-2020
Division of Behavioral Health
Strategic Plan
2017-2020

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Message from the Director, Division of Behavioral Health

Dear Colleagues, Stakeholders and Nebraskans:

I am pleased to present you with the 2017-2020 Strategic Plan for the Nebraska Department of Health and Human Services, Division of Behavioral Health. I am privileged to serve as the director of the Division of Behavioral Health with a team of talented people who are dedicated to improving the lives of Nebraskans with mental illness and substance use disorders. There is no health without Behavioral Health!

This three-year plan is a result of a Comprehensive Needs Assessment completed in 2016 and reflects the voice and recommendations of Nebraska consumers, family members, treatment and prevention system providers, stakeholders and academic partners. The document is a dynamic, living document depicting the direction the Division is taking to meet the changing demands of healthcare in Nebraska.

There are three-year goals providing strategic direction for our collective work. The emphasis on metrics provides a measureable framework to gauge progress towards the goals and the triple aims of healthcare, namely improved health care, improved experience of care and improved affordability of care. A detailed companion work plan will further delineate strategies and activities that clarify the work and provide opportunities for innovation and collaboration.

Thank you to everyone who participated in the Needs Assessment project and in the development of the strategic plan. We look forward to working with you to ensure there is no health without behavioral health.

Sincerely,

Sheri Dawson, Director
Division of Behavioral Health
Department of Health and Human Services
Acknowledgements

The Division of Behavioral Health thanks the following contributors for their assistance and guidance in compiling this document. Gratitude is extended to the many consumers, families, stakeholders and interested persons from the general public who contributed as participants in various segments of the foundational needs assessment process.

- Consumers, families
- Public stakeholders
- DHHS partners
- Division of Behavioral Health:
  - Joint Advisory Committee (JAC)
  - Prevention Advisory Committee
  - Providers
    - Regional administrators, regional behavioral health authorities
    - Senior leadership team
- Leslie Ann Hay, Hay Consulting
- Mary O’Hare, O’Hare Professional Consultation
- Mike Phillips, Douglas County Health Department and JAC member
- National Association of State Mental Health Program Directors (NASMHPD)
  - Brian Hepburn, MD, Executive Director
  - David Shern, PhD, Senior Public Health Advisor
- Shinobu Watanabe-Galloway, PhD, UNMC College of Public Health
**ONE NEBRASKA! ONE PLAN!**

**Introduction**

The Division of Behavioral Health (DBH) is designated by federal and state law as the state’s single authority for mental health and substance use disorders. The Division’s responsibility is to coordinate public behavioral health care under Nebraska’s Department of Health and Human Services (DHHS). The Division carries out its responsibilities through leadership and partnership.

---

**ONE PLAN
TRIPLE AIMS**

**Effective:** Improve the Health of Populations

**Efficient:** Improve Per Capita Cost/Affordability

**Experience:** Improve Consumer Experience of Care

The *Triple Aims of Health Care* provide a framework for the Division’s strategic planning. The Aims are intertwined with the priorities for DHHS and together they address the Governor’s priorities for Nebraska. As One Division within One Team, real improvements in behavioral health care come together to help Nebraskans live better lives.

---

**ONE NEBRASKA
GOVERNOR’S PRIORITIES**

- A more efficient and effective state government
- A more customer focused state government
  - Grow Nebraska
  - Improve public safety
- Reduce regulation & regulatory complexity

---

**DHHS
FOCUSED PRIORITIES**

- Integrating services and partnerships
- Promoting independence through community-based services
- Focusing on prevention to change lives
- Leveraging technology to increase effectiveness
- Increasing operating efficiencies and improvements
ONE NEBRASKA! ONE PLAN!

Vision
The Nebraska public behavioral health system promotes wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-driven system.

Mission
The Division of Behavioral Health provides leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

Operational Structure
The Division of Behavioral Health (DBH) provides leadership in the administration, integration and coordination of the public behavioral health system and takes primary responsibility for the development, dissemination and implementation of the Division’s Strategic Plan for 2017-2020. Plan implementation is carried out by DBH which includes the Regional Centers, Office of Consumer Affairs (OCA), the six (6) regional behavioral health authorities (RBHA) and system partners. Following is an expanded description of each component of the operational structure.

DBH Central is comprised of five operational components, the state’s Regional Centers and the Office of Consumer Affairs:

1. Community-Based Services (CBS): Consists of services and the workforce essential for delivery of statewide, community-based mental health and substance use disorder prevention, treatment, recovery and support services.

2. Data and Quality Improvement (QI): Undertakes systematic and continuous actions that lead to measurable (via data) improvement in divisional operations, health care services and the health status of the consumer.

3. Fiscal: Provides oversight and administration of the Division’s funds from multiple sources including state general funds and block grant funds. It also manages the billing system for services and the development and execution of contracts.

4. System of Care (SOC): Provides a coordinated framework within which behavioral health care is delivered to adults (ASOC) and youth (YSOC).

5. Prevention: Promotes safe and healthy environments that foster youth, family, and community development through the implementation of early intervention and prevention best practices.

Regional Centers are the state’s public psychiatric hospitals located in Norfolk, Lincoln, and Hastings.
- Norfolk Regional Center (NRC) provides intensive sex offender treatment services.
- Lincoln Regional Center (LRC) provides three types of services:
  - psychiatric services for people with severe and persistent mental illness;
• forensic services to provide evaluation, assessment, and treatment for persons as ordered by the Nebraska legal system; and
• adult and youth sex offender transition services.
• Hastings Regional Center (HRC) provides residential substance use disorder treatment for young men.

Office of Consumer Affairs (OCA): The Office of Consumer Affairs conducts activities to promote consumer involvement in the service system and recovery process. Consumers are defined as persons receiving mental health or substance use disorder services. Activities include:
• Facilitation of community forums for consumers to give feedback on the quality of service and to identify gaps in these services.
• Administering for peer support and wellness specialists.
• Facilitation of OCA’s People’s Council designed to advise the DBH around consumer involvement.

Joint Advisory Committee: (State Advisory Committees on Mental Health and Substance Use Disorder Services) This is a 36-member committee appointed by the Governor to advise, assist, support and advocate for mental health and substance use disorder services. Committee members bring unique skills and knowledge to the table to advise the work of the Division.

System Partners and Providers: Effective collaboration among public and private systems, as well as with individual consumers, families, agencies and communities is a critical component of systems of care. Services are administered by a variety of different system partners:
• Administrative Office of Probation
• DHHS: Medicaid and Long-Term Care, Public Health, Children and Family Services, Developmental Disabilities and Veterans’ Affairs
• Nebraska Association of Behavioral Health Organizations (NABHO)
• Nebraska Departments of Correctional Services, Education and Insurance
• Nebraska Tribes
• Nebraska University System
• Regional Behavioral Health Authorities*
• Treatment, prevention and support service providers

*Regional Behavioral Health Authorities (RBHA): DBH contracts with six regional behavioral health authorities which authorizes them to purchase services using state general funds, funds received under the Community Mental Health Services block grant and the Substance Abuse Prevention Treatment block grant, and other discretionary federal grants. Each RBHA is under contract to provide:
• Network management,
• Consumer, prevention and emergency system coordination,
• Youth service coordination, and
• Housing coordination.
ONE PLAN – OPERATIONAL COLLABORATIVE

DBH CENTRAL OFFICE
Senior Leadership Team
Regional Centers
Office of Consumer Affairs

Joint Advisory Committee

DBH PARTNERS
DHHS Divisions/BH Regions
NABHO
Nebraska Tribes
Justice/Probation/Corrections
Departments of Education/Insurance
University System

Prevention Advisory Committee
People’s Council

Treatment, Prevention and Support Service Providers

DBH MH/SUD WORK TEAMS
A  B  C  D  E

LOCAL MH/SUD OPERATIONS
• Regional Efforts  • Community-Based Providers  • Tribes

Work Teams
A. Services, Prevention and Treatment
B. Data & QI
C. Fiscal
D. System of Care
E. Workforce

Team Membership
State, regional, local, tribal and partner representatives with expertise/interest specific to a team’s area of focus.
**Adult System of Care (ASOC):**
A system of care is a different way of doing business. An adult, recovery-oriented system of care assists consumers in achieving their optimal level of self-sufficiency and independence by providing mental health and substance use prevention, treatment and support services at the right time and in the right place. A system of care is recovery-focused, person-centered, strength-based, culturally responsive, individualized, integrated, outcomes-driven, research-based and adequately and flexibly financed. Nebraska’s Adult System of Care (ASOC) incorporates this conceptual framework and the associated system of care guiding principles and core values into a spectrum of effective, community-based services and supports that is organized within a coordinated system of care network.

**Prevention Works, Treatment is Effective, People Recover**
Nebraska Adult System of Care (ASOC)
ONE NEBRASKA! ONE PLAN!

Strategic Plan Development
The Division of Behavioral Health’s strategic plan initiative was a twelve-month endeavor, beginning with a comprehensive needs assessment and ending with an inclusive strategic plan that involved a thorough, highly participatory statewide methodology featuring input from consumers, leadership, providers and advisory groups. The development process encompassed four guiding questions:

1) Where are we? (Conduct a needs assessment),
2) What’s important? (Identify priorities),
3) What must be achieved? (Develop plan goals, objectives) and
4) How are we accountable? (Setting metrics).

1. Where Are We?
A needs assessment was completed in September 2016 by the University of Nebraska Medical Center, College of Public Health. The methodology employed included literature review to identify relevant research articles and technical reports; additional information such as expenditures and service utilization provided by Nebraska Department of Health and Human Services; and focus groups and surveys among consumers, stakeholders, and the general public. Selections from the 2016 Needs Assessment, offered below, provide a snapshot of the status of mental health and substance use in Nebraska. The complete document Nebraska Behavioral Health Needs Assessment 2016 can be accessed at: http://dhhs.ne.gov/behavioral_health/Documents/BHNeedsAssessment.pdf

Snapshot: Mental Illness and Substance Use in Nebraska

- 1 in 5 Nebraskans experienced mental illness within the past year.
- Women, people with lower incomes, and less formal education report poorer mental health status.
- 1 in 3 Native Americans have anxiety or depression and rank high in suicide rates and years lost to suicide.
- About half of Nebraska adults report at least one adverse childhood experience.
- 25% of high school students report feeling depressed in the past year.
- Nebraska ranks 47th in the nation for binge drinking among adults.
- 43% of young adults aged 18-25 report binge drinking in the last month.
- Of those adults in Nebraska with any mental illness, only 47% received treatment.
- Of those persons 12 years and older in Nebraska with illicit drug dependence or abuse, only 11% received treatment.
The results of the needs assessment provided a portrait of “where are we?” and coalesced around three emerging themes; system integration, quality of services, and access to care.

**Needs Assessment: Selected Findings and Recommendations**

- In 2014, 79 counties were state-designated as shortage areas for psychiatrists and mental health practitioners.
- Only 12 of 93 Nebraska counties had a psychiatrist.
- Wait times for treatment varies depending on the type of service needed.
- Only 20% of consumers indicated they can easily get SMI treatment in a timely manner.
- One in three Native Americans in Nebraska have anxiety or depression; among minority populations the percentage of persons reporting serious psychological distress was highest among Hispanics.
- At the region level, halfway house, intermediate residential and short-term residential services for substance use disorders have been near or slightly above 100% capacity in the past 3 fiscal years.
- Integrated care and telehealth have been promoted as potential access to care solutions.
- The majority of consumer respondents indicated that peer-to-peer recovery support was available to them.
- RBHA team meetings lead to building networks that are used to find appropriate services.
- Consumers expressed a strong desire to take a more active part in decision making in the behavioral health system.
- Wait list and capacity functionality should be fully activated in the data system.
- Expansion of prevention activities can decrease the overall burden of behavioral health problems.
- Primary care settings present an opportunity to provide integrated care and education.

**DBH Youth/Family Consumer Satisfaction Survey Results 2012-2015**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Nebraska</th>
<th></th>
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<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2015</td>
</tr>
<tr>
<td>Access</td>
<td>87.4%</td>
<td>85.3%</td>
<td>84.2%</td>
<td>82.1%</td>
<td>86%</td>
</tr>
<tr>
<td>General Satisfaction</td>
<td>79.0%</td>
<td>76.6%</td>
<td>77.9%</td>
<td>76.1%</td>
<td>86%</td>
</tr>
<tr>
<td>Outcomes</td>
<td>63.8%</td>
<td>67.1%</td>
<td>61.6%</td>
<td>60.8%</td>
<td>68%</td>
</tr>
<tr>
<td>Family Involvement</td>
<td>86.3%</td>
<td>89.3%</td>
<td>88.2%</td>
<td>89.8%</td>
<td>88%</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>91.9%</td>
<td>94.0%</td>
<td>92.8%</td>
<td>95.1%</td>
<td>94%</td>
</tr>
<tr>
<td>Functioning</td>
<td>63.4%</td>
<td>66.7%</td>
<td>62.7%</td>
<td>62.4%</td>
<td>70%</td>
</tr>
<tr>
<td>Social Connectedness</td>
<td>81.0%</td>
<td>83.6%</td>
<td>84.3%</td>
<td>77.3%</td>
<td>86%</td>
</tr>
</tbody>
</table>
2. What’s Important?
Identifying critical priorities or “what’s important?” for the Division’s 2017-2020 strategic plan was a four-month process involving input and recommendations from partners.

Process for Identifying Key Priorities, Goals and Objectives
A multi-stage methodology was employed to determine strategic plan direction and content.
3. What Must Be Achieved?

2017-2020 Strategic Goals and Objectives: DBH has organized its work around a focused set of visionary goals, domains and achievable objectives that speak to priorities.

Goals-Pursuit of the Triple Aim of Health Care

The Triple Aim of Health Care framework provided the basis for the DBH strategic plan and the ultimate development of the plan’s strategic goals. The goals for 2017-2020 are:

**Goal 1:** Nebraska Division of Behavioral Health Services are integrated across public and private systems to support consumers and impact health.

**Goal 2:** Nebraska Division of Behavioral Health delivers quality and effective services that help people live better lives.

**Goal 3:** Nebraska citizens experience access to culturally responsive behavioral health services at the right time and place to meet their needs.

**DBH Strategic Plan Domains 2017-2020**

- **Youth System of Care**
- **Operations Including Centralized Data**
- **Services, Including Systems Integration, Evidence-based Practices and Diversity in a Recovery Oriented System of Care.**
- **Prevention Including Disparity**
- **Workforce**

Objectives:

Strategic plan objectives provide the “how” mechanism for achieving the identified goals. They are “SMART” in that they are specific, measureable, attainable, realistic and time-framed. Each objective has been examined, analyzed and ultimately incorporated to ensure it adequately addresses the plan goals and domains and, where appropriate, furthers the philosophy and core values of a system of care (ASOC/YSOC). DBH has identified 30 objectives for 2017-2020.
4. How Are We Accountable?
The Division holds itself accountable for strategic plan results through Results-Based Accountability (RBA) methodology. RBA is a different way of thinking. It is the framework we use to define, measure, track and describe change within the system.

Nebraska is committed to a data-driven strategic plan and metrics offer the vehicle for holding the Division accountable for results over time. Metrics are correlated with the applicable plan objective to denote intended outcomes. Baseline numbers provide a starting point for movement toward the intended target. Desired movement is either:

1. denoting an increase, or
2. denoting a decrease is needed to reach the target.
**GOAL 1.**

**ONE NEBRASKA! ONE PLAN! 2017-2020**

Nebraska Division of Behavioral Health Services are integrated across public and private systems to support consumers and impact health.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Details</th>
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<tbody>
<tr>
<td>Increase the number of children and youth who attend school regularly following 12 months of SOC services and supports.</td>
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<tr>
<td>Increase the ratio of other means of financing to state funds spent on youth behavioral health services.</td>
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<tr>
<td>Reduce utilization of residential and inpatient behavioral health care for youth in any youth service system.</td>
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<tr>
<td>Decrease cost per youth and per adult receiving behavioral health services.</td>
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<tr>
<td>Reduce the suicide rate for identified populations.</td>
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<tr>
<td>Increase the number of behavioral health providers who report practicing in a setting that is integrated with primary care.</td>
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<tr>
<td>Increase the number of programs and management systems with operational interface to the Centralized Data System.</td>
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</tbody>
</table>

**GOAL 2.**

Nebraska Division of Behavioral Health delivers quality and effective services that help people live better lives.

<table>
<thead>
<tr>
<th>Objective</th>
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</thead>
<tbody>
<tr>
<td>Decrease average age of first system contact.</td>
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</tr>
<tr>
<td>Reduce the prevalence of underage alcohol use among individuals 12 to 20 years of age.</td>
<td></td>
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<tr>
<td>Reduce the prevalence of binge drinking among youth (12 to 17 years of age) and young adults (18 to 25 years of age).</td>
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<tr>
<td>Maintain or reduce the prevalence of non-medical use of pain relievers among individuals over 12 years of age.</td>
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<tr>
<td>Reduce the prevalence of high school students who seriously considered attempting suicide in the past year.</td>
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<tr>
<td>Maintain the annual compliance rate of tobacco retailer violations at 10% or below.</td>
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<td>Increase the availability and utilization of evidence-based practices (EBP).</td>
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<tr>
<td>Increase the number of consumers and their families who have stable housing from behavioral health services admission to discharge.</td>
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<tr>
<td>Increase the number of consumers who are employed or seeking employment from behavioral health services admission to discharge.</td>
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</tbody>
</table>
Nebraska citizens experience access to culturally responsive behavioral health services at the right time and place to meet their needs.

<table>
<thead>
<tr>
<th>Goal 3: Experience</th>
<th>Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the number of LMHPs, LADCs, &amp; RNs working in the behavioral health field.</td>
<td>Workforce</td>
<td></td>
</tr>
<tr>
<td>Decrease the vacancy rate for RNs at Lincoln Regional Center.</td>
<td>Workforce</td>
<td></td>
</tr>
<tr>
<td>Decrease the Regional Centers’ turnover rate of unlicensed workforce</td>
<td>Workforce</td>
<td></td>
</tr>
<tr>
<td>Increase the number of persons with lived experience working in the field.</td>
<td>Workforce</td>
<td></td>
</tr>
<tr>
<td>Reduce the proportion of youth who report living in a setting that is not their home (i.e. foster care, jail, prison or hospital) from intake to 12-month follow-up.</td>
<td>Y SOC</td>
<td></td>
</tr>
<tr>
<td>Increase the ratio of community based service expenditures compared to inpatient/residential services expenditures within the BH System of Care.</td>
<td>Y SOC</td>
<td></td>
</tr>
<tr>
<td>Increase the number of behavioral health programs utilizing peer workforce standards.</td>
<td>O</td>
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<tr>
<td>Sustain or increase general satisfaction of consumers receiving behavioral health services.</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Reduce wait time for behavioral health residential and medication management services.</td>
<td>S</td>
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</tr>
<tr>
<td>Reduce the wait time for admission to Lincoln Regional Center (LRC).</td>
<td>S</td>
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</tr>
<tr>
<td>Decrease the average law enforcement holding time for consumers under Emergency Protective Custody.</td>
<td>S</td>
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</tr>
<tr>
<td>Increase the number of behavioral health providers offering services via telehealth in frontier/rural areas.</td>
<td>S</td>
<td></td>
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<tr>
<td>Reduce disparities in access to behavioral health care.</td>
<td>S</td>
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</tr>
<tr>
<td>Increase the number of prescribers providing EBP Medication Assisted Treatment.</td>
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</tbody>
</table>
Goal 1. Nebraska behavioral health services are integrated across public and private systems to support consumers and impact health.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Objective</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOC</td>
<td>1.A. By 2020, increase the number of children and youth who attend school regularly following 12 months of SOC services and supports.</td>
<td>School Attendance</td>
</tr>
<tr>
<td></td>
<td>• Target: Establish by 8/2017</td>
<td></td>
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<tr>
<td></td>
<td>• Baseline: 95.17%</td>
<td></td>
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<td></td>
<td>• Data source: Divisions of Behavioral Health, Medicaid &amp; Long Term Care, Children &amp; Family Services &amp; Probation data records</td>
<td></td>
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<tr>
<td></td>
<td>• Collection cycle: Annually</td>
<td></td>
</tr>
<tr>
<td>SOC</td>
<td>1.B. By 2020, increase the ratio of other means of financing to state funds spent on youth behavioral health services.</td>
<td>Ratio of Other Means of Financing to State Funds Spent on Youth BH Services</td>
</tr>
<tr>
<td></td>
<td>• Target: Establish by 8/2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Baseline: Establish by 8/2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Data source: Divisions of Behavioral Health, Medicaid &amp; Long Term Care, Children &amp; Family Services &amp; Probation, Nebraska Children and Families Foundation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Collection cycle: Annually</td>
<td></td>
</tr>
<tr>
<td>SOC</td>
<td>1.C. By 2020, reduce utilization of residential and inpatient behavioral health care for youth in any youth service system.</td>
<td>Utilization of Residential &amp; Inpatient BH Care for Youth</td>
</tr>
<tr>
<td></td>
<td>• Target: Establish by 8/2017</td>
<td></td>
</tr>
</tbody>
</table>
1.D. By 2020, decrease cost per youth and per adult receiving behavioral health services.

**Cost per Youth**
- Target: Establish by 8/2017
- Baseline: $4,400
- Data source: Divisions of Behavioral Health, Medicaid & Long Term Care, Children & Family Services & Probation data records
- Collection cycle: Annually

**Cost per Adult**
- Target: Establish by 1/2018
- Baseline: Establish by 1/2018
- Data source: Centralized Data System/Electronic Billing System
- Collection cycle: Quarterly

1.E. By 2020, reduce the suicide rate for identified populations.

**Veterans’ Suicide Rate**
- Target: 32 per 100,000
- Baseline: 36 per 100,000
- Data source: 2014 NE Vital Statistics
- Collection cycle: Annually

**Native Americans’ Suicide Rate**
- Target: 9 per 100,000
1.F. By 2020, increase the number of behavioral health providers who report practicing in a setting that is integrated with primary care.

- Baseline: 10 per 100,000
- Data source: 2010-2014 NE Vital Statistics
- Collection cycle: Annually

1.G. By 2020, increase the number of programs and management systems with operational interface to the Centralized Data System.

- Target: 6 per 100,000
- Baseline: 7.5 per 100,000
- Data source: 2014 NE Vital Statistics
- Collection cycle: Annually

- Target: 7.5 per 100,000
- Baseline: 15 per 100,000
- Data source: 2014 NE Vital Statistics
- Collection cycle: Annually

- Target: 13.5 per 100,000
- Baseline: 15 per 100,000
- Data source: 2014 NE Vital Statistics
- Collection cycle: Annually

- Target: Establish by 7/2017
- Baseline: 30.2%
- Data source: Health Professional Tracking Survey
- Collection cycle: Annually

- Target: 25
- Baseline: 12
- Data source: Centralized Data System
- Collection cycle: Annually
### Goal 2. Nebraska behavioral health system delivers quality and effective services that help people live better lives.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Objective</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOC</td>
<td>2.A. By 2020, decrease average age of youths’ first system contact.</td>
<td>Age of First Contact</td>
</tr>
<tr>
<td></td>
<td>• Target: Establish by 8/2017</td>
<td>• Baseline: 9.38 years old</td>
</tr>
<tr>
<td></td>
<td>• Data source: Divisions of Behavioral Health, Medicaid &amp; Long Term Care, Children &amp; Family Services &amp; Probation data records</td>
<td>• Data source: Divisions of Behavioral Health, Medicaid &amp; Long Term Care, Children &amp; Family Services &amp; Probation data records</td>
</tr>
<tr>
<td></td>
<td>• Collection cycle: Quarterly</td>
<td>• Collection cycle: Quarterly</td>
</tr>
<tr>
<td>SOC</td>
<td>2.B. By 2020, reduce the prevalence of underage alcohol use among individuals 12 to 20 years of age.</td>
<td>Underage Alcohol Use</td>
</tr>
<tr>
<td></td>
<td>• Target: 20% report alcohol use in the past month</td>
<td>• Baseline: 21.63% report alcohol use in the past month</td>
</tr>
<tr>
<td></td>
<td>• Collection cycle: Annually</td>
<td>• Collection cycle: Annually</td>
</tr>
<tr>
<td>SOC</td>
<td>2.C. By 2020, reduce the prevalence of binge drinking among youth and young adults.</td>
<td>Binge Drinking Ages 15-18</td>
</tr>
<tr>
<td></td>
<td>• Target: 12.6% report binge drinking in the past month</td>
<td>• Baseline: 14% report binge drinking in the past month</td>
</tr>
<tr>
<td></td>
<td>• Data source: 2015 Youth Risk Behavior Surveillance (YRBS)</td>
<td>• Data source: 2015 Youth Risk Behavior Surveillance (YRBS)</td>
</tr>
<tr>
<td></td>
<td>• Collection cycle: Biennial</td>
<td>• Collection cycle: Biennial</td>
</tr>
<tr>
<td>SOC</td>
<td>2.C. By 2020, reduce the prevalence of binge drinking among youth and young adults.</td>
<td>Binge Drinking Ages 19-25</td>
</tr>
<tr>
<td></td>
<td>• Target: Decrease by 10%</td>
<td>• Baseline: 37.6% report binge drinking in the past month</td>
</tr>
</tbody>
</table>
2.D. By 2020, maintain or reduce the prevalence of non-medical use of pain relievers among individuals over 12 years of age.

<table>
<thead>
<tr>
<th>Target</th>
<th>Data source</th>
<th>Collection cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medical Use of Pain Relievers Ages 12-17</td>
<td>2016 National Youth Adult Alcohol Opinion Survey</td>
<td>In FY 2018 (as funding is available)</td>
</tr>
<tr>
<td>Target: Establish by 6/2017</td>
<td>2012-2013 National Survey on Drug Use &amp; Health data</td>
<td>Annually</td>
</tr>
<tr>
<td>Baseline: 4.68% report non-medical use of pain relievers in the past year</td>
<td></td>
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<tr>
<td>Non-Medical Use of Pain Relievers Ages 18-25</td>
<td>2012-2013 National Survey on Drug Use &amp; Health data</td>
<td>Annually</td>
</tr>
<tr>
<td>Target: Establish by 6/2017</td>
<td>2012-2013 National Survey on Drug Use &amp; Health data</td>
<td>Annually</td>
</tr>
<tr>
<td>Baseline: 8.64% report non-medical use of pain relievers in the past year</td>
<td></td>
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<tr>
<td>Non-Medical Use of Pain Relievers Ages 26+</td>
<td>2012-2013 National Survey on Drug Use &amp; Health data</td>
<td>Annually</td>
</tr>
<tr>
<td>Target: Establish by 6/2017</td>
<td>2012-2013 National Survey on Drug Use &amp; Health data</td>
<td>Annually</td>
</tr>
<tr>
<td>Baseline: 2.89% report non-medical use of pain relievers in the past year</td>
<td></td>
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<tr>
<td>2.E.</td>
<td>By 2020, reduce the prevalence of high school students who seriously considered attempting suicide in the past year.</td>
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<td></td>
</tr>
<tr>
<td><strong>Youth Considering Suicide</strong></td>
<td></td>
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<tr>
<td>• Target: 13% seriously considered suicide in the past year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Baseline: 14.6% seriously considered suicide in the past year</td>
<td></td>
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<tr>
<td>• Data source: 2015 YRBS</td>
<td></td>
<td></td>
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<tr>
<td>• Collection cycle: Biennial</td>
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<thead>
<tr>
<th>2.F.</th>
<th>By 2020, maintain the annual Nebraska retailer violations rate at 10% or below.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compliance with Tobacco Sales Laws</strong></td>
<td></td>
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<tr>
<td>• Target: Maintain under 10%</td>
<td></td>
</tr>
<tr>
<td>• Baseline: 9%</td>
<td></td>
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<tr>
<td>• Data source: 2016 Annual Synar</td>
<td></td>
</tr>
<tr>
<td>• Collection cycle: Annually</td>
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<table>
<thead>
<tr>
<th>2.G.</th>
<th>By 2020, increase availability and utilization of evidence-based practices (EBP).</th>
</tr>
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<tbody>
<tr>
<td><strong>Providers Using EBPs</strong></td>
<td></td>
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<tr>
<td>• Target: Establish by 8/2017</td>
<td></td>
</tr>
<tr>
<td>• Baseline: Establish by 8/2017</td>
<td></td>
</tr>
<tr>
<td>• Data source: Survey</td>
<td></td>
</tr>
<tr>
<td>• Collection cycle: Annually</td>
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</table>

| **EBPs in Use** |
| • Target: Establish by 3/2017 |
| • Baseline: Establish by 3/2017 |
| • Data source: Survey |
| • Collection cycle: Annually |

| **Providers Reporting Fidelity Evaluations** |
| • Target: Establish by 3/2017 |
| • Baseline: Establish by 3/2017 |
| • Data source: Survey |
| • Collection cycle: Annually |
### Consumers Receiving EBPs
- **Target:** TBD
- **Baseline:** TBD
- **Data source:** TBD
- **Collection cycle:** TBD

### Consumers with improved outcomes as a result of EBPs.
- **Target:** TBD
- **Baseline:** TBD
- **Data source:**
- **Collection cycle:** Annually

### 2.H. By 2020, increase the number of consumers and their families who have stable housing from behavioral health services admission to discharge.

#### Stable Housing
- **Target:** 85%
- **Baseline:** 83.3%
- **Data source:** 2016 Consumer Treatment Data-Centralized Data system
- **Collection cycle:** Quarterly

### 2.I. By 2020, increase the number of consumers who are employed or seeking employment from behavioral health services admission to discharge.

#### Employment
- **Target:** Establish by 3/2017
- **Baseline:** 3,451
- **Data source:** 2016 Consumer Treatment Data-Centralized Data system
- **Collection cycle:** Quarterly

#### Supported Employment
- **Target:** 60%
- **Baseline:** 60.4%
- **Data source:** 2016 Consumer Treatment Data-Centralized Data system
- **Collection cycle:** Quarterly
Goal 3. Nebraska citizens experience access to culturally responsive behavioral health services at the right time and place to meet their needs.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Objectives</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.A. By 2020, increase the number of LMHPs and LADCs.</td>
<td>LMHPs</td>
</tr>
</tbody>
</table>
|        | • Target: Establish 8/2017  
• Baseline: 8/2017  
• Data source: 2016 Health Professional Tracking Survey  
• Collection cycle: Annually  
• LADCs |
|        | 3.B. By 2020, decrease the vacancy rate of LRC RNs. | Vacancy Rate of LRC RNs |
|        | • Target: 29%  
• Baseline: 33.8%  
• Data source: Human Resources Vacancy  
• Collection cycle: Monthly |
|        | 3.C. By 2020, decrease the Regional Centers’ turnover rate of unlicensed workforce. | Regional Centers’ Turnover Rate of Unlicensed Workforce |
|        | • Target: TBD  
• Baseline: TBD  
• Data source: DHHS/HR database  
• Collection cycle: Quarterly |
|        | 3.D. By 2020, increase the number of persons with lived experience working in the field. | Persons with Lived Experience Working in the Field |
| SOC | 3.E. By 2020, reduce the proportion of youth who report living in a setting that is not their home (i.e. foster care, jail, prison or hospital) from intake to 12 month follow-up. | • Target: Establish by 7/2017  
• Baseline: Establish by 7/2017  
• Data source: Establish by 7/2017  
• Collection cycle: Establish by 7/2017 |
| Out-of-Home Placements | • Target: Established by 8/2017  
• Baseline: 17.7%  
• Data source: Divisions of Behavioral Health, Medicaid & Long Term Care, Children & Family Services & Probation data records  
• Collection cycle: Quarterly |
| SOC | 3.F. By 2020, increase the ratio of community-based service expenditures compared to inpatient/residential services expenditures within the youth SOC. | Ratio of Community Based Service Expenditures to Inpatient/Residential Services Expenditures for Youth |
| | • Target: Establish by 8/2017  
• Baseline: 2 to 1 community-based to inpatient/residential services  
• Data source: Divisions of Behavioral Health, Medicaid & Long Term Care, Children & Family Services & Probation data records  
• Collection cycle: Annually |
| SOC | 3.G. By 2020, increase the number of behavioral health programs utilizing peer workforce standards. | Use of Peer Workforce Standards |
| | • Target: 12/2017  
• Baseline: 12/2017  
• Data source: Survey  
• Collection cycle: Annually |
| SOC | 3.H. By 2020, sustain or increase general satisfaction of consumers receiving behavioral health services. | Consumer Satisfaction |
| | • Target: 87%  
• Baseline: 87.3% |
<table>
<thead>
<tr>
<th>3.I. By 2020, reduce wait time for behavioral health residential and medication management services.</th>
<th>Residential Services Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Target: Establish by 6/2017</td>
<td>• Target: Establish by 6/2017</td>
</tr>
<tr>
<td>• Baseline: Establish by 6/2017</td>
<td>• Baseline: Establish by 6/2017</td>
</tr>
<tr>
<td>• Data source: Centralized Data System</td>
<td>• Data source: Centralized Data System</td>
</tr>
<tr>
<td>• Collection cycle: Quarterly</td>
<td>• Collection cycle: Quarterly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.J. By 2020, reduce the wait time for admission to Lincoln Regional Center (LRC).</th>
<th>LRC Wait Time-MHB Commit</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Target: 8 Days</td>
<td>• Target: 8 Days</td>
</tr>
<tr>
<td>• Baseline: 10.6 Days</td>
<td>• Baseline: 10.6 Days</td>
</tr>
<tr>
<td>• Data source: Avatar</td>
<td>• Data source: Avatar</td>
</tr>
<tr>
<td>• Collection cycle: Monthly</td>
<td>• Collection cycle: Monthly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.K. By 2020, decrease the average law enforcement holding time for consumers under Emergency Protective Custody.</th>
<th>Law Enforcement Holding Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Target: Establish by 1/2018</td>
<td>• Target: Establish by 1/2018</td>
</tr>
<tr>
<td>• Baseline: Establish by 1/2018</td>
<td>• Baseline: Establish by 1/2018</td>
</tr>
<tr>
<td>• Data source: Law enforcement report via Emergency Coordinators</td>
<td>• Data source: Law enforcement report via Emergency Coordinators</td>
</tr>
</tbody>
</table>
### 3.L. By 2020, increase behavioral health providers offering services via telehealth in frontier/rural areas.

- **Therapy via Telehealth**
  - Target: Establish by 8/2017
  - Baseline: Establish by 8/2017
  - Data source: Establish by 8/2017
  - Collection cycle: Establish by 8/2017

### 3.M. By 2020, reduce disparities in access to behavioral health care.

- **Diverse Populations Receiving Behavioral Health Services**
  - Target: Establish by 8/2017
  - Baseline: Establish by 8/2017
  - Data source: Centralized Data source
  - Collection cycle: Annually

### 3.N. By 2020, increase the number of prescribers providing EBP Medication Assisted Treatment.

- **Prescribers of Medication Assisted Treatment**
  - Target: Establish by 8/2017
  - Baseline: Establish by 8/2017
  - Data source: SAMHSA Registry
  - Collection cycle: Annually
Nebraska Strategic Prevention Framework – Partnerships for Success (SPF-PFS)

Evaluation Plan

2019

Prepared for:
Lindsey Hanlon
SPF-PFS Director
Nebraska Department of Health and Human Services
Division of Behavioral Health

Prepared by:
Mindy Anderson-Knott
SPF-PFS Evaluator
Schmeeckle Research
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Introduction

Persistently higher rates of alcohol use are found among Nebraska youth than the national average. This places the reduction of underage drinking as a high priority at the statewide level and in communities across Nebraska. Alcohol use is both a product of and contributing factor in major community problems. Based on various protective and risk factors within communities, some counties and regions are in more immediate need of assistance to address alcohol use and abuse than others, particularly among youth. Given the complex and intertwined nature of underlying community conditions, an integrated and extensive plan is necessary to address the issues. In order to achieve the goal of implementing an effective prevention plan and promote sustainable systems change, the Strategic Prevention Framework is utilized.

The Strategic Prevention Framework Partnership for Success (SPF-PFS) project seeks to reduce problems related to underage drinking by preventing the onset and reducing underage drinking among Nebraskans aged 9 to 20. The focus is on targeted sub-populations based on need, established through protective and risk factor indicators.

Through the use of a risk-and-protective-factor framework, the Division of Behavioral Health chose to fund communities identified with personal, family, and/or community characteristics that increase the likelihood of a substance abuse problem developing. Targeted counties were selected based on their problematic binge drinking behavior and increased acceptability for binge and underage drinking. These counties were selected as a result of comparing demographic, survey and health profiles of the State's 93 counties and ranking each county against the statewide average of the selected indicators. A detailed description of these indicators can be found in Nebraska's SPF-PFS 2018 application. Thirty-three counties were identified as targeted counties to receive SPF-PFS funding (see Table 1).
Nebraska is divided into six (sub state) Regional Behavioral Health Authorities or “Regions” serving as quasi-governmental agencies with which the state contracts for community based treatment and prevention services. The Nebraska Department of Health and Human Services Division of Behavioral Health has chosen to sub grant SPF-PFS funding through five of the six Regions and allocate their awards based on the number of targeted counties in that Region. The Regions in turn are subcontracting the SPF-PFS dollars to eligible community coalitions (sub-recipients). The behavioral health regions contracted with 18 community coalitions to implement SPF-PFS in the 33 targeted counties.

The Division of Behavioral Health requires SPF planning by any coalition regardless of funding source. The influence of the SPF has multiplied through the work of the Regional Prevention Coordinators, which now provide SPF-based training and technical assistance to all area coalitions. Community coalitions benefit from this hands-on, face-to-face training and technical assistance that takes them through every step of the prevention planning process and allows them to network and strategize with their peers. Bolstered by the provision of specific techniques and tools designed for each stage of the SPF process, communities have demonstrated significant increases in their capacity to engage in effective planning. The Regional
Prevention Coordination System, in partnership with the State and community coalitions, will continue to build on existing success by further providing extensive community-based training and technical assistance on all stages of the Strategic Prevention Framework.

Schmeeckle Research and the University of Nebraska-Lincoln's Methodology and Evaluation Research Core Facility will be utilized to conduct the evaluation. Mindy Anderson-Knott, a certified evaluator and the former onsite evaluation coordinator for the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) and lead evaluator for the 2013 Strategic Prevention Framework-Partnerships for Success (SPF-PFS) Grant, will be leading the evaluation. The evaluation will assess outcomes of Nebraska’s Strategic Prevention Framework Partnership for Success project to assess the project in meeting its goals and objectives:

- Prevent the onset and reduce the prevalence of underage alcohol use, including binge drinking, among individuals 9 to 20 years old.
- Prevent the onset and reduce the prevalence of marijuana use among individuals 9 to 20 years old.
- Increase the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use among individuals 9 to 20 years old.
- Strengthen capacity and infrastructure at the state and community levels in support of prevention efforts.
- Leverage, redirect, and realign local funding streams for prevention related to underage drinking, and target the increased marijuana use among this population.

This document provides an outline of the approach to this evaluation, including detailed descriptions of the process and outcome evaluation questions, methods employed for data collection, analysis approaches, reporting plans, and the proposed timeline.

**Evaluation Approach**

The purpose of the SPF-PFS evaluation is to assess the impact on the state- and community level outcomes, as well as to identify and describe strengths and limitations associated with the administration of the grant. The SPF-PFS will be assessed utilizing both process and outcome evaluations. The process evaluation will inform the administration of the SPF-PFS by providing information needed to most effectively meet the proposed goals and objectives and to explain variation in outcomes. The impact of SPF-PFS efforts relative to their stated goals and objectives will be assessed in the outcome evaluation.
This report outlines the statewide evaluation plan. Additionally, individual evaluation plans have been developed in coordination with sub-recipients to establish the most effective community level evaluation design.

**Evaluation Questions**

To frame the evaluation, a series of evaluation questions were developed to assess the implementation and impact of the SPF-PFS. First, the process evaluation questions are provided, followed by the outcome evaluation questions. To further clarify the scope of the questions, they are separated by state and community level. Table 1 lists the evaluation questions, organized by the grant’s five goals. The data sources that will be used to assess each evaluation question are also provided.
Table 1. Evaluation Questions and Data Sources

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Evaluation Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1: Prevent the onset and reduce the prevalence of underage alcohol use, including binge drinking, among individuals 9 to 20 years old.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Objective 1.1:</strong> By 2023 decrease prevalence of twelfth graders past month alcohol use, in funded geographic regions, to 33% or less as measured by the Nebraska Risk and Protective Factor Student Survey.</td>
<td></td>
</tr>
<tr>
<td><strong>Objective 1.2:</strong> By 2023 decrease the prevalence of twelfth graders past month binge drinking, in funded geographic regions, to 16% or less as measured by the Nebraska Risk and Protective Factor Student Survey.</td>
<td></td>
</tr>
<tr>
<td><strong>Objective 1.3:</strong> By 2023 decrease the prevalence of youth under 21 years old committing alcohol-related crimes, in funded regions, to a rate of 86.0 arrests per 10,000 population as measured through Uniform Crime Reports data.</td>
<td></td>
</tr>
<tr>
<td><strong>State Level Process:</strong></td>
<td></td>
</tr>
<tr>
<td>1. How did intervention type and combinations of interventions impact implementation and outcomes?</td>
<td>Workplans, PLI's, NRPFSS, NYAAOS</td>
</tr>
<tr>
<td>2. How did contextual factors impact implementation and outcomes?</td>
<td>Site visits, Quarterly reports, PLI's, NRPFSS, NYAAOS</td>
</tr>
<tr>
<td>3. How did community characteristics impact implementation and outcomes?</td>
<td>Site visits, Quarterly reports, PLI's, NRPFSS, NYAAOS</td>
</tr>
<tr>
<td>4. How did facilitators and barriers affect implementation?</td>
<td>Site visits, Quarterly reports</td>
</tr>
<tr>
<td><strong>Community Level Process:</strong></td>
<td></td>
</tr>
<tr>
<td>1. Were selected strategies implemented with fidelity?</td>
<td>NPIRS</td>
</tr>
<tr>
<td>2. How did facilitators and barriers affect implementation?</td>
<td>Site visits, Quarterly reports</td>
</tr>
<tr>
<td><strong>State Level Outcome:</strong></td>
<td></td>
</tr>
<tr>
<td>1. Did the implementation of SPF-PFS prevent the onset and reduce the prevalence of underage alcohol use, including binge drinking, among individuals 9 to 20 years old?</td>
<td>YRBS, NRPFSS, NYAAOS, PLI's</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>a. Did the prevalence of twelfth graders past month alcohol use, in funded geographic regions, decrease to 33% or less as measured by the Nebraska Risk and Protective Factor Student Survey by 2023?</td>
<td>NRPFSS</td>
</tr>
<tr>
<td>b. Did the prevalence of twelfth graders past month binge drinking, in funded geographic regions, decrease to 16% or less as measured by the Nebraska Risk and Protective Factor Student Survey by 2023?</td>
<td>NRPFSS</td>
</tr>
<tr>
<td>c. Did the prevalence of youth under 21 years old committing alcohol-related crimes, in funded regions, decrease to a rate of 86.0 arrests per 10,000 population as measured through Uniform Crime Reports data by 2023?</td>
<td>Crime Commission</td>
</tr>
</tbody>
</table>

**Community Level Outcome:**

1. Did the implementation of SPF-PFS prevent the onset and reduce the prevalence of underage alcohol use, including binge drinking, among individuals 9 to 20 years old in the targeted county/ies?  

**Goal 2: Prevent the onset and reduce the prevalence of marijuana use among individuals 9 to 20 years old.**

**Objective 2.1:** By 2023 decrease the prevalence of twelfth graders past month marijuana use, in funded geographic regions, to 14% or less as measured by the Nebraska Risk and Protective Factor Student Survey.

**State Level Process:**

5. How did intervention type and combinations of interventions impact implementation and outcomes?  

6. How did contextual factors impact implementation and outcomes?  

<p>| Workplans, PLI's, NRPFSS, NYAAOS |
| Site visits, Quarterly reports, PLI's, NRPFSS, NYAAOS |</p>
<table>
<thead>
<tr>
<th>7. How did community characteristics impact implementation and outcomes?</th>
<th>Site visits, Quarterly reports, PLI's, NRPFSS, NYAOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. How did facilitators and barriers affect implementation?</td>
<td>Site visits, Quarterly reports</td>
</tr>
</tbody>
</table>

**Community Level Process:**

3. Were selected strategies implemented with fidelity? NPIRS

4. How did facilitators and barriers affect implementation? Site visits, Quarterly reports

**State Level Outcome:**

1. Did the implementation of SPF-PFS prevent the onset and reduce the prevalence of marijuana use among individuals 9 to 20 years old? YRBS, NRPFSS, NYAOS, PLI's

   a. Did the prevalence of twelfth graders past month marijuana use, in funded geographic regions, decrease to 14% or less as measured by the Nebraska Risk and Protective Factor Student Survey by 2023? NRPFSS

2. Did the implementation of SPF-PFS prevent the onset and reduce the prevalence of marijuana use among individuals 9 to 20 years old in the targeted county/ies? NRPFSS, NYAOS, PLI's, College surveys

**Goal 3:** Increase the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use among individuals 9 to 20 years old.

**Objective 3.1:** Create an Approved Nebraska Evidence Based Program (EBP) Listing for communities to use for the prevention of alcohol use by the end of Year one.

**Objective 3.2:** Increase the use of Evidence Based Programs used by coalitions for alcohol prevention to at least 60% of strategies used in each region as measured by the Nebraska Prevention Information Reporting System by 2019. By 2023 the use of Evidence Based Programs used should be at least 70%.

**State Level Process:**
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Who was involved in the development of the Approved Nebraska Evidence Based Program (EBP) Listing?</td>
<td>PAC/SEOW FG, RPC FG, EBP Listing Documentation</td>
</tr>
<tr>
<td>2.</td>
<td>How did facilitators and barriers affect the development of the Approved Nebraska Evidence Based Program (EBP) Listing?</td>
<td>PAC/SEOW FG, RPC FG</td>
</tr>
<tr>
<td>3.</td>
<td>Did the State and Region provide support to community coalitions in identifying and selecting EBP’s?</td>
<td>Site visits, Quarterly reports</td>
</tr>
<tr>
<td>4.</td>
<td>How did the SPF process affect the selection of strategies?</td>
<td>Site visits, Quarterly reports</td>
</tr>
<tr>
<td></td>
<td><strong>Community Level Process:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.  How was the Approved Nebraska Evidence Based Program (EBP) Listing used by coalitions?</td>
<td>Site visits, Quarterly reports</td>
</tr>
<tr>
<td></td>
<td>6.  How did the SPF process affect the selection of strategies?</td>
<td>Site visits, Quarterly reports</td>
</tr>
<tr>
<td></td>
<td>7.  How did facilitators and barriers affect the selection of strategies?</td>
<td>Site visits, Quarterly reports</td>
</tr>
<tr>
<td></td>
<td><strong>State Level Outcome:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.  Did the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use among individuals 9 to 20 years old increase?</td>
<td>Workplans</td>
</tr>
<tr>
<td></td>
<td>a.  Was an Approved Nebraska Evidence Based Program (EBP) Listing for communities to use for the prevention of alcohol use created by the end of Year one?</td>
<td>EBP Listing Documentation</td>
</tr>
<tr>
<td></td>
<td>b.  Were at least 60% of PFS funds from all PFS subgrantees used on EBP’s, as measured by the Nebraska Prevention Information Reporting System by September 30, 2019?</td>
<td>Workplans and Budgets</td>
</tr>
<tr>
<td></td>
<td>c.  Were at least 70% of PFS funds from all PFS subgrantees used on EBP’s, as measured by the Nebraska Prevention Information Reporting System by 2023?</td>
<td>Workplans and Budgets</td>
</tr>
<tr>
<td></td>
<td><strong>Community Level Outcome:</strong></td>
<td></td>
</tr>
</tbody>
</table>
1. Did the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use among individuals 9 to 20 years old increase? **Workplans**

   a. Were at least 60% of PFS funds used on EBP’s, as measured by the Nebraska Prevention Information Reporting System by September 30, 2019? **Workplans and Budgets**

   b. Were at least 70% of PFS funds used on EBP’s, as measured by the Nebraska Prevention Information Reporting System by 2023? **Workplans and Budgets**

**Goal 4: Strengthen capacity and infrastructure at the state and community levels in support of prevention efforts.**

**State Level Process:**

1. Did the State and Region provide support to community coalitions in developing data driven workplans? **Site visits, RPC FG**

2. Did the State and Region provide training and technical assistance to strengthen capacity and infrastructure at the community level in support of prevention efforts? **Site visits, Coalition coordinator survey, Quarterly reports, T/TA tracking form, NPIRS**

3. How did the quantity and quality of training and technical assistance impact implementation? **Site visits, Coalition coordinator survey, RPC FG, Quarterly reports**

4. Were Cultural and Linguistically Appropriate Standards (CLAS) used to improve capacity at the state level? **Site visits, SEOW/PAC FG, RPC FG**

5. How was coalition capacity and functioning related to implementation and outcomes? **Capacity survey, site visits, NRPFSS, NYAOS, PLI’s**

6. How did facilitators and barriers affect capacity and infrastructure at the state and region level? **Site visits, SEOW/PAC FG, RPC FG**

**Community Level Process:**
1. Did sub-recipients implement each SPF step with fidelity?  
   - Site visits (SPF Rubrics)

2. Were Cultural and Linguistically Appropriate Standards (CLAS) used to improve capacity at the community level?  
   - Capacity survey, Site visits, Quarterly reports

3. How did facilitators and barriers affect capacity and infrastructure at the community level?  
   - Site visits, Quarterly reports

**State Level Outcome:**
1. Were prevention capacity and infrastructure strengthened at the state level?  
   - Coalition coordinator survey, Site visits, SEOW/PAC FG, RPC FG

**Community Level Outcome:**
1. Were prevention capacity and infrastructure strengthened at the community level?  
   - Coalition capacity survey, site visits

Goal 5: Leverage, redirect, and realign local funding streams for prevention related to underage drinking, and target the increased marijuana use among this population.

**State Level Process:**
1. How did facilitators and barriers affect sub-recipients’ ability to leverage, redirect, and realign funding streams for prevention related to underage drinking, and target the increased marijuana use among this population?  
   - Site visits, RPC FG, Quarterly reports

**Community Level Process:**
1. How did facilitators and barriers affect sub-recipients’ ability to leverage, redirect, and realign funding streams for prevention related to underage drinking, and target the increased marijuana use among this population?  
   - Site visits, Quarterly reports

**State Level Outcome:**
<table>
<thead>
<tr>
<th>State Level Outcomes:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the implementation of SPF-PFS reduce alcohol-related consequences among youth ages 9-20 at the state level?</td>
<td>Crime Commission, Hospital Discharge, Highway Safety</td>
</tr>
<tr>
<td>2. Did the implementation of SPF-PFS impact alcohol-related perceptions and attitudes in the targeted communities?</td>
<td>NRPFSS, NYAAOS, NASIS</td>
</tr>
<tr>
<td>3. Did the implementation of SPF-PFS reduce racial/ethnic behavioral health disparities among youth ages 9-20 at the state level?</td>
<td>YRBS, NRPFSS, NYAAOS, Crime Commission, Hospital Discharge, Highway Safety</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Level Outcomes:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the implementation of SPF-PFS reduce alcohol-related consequences among youth ages 9-20 in the targeted communities?</td>
<td>Crime Commission, Hospital Discharge, Highway Safety</td>
</tr>
<tr>
<td>2. Did the implementation of SPF-PFS impact alcohol-related perceptions and attitudes in the targeted communities?</td>
<td>NRPFSS, NYAAOS, NCAOS, College surveys</td>
</tr>
<tr>
<td>3. Did the implementation of SPF-PFS reduce racial/ethnic behavioral health disparities among youth ages 9-20 in the targeted communities?</td>
<td>NRPFSS, NYAAOS, Crime Commission, Hospital Discharge, Highway Safety</td>
</tr>
</tbody>
</table>
Evaluation Methods

Process Evaluation
Multiple evaluation methods will be employed to gather process evaluation data. The evaluation will use existing information whenever possible to reduce burden, including NPIRS, quarterly reports and other documentation. Table 2 summarizes measures and corresponding data sources for the state and community level process evaluation, while the text below describes each data source in more detail.

Workplans and Quarterly Reports
All sub-recipients are required to submit to the Division of Behavioral Health an annual workplan with budget, which will provide details on the strategies to be implemented. Funded sub-recipients will also provide quarterly reports, which will include an update on accomplishments and barriers for each of the SPF steps. The Division of Behavioral Health will share these reports with the evaluation team for review. Together, this information will be used to assess adherence to the SPF steps, implementation of selected strategies, training and technical assistance received, and to identify successes and barriers.

State Level Key Stakeholder Focus Groups
Two focus groups will be conducted with state level key stakeholders. One focus group will be conducted with representatives from the Prevention Advisory Council (PAC) and the State Epidemiological Outcomes Workgroup (SEOW) Executive Committee, while the other will be conducted with the Regional Prevention Coordinators. The focus groups will gather information regarding their perceptions of the overall SPF-PFS, as well as specific aspects including the development of the EBP Listing, training and technical assistance provided, assistance provided to sub-recipients in developing data driven workplans, incorporation of CLAS standards and perceptions of capacity at the state, regional, and local levels. The focus groups will be conducted in the first and final years of the grant. The focus groups conducted in the first year will provide a baseline assessment of state and regional infrastructure, while the final year focus groups will provide process data to explain outcomes and describe perceived impacts.

Sub-recipient Site Visits
The evaluator will conduct annual site visits with each funded community coalition. The site visits conducted in the first year will provide a baseline assessment of SPF adherence, community readiness, capacity, leveraging of resources, incorporation of CLAS standards, and facilitators and barriers experienced in the first year. The visits taking place during years 2- will provide insightful process evaluation information to guide modifications to further improve implementation and administration. The final site visit in the last year will elicit information to further explain final outcomes and describe the impact on underage drinking, state and
community level capacity, prevention infrastructure, and changes in the leveraging of resources. In addition to collecting in-depth qualitative feedback, the SPF Model Fidelity Rubric designed by a national workgroup of SPF SIG project directors and evaluators will be utilized during the visits to assess fidelity to the SPF Model.

**Nebraska Prevention Information Reporting System (NPIRS)**

The Nebraska Prevention Information Reporting System (NPIRS) will be utilized to provide process data regarding strategy implementation. Regional staff and sub-recipients enter all PFS activities into the NPIRS system on a monthly basis to track progress. The system will provide data on the number of participants served/reached, as well as their demographics. In addition, the system will provide fidelity data to describe how the strategy was implemented. The NPIRS system will be accessible to the evaluator.

**Coalition Capacity Member Survey and Coalition Coordinator Survey**

During the first, third, and final years of the grant, a survey will be administered to all coalition members to measure coalition capacity. In addition, the coalition coordinators will receive additional items as part of the coalition coordinator survey, which will measure state and regional capacity, as well as provide additional information about the coalition. The survey will assess coalition members’ perceptions of several prevention system qualities, including the SPF steps, leadership, collaboration, communication, structure, membership, and impact. The evaluation team will work with coalition coordinators to establish the sample frame of coalition members. The survey will be administered as a web survey, with options of administering the survey in person at coalition meetings, and also mailing paper surveys to non-respondents to achieve a representative response.

**Training/Technical Assistance Tracking Form**

Regional prevention staff, DBH staff, and the evaluator will report all training and technical assistance provided to sub-recipients through a training and technical assistance form. The information may be submitted at any time, but must be submitted at least quarterly, and can be submitted through an online form or through the use of a paper form. The evaluator will review the information on a quarterly basis and share it with DBH for entry into SPARS.

**Evidence-Based Program (EBP) Listing Documentation**

The process of developing the EBP Listing will be documented by the evaluator. This documentation will include tracking who is involved in the development of the listing, meetings, and the product(s) delivered and the dissemination process.
<table>
<thead>
<tr>
<th>Measure(s)</th>
<th>Data Sources</th>
<th>How Collected</th>
<th>Who will be collecting?</th>
<th>When will it be collected?</th>
</tr>
</thead>
<tbody>
<tr>
<td>T/TA activities</td>
<td>NPIRS</td>
<td>Online reporting system</td>
<td>DBH</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>TA tracking form</td>
<td>Web or paper form</td>
<td>Evaluator</td>
<td>Ongoing</td>
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<tr>
<td>Strategy Selections</td>
<td>Workplans and Budgets</td>
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<td>DBH</td>
<td>Annually</td>
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<td>Documentation of process</td>
<td>Evaluator</td>
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<td>NPIRS</td>
<td>Online Reporting System</td>
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<td>Quarterly Reports</td>
<td>Electronic submission using template</td>
<td>DBH</td>
<td>Quarterly</td>
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<td>Site Visits</td>
<td>In-person interviews during on-site visit</td>
<td>Evaluator</td>
<td>Annually</td>
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<td>Coalition Capacity Survey</td>
<td>Online survey</td>
<td>Evaluator</td>
<td>1st, 3rd, and 5th year</td>
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<td>State/Region and Community Capacity: resources, assets, readiness, SPF adherence, use of CLAS</td>
<td>Coalition Coordinator Survey</td>
<td>Online survey</td>
<td>Evaluator</td>
<td>1st, 3rd, and 5th year</td>
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<td>State Stakeholder Focus Groups</td>
<td>In-person focus groups</td>
<td>Evaluator</td>
<td>1st and 5th year</td>
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<td>Site Visits</td>
<td>In-person interviews during on-site visit</td>
<td>Evaluator</td>
<td>Annually</td>
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</table>
Outcome Evaluation

In addition to the measures described above, a variety of other data sources will be used to further assess the impact of SPF-PFS on underage drinking behaviors, intervening variables and consequences, which are described in detail below. Data sources using sampling techniques designed to allow statewide estimates will be used to evaluate the impact on the state as a whole. In contrast, community level impacts will be assessed by analyzing data collected from a census or sample drawn with the intent of providing local level estimates. As the SPF-PFS is not targeted as a statewide effort, community level analysis will be the primary focus and comparisons between targeted and non-targeted counties will be made whenever data is available at the county level. Table 3 shows the data sources and specific measures that will be used to analyze statewide and community level impacts. In all cases, national outcome measures are primarily used. In some instances, these measures are supplemented with additional measures that have been tested and used longitudinally in ongoing surveys (e.g., NRPFSS and NYAAOS).

Youth Risk Behavior Survey
The Youth Risk and Behavior Survey (YRBS), a part of the Student Health and Risk Prevention (SHARP) Surveillance System, provides state level data on past and current use of alcohol, as well as addressing excessive use and riding with an impaired driver. The YRBS instruments have undergone laboratory and field testing on reliability by the CDC, and the data is collected from a random sample of high school students in Nebraska in grades 9 through 12 and is collected by the BOSR. The survey is administered in classrooms through a two-stage cluster design, whereby a random sample of public high schools is drawn by the CDC, then a random sample of classrooms is sampled within the selected and participating schools. The YRBS is conducted biennially by the BOSR in the fall of even years.

Nebraska Risk & Protective Factor Student Survey
The Nebraska Risk & Protective Factor Student Survey (NRPFSS), also a part of the SHARP Surveillance System, consists of community level data on lifetime use of alcohol, the age of onset, and past 30 day use. Similar to the YRBS, the NRPFSS is conducted biennially during even years in-person in Nebraska schools and is collected by the BOSR. The NRPFSS is designed and implemented as a census of students in grades 8, 10, and 12 where every public and non-public school with an eligible grade can choose to participate. Risk and protective factors found in the NRPFSS have been used from the Communities that Care (CTC) survey, the foundation of reliable and valid risk and protective factor information. In the 2016 administration of the NRPFSS, the overall participation statewide was 37.6% (N=28,710).

Nebraska Young Adult Alcohol Opinion Survey
The Nebraska Young Adult Alcohol Opinion Survey (NYAAOS) is administered by the BOSR to a sample of young adults ages 19 to 25 generated by the Nebraska Department of Motor Vehicles Driver Record Database. In the most recent
administration, conducted in 2018, the sample was stratified first by county to represent each of the SPF-PFS counties, and second by the six Nebraska behavioral health regions so that an approximately equal number of respondents was sampled in each region. The mail survey, which also utilized a $1 cash incentive, provides statewide data on lifetime and current use of alcohol, attitudes towards alcohol-related law enforcement, as well as community perceptions. In the 2018 administration of the NYAAOS, when adjusted for known ineligibles and undeliverable returns, the survey had response rate of 18.7% (N=1,967). Since the sample included information about the respondents, non-response analyses were conducted and found that respondents were well representative of the sample; thus non-response bias is not a significant concern. The NYAAOS will be administered at two time points during the funding period. The SEOW will discuss mechanisms to improve response rates, including gaining feedback on survey layout and cover letter wording, exploring ways to obtain email addresses and to market the survey, and identifying partnerships and/or grant opportunities to provide additional sponsorship or funding to incorporate additional methods, such as upfront incentives and additional contacts.

Nebraska Annual Social Indicators Survey/Nebraska Community Alcohol Opinion Survey
The Nebraska Annual Social Indicators Survey (NASIS) is an annual omnibus mail survey administered by the BOSR to residents of the state of Nebraska age 19 or over. The sample is a simple random sample drawn from a postal delivery sequence of household addresses to provide a representative statewide sample of Nebraska households. The last birthday method is used to randomly select an adult in the household to complete the survey. The 2018 survey utilized four mailings. The survey will be administered in the first, third, and final year of the grant with intervening variable and community perception measures to provide statewide and community level estimates. In the 2018 administration of the NASIS, the response rate was 26.1%. The NASIS typically yields approximately 900 completed surveys, so the 2019 administration will be used to provide statewide baseline estimates. The SPF-PFS relevant questions will be included as one page of the survey, which will also include items on other topics since it is an omnibus survey. In addition, a brief subsection of the NASIS survey, the Nebraska Community Alcohol Opinion Survey (NCAOS) will be used for an oversample in the SPF-PFS targeted counties (using the same random sampling design as NASIS, but after removing NASIS selected households). The two-page NCAOS survey will include demographics and SPF-PFS relevant questions only. In total, combining NASIS and NCAOS, it is expected that 200 surveys will be completed for each of the targeted coalitions.

College Alcohol Surveys
Multiple colleges across the state will implement various college climate surveys, which will measure alcohol and marijuana use. Some colleges will be using existing surveys, such as the American College Health Assessment, while others will be using locally developed surveys.
**Program Level Survey**

Sub-recipients implementing individual level strategies will collect pre- and post-test surveys (or retrospective). The surveys will be administered to all participants receiving the programming. Participants will be matched over time through the use of an identification number generated from multiple survey items that remain stable over time, such as birthdate and gender. The evaluation team will work in tandem with coalition coordinators to ensure program level surveys are completed by a minimum of 70% of participants. If response rates are below that threshold, technical assistance will be sought to develop strategies for increasing response.

**Other Data Sources**

In addition to the surveys discussed above, other sources of data will be obtained from the Nebraska Crime Commission, Nebraska Hospital Discharge Data, and the Nebraska Office of Highway Safety. These resources will provide information on alcohol related motor vehicle accidents, corrections, and hospitalizations. These data will be available at the county level. Other additional data sources may also be pursued to provide further insight into underage drinking, such as campus violation data.

**Behavioral Health Disparities**

Nebraska is experiencing dramatic demographic changes with regard to race/ethnicity. According to the U.S. Census Bureau, between 2000 and 2010, the minority population in Nebraska increased by 51%. Given the growing minority population, it is vital to investigate health disparities related to underage drinking. Moreover, Nebraska DHHS Vital Statistics show a disparity in alcohol-related deaths, with more American Indians, African Americans, and Hispanics dying due to alcohol from 2006-2010 compared to Whites. All survey data, and administrative data that includes race/ethnicity and/or gender, will be used to identify health disparities and to observe changes in these disparities over time. Currently, gender, race, and age are variables available for all survey data. Consequence data typically provides information by gender, and occasionally by race when the number of cases is sufficient, and data is available.
### Table 3. Outcome Evaluation Measures and Sources

<table>
<thead>
<tr>
<th>Construct</th>
<th>Measure(s)</th>
<th>Data Sources</th>
<th>Targeted Population</th>
<th>How Collected</th>
<th>Who will collect?</th>
<th>When collected?</th>
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</thead>
<tbody>
<tr>
<td>Lifetime Use</td>
<td>During your life, on how many days have you had at least one drink of alcohol?</td>
<td>YRBS</td>
<td>Students in grades 9-12</td>
<td>In-school Survey</td>
<td>BOSR</td>
<td>2018, 2020, 2022</td>
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<td>Age of onset</td>
<td>How old were you when you had your first drink of alcohol other than a few sips?</td>
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<tr>
<td>Past 30 day alcohol use</td>
<td>During the past 30 days, on how many days did you have at least one drink of alcohol?</td>
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<td>Binge Drinking</td>
<td>During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?</td>
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<td>Past 30 day marijuana use</td>
<td>During the past 30 days, how many times did you use marijuana?</td>
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<td>Alcohol Lifetime Use</td>
<td>In your life, how many times have you had alcoholic beverages to drink - more than a few sips?</td>
<td>NRPFSS</td>
<td>Students in grades 8, 10, 12</td>
<td>In-school survey</td>
<td>BOSR</td>
<td>2018, 2020, 2022</td>
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<td>Alcohol age of onset</td>
<td>How old were you when you first had more than a sip or two of beer, wine, or hard liquor (for example, vodka, whiskey, or gin)?</td>
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<td>Alcohol Past 30 day use</td>
<td>During the past 30 days, how many times have you had beer, wine, or hard liquor to drink?</td>
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<td>Binge Drinking</td>
<td>Have you had five or more drinks of alcohol in a row, that is, within a couple of hours during the past 30 days?</td>
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<td>Construct</td>
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<td>Marijuana Lifetime Use</td>
<td>In your life, how many times have you used marijuana?</td>
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<td>Marijuana age of onset</td>
<td>How old were you when you first smoked marijuana?</td>
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<td>Marijuana Past 30 day use</td>
<td>During the past 30 days, how many times have you used marijuana?</td>
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<td>Attitudes toward alcohol/marijuana use</td>
<td>How wrong do you think it is for someone your age to drink beer, wine or hard liquor regularly, that is, at least once or twice a month?</td>
<td>NRPFSS</td>
<td>Students in grades 8, 10, 12</td>
<td>In-school survey</td>
<td>BOSR</td>
<td>2018, 2020, 2022</td>
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<td>Perception of risk from drinking/marijuana</td>
<td>How wrong do you think it is for someone your age to smoke marijuana?</td>
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<td>Perception of peer use</td>
<td>Thinking about all the students in your grade at your school, how many do you think drank beer, wine, or hard liquor during the past 30 days?</td>
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<td>Thinking about all the students in your grade at your school, how many do you think smoked marijuana during the past 30 days</td>
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<td>Construct</td>
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<td><strong>Access</strong></td>
<td>If you wanted to, how easy would it be for you to get some beer, wine, or hard liquor? If you wanted to, how easy would it be for you to get some marijuana?</td>
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<tr>
<td><strong>Parent/Community/Peer perceptions</strong></td>
<td>How wrong do your parents or caregivers feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day? How wrong do your parents or caregivers feel it would be for you to smoke marijuana? How wrong would most adults (over 21) in your neighborhood, or the area around where you live, think it is for kids your age to drink alcohol? How wrong would most adults (over 21) in your neighborhood, or the area around where you live, think it is for kids your age to use marijuana? How wrong do your friends feel it would be for you to have one or two drinks of an alcoholic beverage nearly every day? How wrong do your friends feel it would be for you to smoke marijuana?</td>
<td>NRPFSS</td>
<td>Students in grades 8, 10, 12</td>
<td>In-school survey</td>
<td>BOSR</td>
<td>2018, 2020, 2022</td>
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<td><strong>Talk about alcohol</strong></td>
<td>During the past 12 months, have you talked with at least one of your parents or caregivers about the dangers of alcohol?</td>
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<td><strong>Prevention messaging</strong></td>
<td>In the past 12 months, have you seen or heard any anti-alcohol or anti-drug messages on TV, the internet, the radio, or in newspapers or magazines?</td>
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<td>Attitudes toward alcohol use and marijuana</td>
<td>How wrong... Individuals under the age of 18 to have one or two drinks</td>
<td>NASIS/</td>
<td>Adults</td>
<td>Mail Survey</td>
<td>BOSR</td>
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<td>Individuals 21 and older to provide alcohol for people under 21 years</td>
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<td>Individuals under the age of 18 to use marijuana or cannabis</td>
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<td>Perception of community</td>
<td>How wrong would most adults in your community think it is for</td>
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<td>How much do you think people risk harming themselves physically or in</td>
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<td>Perception of risk of marijuana</td>
<td>How much do you think people risk harming themselves physically or in</td>
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<td>other ways if they use marijuana or cannabis once or twice a week?</td>
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<td>Access to alcohol</td>
<td>During the past 12 months, have you allowed individuals under the age</td>
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<td>of 21 to drink alcohol on your property?</td>
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<td>Construct</td>
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<td>Lifetime Use</td>
<td>Have you ever had a drink of an alcoholic beverage?</td>
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<td>Past 30 day alcohol use</td>
<td>When was the last time you had at least one drink of any alcoholic beverage such as beer, wine, wine coolers, malt beverages, or liquor?</td>
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<td>Binge Drinking</td>
<td>During the past 30 days, on how many days did you have 4/5 or more drinks of alcohol in a row, that is, within a couple of hours?</td>
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<td>Past 30 day marijuana use</td>
<td>During the past 30 days, on how many days did you use marijuana or cannabis?</td>
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<tr>
<td>Perception of risk of alcohol</td>
<td>How much do you think people risk harming themselves physically or in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?</td>
<td>NYAAOS</td>
<td>19-25 year olds</td>
<td>Mail Survey</td>
<td>BOSR</td>
<td>2020, 2022</td>
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<td>Perception of risk of marijuana</td>
<td>How much do you think people risk harming themselves physically or in other ways if they use marijuana or cannabis once or twice a week?</td>
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<td>Perception of peer use</td>
<td>What percentage of people your age do you think... have had at least one drink of alcohol?</td>
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<td>What percentage of people your age do you think... have had five or more drinks of alcohol?</td>
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<td>What percentage of people your age do you think... have used marijuana or cannabis?</td>
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<td>Construct</td>
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<tr>
<td>Attitudes toward alcohol use and marijuana</td>
<td>How wrong... Individuals under the age of 18 to have one or two drinks</td>
<td>NYAAOS</td>
<td>19-25 year olds</td>
<td>Mail Survey</td>
<td>BOSR</td>
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<td>Individuals under the age of 18 to have five or more drinks at one setting</td>
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<td>Individuals 18 to 20 years old to have one or two drinks</td>
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<td>Individuals 21 and older to provide alcohol for people under 21 years old</td>
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<td>Individuals 18-20 years old to use marijuana or cannabis</td>
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<td></td>
<td>Individuals 21 and older to use marijuana or cannabis</td>
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<td>Past 30 day alcohol use</td>
<td>During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?</td>
<td>Program Level Instrument</td>
<td>Program Participant s</td>
<td>Self-Admin Paper Survey</td>
<td>Evaluator/Program Staff</td>
<td>Before/Aft er Program</td>
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<td>Binge Drinking</td>
<td>During the past 30 days, on how many days did you have 5 or more alcoholic beverages in a row, that is, within a couple of hours?</td>
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<td>Past 30 day marijuana use</td>
<td>During the past 30 days, on how many days did you use marijuana?</td>
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<td>Construct</td>
<td>Measure(s)</td>
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<td>Perception of risk of harm of alcohol</td>
<td>How much do you think people risk harming themselves (physically and in other ways) if they have 5 or more drinks of an alcoholic beverage once or twice a week? How much do you think people risk harming themselves (physically and in other ways) if they take one or two drinks of an alcoholic beverage (beer, wine, or hard liquor) nearly every day?</td>
<td>Program Level Instrument</td>
<td>Program Participant(s)</td>
<td>Self-Admin Paper Survey</td>
<td>Evaluator/Program Staff</td>
<td>Before/After Program</td>
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<td>Perception of risk of harm of marijuana</td>
<td>How much do people risk harming themselves physically and in other ways when they smoke marijuana once a month? How much do you think people risk harming themselves (physically and in other ways) if they smoke marijuana once or twice a week?</td>
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<td>Perception of wrongness</td>
<td>How wrong do you think it is for someone your age to drink beer, wine or hard liquor (for example vodka, whiskey or gin) regularly, that is at least once or twice a month? How wrong do you think it is for someone your age to smoke marijuana?</td>
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<tr>
<td>Perception of peer use</td>
<td>Thinking about all the students in your grade at your school, how many do you think drank beer, wine, or hard liquor during the past 30 days? Thinking about all the students in your grade at your school, how many do you think smoked marijuana during the past 30 days</td>
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<td>Talk to parent</td>
<td>During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use?</td>
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<td>Construct</td>
<td>Measure(s)</td>
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<td>T/TA</td>
<td>How would you rate the Training and Technical Assistance (T/TA) you’ve received regarding PFS from DHHS Division of Behavioral Health?</td>
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<td></td>
<td>Coalition Coordinators</td>
<td>Online survey</td>
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<td></td>
<td>How would you rate the Training and Technical Assistance (T/TA) you’ve received regarding PFS from Regional Behavioral Health Prevention staff?</td>
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<td></td>
<td>How would you rate the performance of the DHHS Division of Behavioral Health staff in... Providing solutions when problems arise</td>
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<td>How would you rate the performance of the DHHS Division of Behavioral Health staff in... Response time and quality of feedback</td>
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<td>How would you rate the performance of the DHHS Division of Behavioral Health staff in... Promotion of evidence based practices</td>
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<td>Capacity/Infrastructre</td>
<td>How would you rate the performance of the DHHS Division of Behavioral Health staff in... Coordination with Regional Behavioral Health Prevention Staff</td>
<td>Coalition Coordinator survey</td>
<td>Coalition Coordinators</td>
<td>Online survey</td>
<td>Evaluator</td>
<td>1st, 3rd, and 5th year</td>
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<td></td>
<td>How would you rate the performance of the DHHS Division of Behavioral Health staff in... Data collection and report management</td>
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<td>How would you rate the performance of the DHHS Division of Behavioral Health staff in... Clear and effective communication</td>
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<td></td>
<td>The PAC contributes to statewide prevention system development efforts</td>
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<td></td>
<td>The PAC effectively advises PFS efforts</td>
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<td></td>
<td>The Statewide Epidemiological Outcomes Workgroup (SEOW) contributes to statewide prevention system development efforts</td>
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<td></td>
<td>The Statewide Epidemiological Outcomes Workgroup (SEOW) effectively contributes to PFS efforts</td>
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<td></td>
<td>Our coalition benefits from interacting with other PFS-funded coalitions</td>
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<td></td>
<td>Our coalition has enough staff with the right skills</td>
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<td>Construct</td>
<td>Measure(s)</td>
<td>Data Sources</td>
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<tr>
<td>Capacity</td>
<td>Assessment scale (3 items)</td>
<td>Coalition Capacity Survey</td>
<td>Coalition Members</td>
<td>Online survey</td>
<td>Evaluator</td>
<td>1st, 3rd, and 5th year</td>
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<td>Planning scale (3 items)</td>
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<td></td>
<td>Implementation scale (3 items)</td>
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<td>Evaluation scale (3 items)</td>
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<td>Cultural competency scale (3 items)</td>
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<td>Sustainability scale (3 items)</td>
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<td>Structure/membership scale (5 items)</td>
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<td>Leadership scale (5 items)</td>
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<td>Involvement scale (3 items)</td>
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<td>Communication scale (4 items)</td>
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<td></td>
<td>Who do you feel your coalition/community group is currently lacking representation from that would help your coalition/community group in accomplishing your goals?</td>
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<td></td>
<td>Rate the strength of your coalition’s/community group’s collaboration with each of the following organizations (schools, faith based orgs, law enforcement, city govt, business, media, community orgs)</td>
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<td>T/TA</td>
<td>To what extent do you agree or disagree that training is provided to coalition/community group members on relevant topics?</td>
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<td>Construct</td>
<td>Measure(s)</td>
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<tr>
<td>Alcohol and drug enforcement</td>
<td>Liquor law violations of those 9-20</td>
<td>Crime Commission</td>
<td>9-20 year olds</td>
<td>Administrative Data</td>
<td>Evaluator/Epidemiologist</td>
<td>Annually</td>
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<td>DUI arrests of those 9-20</td>
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<td>Drug arrests of those 9-20</td>
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<td>ER visits due to alcohol and marijuana</td>
<td>Number of hospitalizations due to alcohol and marijuana among 9-20 year olds</td>
<td>Hospital Discharge Data</td>
<td>9-20 year olds</td>
<td>Administrative Data</td>
<td>Evaluator/Epidemiologist</td>
<td>Annually</td>
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<td>Impaired driving consequences</td>
<td>Alcohol-related or marijuana-related motor vehicle accidents involving those 9-20</td>
<td>Office of Highway Safety</td>
<td>9-20 year olds</td>
<td>Administrative Data</td>
<td>Evaluator/Epidemiologist</td>
<td>Annually</td>
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</table>
Analysis

In year one, descriptive analyses will be employed to establish a baseline describing the targeted communities in comparison to non-targeted communities. The baseline assessment will include both process and outcome measures and will identify any existing racial/ethnic health disparities relevant to underage drinking. Quantitative data will provide baseline benchmarks, which impacts will be measured against. Sample sizes are expected to be sufficient, which are estimated below:

YRBS: N= 1,900 representing the state
NRPFSS: N=20,000 with variation by county to provide county level data (it is anticipated that coalition level estimates will be released for each targeted coalition, which represents either a single county or multiple counties)
NYAAOS: N=3,500 representing the state (it is anticipated that coalition level estimates will be released for each targeted coalition, which represents either a single county or multiple counties)
NASIS: N=900 representing the state
NCAOS: N=200 per targeted coalition

Qualitative data collected through interviews, focus groups, and document review will be analyzed using a thematic analytic approach. Themes will be identified after data collection is complete, but will include descriptions of implementation and areas identified as barriers and successes. To supplement the qualitative descriptions of implementation, quantitative comparisons will be utilized to assess dosage and the extent to which they were implemented with fidelity. After implementation begins, trend data will be analyzed to assess impacts; trend data for the previous five years will also be included when available to determine changes in trends. Due to oversampling and/or the use of a census, sample sizes (provided for each data source in the previous section) will provide sufficient power to conduct the necessary analyses. As the SPF-PFS is not targeted as a statewide effort, community level analysis will be the primary focus and comparisons between racial/ethnic minority groups and between targeted and non-targeted counties will be made when feasible. In addition to analyzing cross-sectional survey and administrative data, paired-sample t-tests will be conducted with program level pre- and post-tests to assess individual level programming. Finally, process data, including fidelity rubric scores and dosage, will be used throughout the funding period to guide modifications and as part of the outcome evaluation to explain differences in outcomes.

Reporting

The evaluation team will communicate regularly with state agency program staff and will participate in project-related meetings. Regular evaluation updates will be
provided to the SEOW and/or PAC at their quarterly meetings. The evaluation team will submit an annual statewide report to the Division of Behavioral Health summarizing evaluation data collected to date. In addition to statewide reporting, annual reports will be provided to each sub-recipient. These progress reports will assist sub-recipients in determining whether their goals, objectives, and outcomes are achieved, and will provide information to guide program modifications. A final summative report will also be provided to each sub-recipient, and to the DBH, in the final year.

**Timeline**

Table 4 shows the five-year evaluation timeline that includes activities discussed in this report.
### Table 4. SPF-PFS Evaluation Timeline

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<td>Q1 Oct-Dec '18</td>
<td>Q2 Jan-Mar '19</td>
<td>Q3 Apr-Jun '19</td>
<td>Q4 Jul-Sep '19</td>
<td>Q1 Oct-Dec '19</td>
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<td>Develop State Level Evaluation Plan</td>
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<td>Develop Community Level Evaluation Plans</td>
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<td>NPIRS</td>
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<td>Quarterly Reports</td>
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<td>Stakeholder Focus Groups</td>
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<td>NYAAOS</td>
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<td>NASIS/NCAOS</td>
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<td>Program Level Data Collection</td>
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<td>Site Visits</td>
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<td>Consequence Data</td>
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<td>Annual Evaluation Report</td>
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Appendix A: Coalition Coordinator and Capacity Surveys
Coalition Coordinator Survey

Q1 Thank you in advance for participating in this survey. The survey will assess different aspects of the capacity of your PFS coalition. Completing this survey will help your coalition better understand its strengths and weaknesses, and as a result, better plan and implement local prevention initiatives. The survey will take approximately 20 minutes to complete. Your answers will be kept confidential and you may skip any question you do not wish to answer. Your coalition will receive a report with the combined results from all participants once they are tabulated. There will be two main sections to this survey. **Section I** will consist of questions specifically for you as a coordinator to answer regarding the functioning of your coalition. **Section II** will consist of the Coalition Capacity Survey sent out to your membership. Your responses to these questions will be combined with others from your coalition to present aggregated results regarding perceptions of the coalition.

Q3 During the past 12 months, how many general coalition meetings have been held?

- None (1)
- 1-3 meetings (2)
- 4-6 meetings (3)
- 7-9 meetings (4)
- 10-12 meetings (5)
- 13 or more meetings (6)
- I don’t know (7)
Q4 Does your coalition have established expectations for active members (e.g., setting a minimum number of meetings that must be attended annually)?

- Yes (1)
- No (2)
- I don’t know (3)

Q5 Do new coalition members receive an orientation and copies of relevant background materials?

- Yes (1)
- No (2)
- I don’t know (3)
Q6 Approximately how many of your coalition members are *actively* involved in the coalition?

- None (0%) (1)
- Few (1-10%) (2)
- Some (11-30%) (3)
- Some to half (31-50%) (4)
- Half to most (51-70%) (5)
- Most (71-90%) (6)
- Almost all (91-100%) (7)
- I don't know (8)
Q7 Does your coalition have a vision and/or mission statement?

- Yes (1)
- No (2)
- I don’t know (3)

Display This Question:
If Does your coalition have a vision and/or mission statement? = Yes

Q8 When was your coalition's vision and/or mission statement last updated?

- Within the past 6 months (1)
- More than 6 months ago, but within the past year (2)
- More than 1 year ago, but within the past 3 years (3)
- More than 3 years ago, but within the past 5 years (4)
- More than 5 years ago, but within the past 10 years (5)
- More than 10 years ago (6)
- I don’t know (7)
Q9 Has your coalition ever conducted a self-assessment assessing its strengths and weaknesses?

- Yes  (1)
- No  (2)
- I don’t know  (3)

Display This Question:
If Has your coalition ever conducted a self-assessment assessing its strengths and weaknesses? = Yes

Q10 When was your coalition's self-assessment last conducted?

- Within the past 6 months  (1)
- More than 6 months ago, but within the past year  (2)
- More than 1 year ago, but within the past 3 years  (3)
- More than 3 years ago, but within the past 5 years  (4)
- More than 5 years ago, but within the past 10 years  (5)
- More than 10 years ago  (6)
- I don’t know  (7)
Q11 Has your coalition ever completed an assessment of the readiness of your community to engage in substance abuse prevention activities?

- Yes (1)
- No (2)
- I don’t know (3)

Display This Question:
If Has your coalition ever completed an assessment of the readiness of your community to engage in s... = Yes

Q12 When was your coalition's assessment of the readiness of your community last conducted?

- Within the past 6 months (1)
- More than 6 months ago, but within the past year (2)
- More than 1 year ago, but within the past 3 years (3)
- More than 3 years ago, but within the past 5 years (4)
- More than 5 years ago, but within the past 10 years (5)
- More than 10 years ago (6)
- I don’t know (7)
Q13 Has your coalition ever assessed the human resources (e.g., staff, volunteers) available in your community to support substance abuse prevention?

- Yes (1)
- No (2)
- I don’t know (3)

Display This Question:
If Has your coalition ever assessed the human resources (e.g., staff, volunteers) available in your... = Yes

Q14 When was your coalition's assessment of the human resources available in your community last conducted?

- Within the past 6 months (1)
- More than 6 months ago, but within the past year (2)
- More than 1 year ago, but within the past 3 years (3)
- More than 3 years ago, but within the past 5 years (4)
- More than 5 years ago, but within the past 10 years (5)
- More than 10 years ago (6)
- I don’t know (7)
Q15 Has your coalition ever assessed the financial resources (e.g., donations, in-kind contributions, funding) available in your community to support substance abuse prevention?

- Yes (1)
- No (2)
- I don’t know (3)

Display This Question:
If Has your coalition ever assessed the financial resources (e.g., donations, in-kind contributions, funding) available in your community to support substance abuse prevention? = Yes

Q16 When was your coalition's assessment of the financial resources available in your community last conducted?

- Within the past 6 months (1)
- More than 6 months ago, but within the past year (2)
- More than 1 year ago, but within the past 3 years (3)
- More than 3 years ago, but within the past 5 years (4)
- More than 5 years ago, but within the past 10 years (5)
- More than 10 years ago (6)
- I don’t know (7)
Q21 Does your coalition have established by-laws?

○ Yes (1)

○ No (2)

○ I don't know (3)

Q22 Does your coalition have an executive board or core group of leaders who meet independent of the larger coalition?

○ Yes (1)

○ No (2)

○ I don't know (3)

Display This Question:
If Does your coalition have an executive board or core group of leaders who meet independent of the... = Yes

Q23 How are the leadership of the executive board organized and tasks delegated?

○ Coordinator delegates tasks (1)

○ Each member volunteers for desired tasks (2)

○ Staff, members, and coordinator work interdependently with one another (4)

○ No organization (3)

Q24 Does your coalition have established subcommittees? Note that subcommittees are not sub-coalitions; rather, they are smaller groups of coalition members
addressing specific topics (e.g., media, policy, capacity building, cultural competency, grant writing, etc.).

- Yes (1)
- No (2)
- I don’t know (3)

Display This Question:
If Does your coalition have established subcommittees? Note that subcommittees are not sub-coalition... = Yes

Q25 How are the leadership of the subcommittees organized and tasks delegated?

- Coordinator delegates tasks (1)
- Each member volunteers for desired tasks (2)
- Staff, members, and coordinator work interdependently with one another (4)
- No organization (3)
Q26 Does your coalition have a written sustainability plan?

- Yes (1)
- No (2)
- I don’t know (3)

**Display This Question:**
If Does your coalition have a written sustainability plan? = Yes

Q27 When was your coalition’s written sustainability plan most recently completed?

- Within the past 6 months (1)
- More than 6 months ago, but within the past year (2)
- More than 1 year ago, but within the past 3 years (3)
- More than 3 years ago, but within the past 5 years (4)
- More than 5 years ago, but within the past 10 years (5)
- More than 10 years ago (6)
- I don’t know (7)
Q28 Has your coalition discussed how to sustain community outcomes beyond current funding?

- Yes (1)
- No (2)
- I don’t know (3)

Q29 Has your coalition discussed how to obtain future funding (e.g., Block Grant, DFC, Juvenile Justice, other)?

- Yes (1)
- No (2)
- I don’t know (3)

Q30 Does your coalition keep the community updated on its activities (through a newsletter, website, etc.)?

- Yes (1)
- No (2)
- I don’t know (3)
Q31 How would you rate the Training and Technical Assistance (T/TA) you've received regarding PFS from Regional Behavioral Health Prevention staff?

- Very Poor (1)
- Poor (2)
- Fair (3)
- Good (4)
- Very Good (6)
- Not applicable (5)
Q32 How would you rate the Training and Technical Assistance (T/TA) you’ve received regarding PFS from DHHS Division of Behavioral Health?

- Very Poor (1)
- Poor (2)
- Fair (3)
- Good (4)
- Very Good (5)
- Not applicable (6)

Q33 How would you rate the performance of the DHHS Division of Behavioral Health staff in the following areas with regard to the goals of the PFS grant?
<table>
<thead>
<tr>
<th></th>
<th>Very Poor (50)</th>
<th>Poor (51)</th>
<th>Fair (52)</th>
<th>Good (53)</th>
<th>Very Good (54)</th>
<th>I don't know (55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination with Regional Behavioral Health Prevention Staff (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data collection and report management (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotion of evidence based practices (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce development and training (9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear and effective communication (10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing solutions when problems arise (11)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response time and quality of feedback (12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q34 How often do you communicate with other PFS-funded coalitions within your region?

- Often (1)
- Sometimes (2)
- Not very often (3)
- Not at all (4)
- I don't know (5)

Q35 How often do you communicate with other PFS-funded coalitions outside of your region?

- Often (1)
- Sometimes (2)
- Not very often (3)
- Not at all (4)
- I don't know (5)
Q36 How valuable are the Prevention Advisory Council (PAC) meetings to your PFS efforts?

- Very valuable (1)
- Somewhat valuable (2)
- Not very valuable (3)
- Not at all valuable (4)
- I have not yet attended a PAC meeting (5)

Q37 How well does the Prevention Advisory Council (PAC) represent the diversity of the state in regards to population demographics and agency-level stakeholders?

- Very well (1)
- Somewhat well (2)
- Not very well (3)
- Not at all well (4)
- I don't know (5)

Display This Question:

If How well does the Prevention Advisory Council (PAC) represent the diversity of the state in regard... = Not very well

Or How well does the Prevention Advisory Council (PAC) represent the diversity of the state in regard... = Not at all well
Q38
Who do you believe should be added to the PAC?

____________________________________________

____________________________________________

____________________________________________
<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Agree (3)</th>
<th>Strongly Agree (4)</th>
<th>Not applicable (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PAC contributes to statewide prevention system development efforts. (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The PAC effectively advises PFS efforts. (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Statewide Epidemiological Outcomes Workgroup (SEOW) contributes to statewide prevention system development efforts. (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Statewide Epidemiological Outcomes Workgroup (SEOW) effectively contributes to PFS efforts. (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our coalition benefits from interacting with other PFS-funded coalitions. (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our coalition has enough staff with the right skills. (6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Coalition Capacity Survey
Partnerships for Success (PFS)
Coalition Capacity Survey

Thank you in advance for participating in this survey. The survey will assess different aspects of the capacity of your coalition/community group. Completing this survey will help your coalition better understand its strengths and weaknesses, and as a result, better plan and implement local prevention initiatives. The survey will take approximately 10 minutes to complete. Your answers will be kept confidential and you may skip any question you do not wish to answer. Your coalition/community group will receive a report with the combined results from all participants once they are tabulated, but no individual responses will be reported.

The first set of questions focuses on applying the Strategic Prevention Framework (SPF) in your coalition/community group.

1. **To what extent do you agree or disagree with the following statements about your coalition’s/community group’s capacity to conduct assessment?**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>I participate in reviewing needs assessment data.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have a clear understanding of the needs of my community.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Limited data at the local level presents a barrier to our assessment process.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

2. **Additional comments regarding strengths or challenges related to assessment.**

3. **The following section is about your planning experience. To what extent do you agree or disagree with each of the following statements?**
4. Additional comments regarding strengths or challenges related to planning.

5. The next section is about your experience with implementation of strategies. To what extent do you agree or disagree with each of the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our coalition/community group strictly implements strategies in the manner they are designed.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I understand the need for implementing evidence-based programs, policies, and practices.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Action plans and target dates are developed for each task or project.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

6. Additional comments regarding strengths or challenges related to implementation.

7. The following section is about your coalition’s/community group’s evaluation experience. To what extent do you agree with each of the following statements?
Our coalition/community group uses the data we collect to evaluate our work and report the results of those evaluations.

Coalition/community group members participate in reviewing data for planning and evaluation purposes.

Our coalition/community group uses evaluation data to modify our efforts.

8. Additional comments regarding strengths or challenges related to evaluation.

9. Please indicate the extent to which you agree or disagree with each of the following statements about your coalition’s/community group’s attention to cultural competency and behavioral health disparities?

Our coalition/community group considers cultural factors when selecting strategies.

Our coalition/community group lacks representation from cultural groups in our community.

Our coalition/community group recognizes the importance of respecting cultural diversity (including racial/ethnic, gender, socioeconomic, and lifestyle).

10. What cultural groups, if any, do you believe are lacking representation in your coalition/community group?
11. Additional comments regarding strengths or challenges related to cultural competency and behavioral health disparities.

12. To what extent do you agree or disagree with the following statements regarding the sustainability of your coalition/community group?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our coalition/community group plans ahead for its long-term sustainability.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I believe our coalition/community group has the capacity to sustain our prevention efforts over time.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am confident that most of our selected strategies will continue after the PFS grant funding ends.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

13. Additional comments regarding strengths or challenges related to sustainability.
The next set of questions ask about training and technical assistance.

14. To what extent do you agree or disagree that training is provided to coalition/community group members on relevant topics?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

15. The following is a list of training or technical assistance areas. Please select which of these areas would be of interest to you or your coalition/community group over the next 2 years? (Select all that apply)

- Assessing the needs and interests of the community
- Collecting, analyzing, and/or reporting data
- Obtaining and/or staying informed about substance abuse research
- Keeping coalition members engaged
- Recruiting new coalition members
- Sharing information about the work of the coalition within the community
- Building partnerships with community leaders
- Improving leadership skills
- Identifying strategies to address substance abuse prevention in the community
- Implementing environmental strategies
- Evaluating the coalition's substance abuse prevention efforts
- Implementing individual strategies
- Prevention Skills Training
- Addressing behavioral health disparities in substance abuse prevention work
- Sustaining community outcomes beyond current funding
- Obtaining additional funding

16. Please describe any other training or technical assistance that your coalition/community group would benefit from?
17. The following statements are about your coalition’s/community group’s structure and membership. Please indicate to what extent you agree or disagree with each of the statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our coalition/community group lacks representation from groups that would help us accomplish our goals (e.g. youth, schools, law enforcement).</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>My role in the coalition/community group is well-defined.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Meetings are held in centrally accessible, comfortable places at convenient times for all members.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>We accomplish meeting objectives in meetings that start and end on time.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I know where to access substance use prevention resources.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

18. Who do you feel your coalition/community group is currently lacking representation from that would help your coalition/community group in accomplishing your goals? (Select all that apply)

- [ ] Youth
- [ ] Parents
- [ ] Businesses
- [ ] Media
- [ ] Schools
- [ ] Youth serving organizations
- [ ] Law enforcement
- [ ] Faith based community
- [ ] Civic and volunteer groups
- [ ] Health care professionals
- [ ] State, local, or tribal agencies
- [ ] Other

19. Additional comments regarding strengths or challenges related to the coalition/community group structure and membership, including any suggestions to improve its effectiveness.
20. Please rate the strength of your coalition’s/community group’s collaboration with each of the following organizations on a scale of 1-5, where 1 is weak and 5 is strong.

<table>
<thead>
<tr>
<th>Organization</th>
<th>1 (Weak)</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (Strong)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elementary, middle, or high schools</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faith based organizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Law enforcement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City government</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local media (newspaper, radio, TV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community organizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. Describe any specific organizations you believe your coalition/community group should work toward strengthening a collaboration with.


22. Please indicate to what extent you agree or disagree with each of the following statements about the coalition’s/community group’s leadership.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaders keep the coalition/community group focused on and progressing towards its goals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leaders encourage open dialog and expression of views among members.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leaders utilize the skills and experience of the members.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with the balance of power between staff, leaders, and members.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are opportunities for coalition/community group members to take leadership roles.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
23. Please indicate to what extent you agree or disagree with each of the following statements about your involvement in the coalition/community group.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>My time spent on coalition/community group efforts is worthwhile.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Our coalition/community group is making a difference in the community.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Our coalition/community group is stronger because I am a member.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

24. How satisfied are you with the...

<table>
<thead>
<tr>
<th>Activity</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of media (including social media) to promote awareness of the coalition's/community group's goals, actions, and accomplishments?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Communication between coalition/community group members and staff?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Extent to which coalition/community group members are listened to and heard?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Communication between the coalition/community group and the community?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Finally, we have some questions about you.

25. How long have you been or were you a member of your coalition/community group?
   - Less than a year
   - 1 year – less than 3 years
   - 3 years – less than 5 years
   - 5 years of more
   - I am not a member

26. During the past 12 months, how many of your coalition's/community group’s meetings have you attended?
   - None
   - At least one, but less than half
   - About half
   - More than half, but not all
   - All or nearly all

27. Please describe any suggested changes that would increase your attendance.

28. Why are you a member of your coalition/community group?

29. Are you a member of your coalition/community group because it is a part of your job?
   - Yes
   - No

30. Do you live or work in the community served by your coalition/community group?
   - Yes, I live in the community
   - Yes, I work in the community
   - Yes, I live AND work in the community
   - No, I do not live or work in the community

31. What is your age?
   - Less than 24 years
   - 25-39 years
   - 40-64 years
   - 65+ years

32. Are you:
   - Male
   - Female

33. Do you consider yourself to be Hispanic or Latino/a?
   - Yes
   - No

34. What race or races do you consider yourself to be? (Check all that apply)
   - White
   - Black or African American
   - Asian or Asian American
   - American Indian or Alaska Native
   - Native Hawaiian or other Pacific Islander
   - Other, specify
Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

DBH funds a continuum of services to allow persons with Mental Illness to live, work and receive treatment and supports in the least restrictive environment to meet their needs. Focusing on SAMHSA’s components of recovery, services focus on integrated physical healthcare to support individuals to remain in community living. Rehabilitative services support individuals to learn skills to alleviate functional deficits which exist due to an individual’s mental illness. Support services, including housing and employment and peer support, provide more teaching and support to allow individuals access to safe affordable housing and employment, and social connection.

A list of contracted services is reported below. Also, a link to Nebraska Behavioral Health System Service Definitions (a.k.a. Lime Book) is here:

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

   a) Physical Health  
   b) Mental Health  
   c) Rehabilitation services  
   d) Employment services  
   e) Housing services  
   f) Educational Services  
   g) Substance misuse prevention and SUD treatment services  
   h) Medical and dental services  
   i) Support services  
   j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)  
   k) Services for persons with co-occurring M/SUDs

   Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state’s case management services

   The Nebraska Behavioral Health System (NBHS) services are classified as Fee for Service (FFS) and Non Fee for Service (NFFS) or expense-based. There are certain services, such as Community Support or Intensive Case Management, that have a primary case management function required by service definition. In other services, there care management elements are part of the larger service delivery expectation. As such, case management tasks are built in to rate setting or other cost models for most services funded by the Division of Behavioral Health (DBH).

   Rates for the community-based system are established utilizing a cost model for all FFS mental health and substance use services. The cost model approach delivers:

   <> Standardize cost expectations for services that the state will purchase

Printed: 8/30/2019 1:29 PM - Nebraska - OMB No. 0930-0168  Approved: 04/19/2019  Expires: 04/30/2022
< > Ensure ability of state to actively manage SERVICE system and apply behavioral health best practices rehabilitation and recovery service delivery knowledge
< > Ensure basic staffing of services to know what is being purchased
< > Greater control of costs of service; rate not tied to individual provider staffing and salary determinations or a requirement to raise rates based on the provider with the highest costs
< > Ability to apply best average statewide based on standardized service delivery expectation
< > Greater accountability for use of public funds
< > Provide ability to link standardized service definitions to uniform service delivery
< > Ensure consumers can receive same service across State of Nebraska
< > Ensure that costs are not arbitrarily driven up without changing the service

Rate increases in NBHS have been made when the legislature mandates and specifically funds them.


4. Describe activities intended to reduce hospitalizations and hospital stays.

Hospital inpatient readmissions are monitored on a monthly basis to ensure rates of readmission remain low. Emergency Protective Custody (EPC) holds are tracked and reviewed on a monthly basis through data provided by providers of services and Emergency Coordinators across the state. The DBH has identified performance measures to drive improved emergency system services and in turn further reduce hospitalization admissions and inpatient length of stay. Continued efforts with community providers and inpatient care providers both (community based and state hospital) to implement process improvement activities and utilize the Centralized Data System are anticipated to provide data to support and/or change practices that will positively impact lengths of stay and utilization of residential and inpatient care.

The DBH has conducted Mental Health Board training with individuals who serve on Mental Health Boards across the state to help with consistent application of clinical criteria used to determine if an individual’s needs to be committed for outpatient or inpatient care. Additionally, the DBH has created reporting capability to show individuals who have higher-than-average readmissions to inpatient settings. When these individuals are identified, specific coordination with the Regional Behavioral Health Authority (RBHA) and network providers will be initiated to assist in establishing appropriate service referrals and crisis planning to support the individual in the community.

The DBH has implemented targeted access measures for specific services; access to medication management service following a discharge from an inpatient setting was one such prioritized service and often presented as a barrier to earlier discharge or was seen as a key factor in readmission to hospitalization. The DBH worked with the Advisory Councils, RBHAs and network hospitals to define the access measure and has built in reporting capability to help track this over time. It is expected that improvement in access to ongoing medication management following discharge from inpatient care will have positive impact on readmission rates.

Additionally, reduction in utilization of inpatient and residential care is a key outcome being monitored through the youth system of care work. This is being done through ongoing expansion of the community based service system, developing workforce competencies in serving youth with complex needs, and continuing to invest in prevention and early intervention programs.
Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state’s M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.Adults with SMI</td>
<td>62,093</td>
<td>10,993</td>
</tr>
<tr>
<td>2.Children with SED</td>
<td>28,449</td>
<td>1,667</td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Column B Estimates of “Statewide Prevalence”: Source Row 1-Adults with SMI: Estimate obtained by multiplying the 2017 American Community Survey (ACS) estimate for Nebraskans 18+, 1,444,034, by 2016/2017 NSDUH estimated percent of Nebraskans with SMI, 4.3. – Source Row2-Children with SED: “URS Table 1: Number of Children with a Serious Emotional Disturbance, age 9 to 17, by State, 2017” Estimate based on Level of Functioning threshold score of <=60 using upper limit.

Column C Estimates of “Statewide Incidence”: Source Row 1-Adults with SMI: URS Table 16 “Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services” – Source Row 2-Children with SED: Table 16.

Use the following links for more information:

DBH Strategic Plan 2017-2020:

Nebraska Behavioral Health Needs Assessment 2016 can be accessed at: http://dhhs.ne.gov/Behavioral%20Documents/Needs%20Assessment%20-%202016.pdf#search=needs%20assessment
Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

<p>| | | | |</p>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>a) Social Services</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>b) Educational services, including services provided under IDE</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>c) Juvenile justice services</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>d) Substance misuse prevention and SUD treatment services</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>e) Health and mental health services</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>f) Establishes defined geographic area for the provision of services of such system</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

**Criterion 4**

**a.** Describe your state’s targeted services to rural population.

The DBH provides community-based services to individuals with mental health and/or substance use disorders who live in rural areas, which geographically represents much of Nebraska. As of July 1, 2018, the U.S. Census estimated that Nebraska’s total population was 1,929,268, with approximately 34.43% of persons living in rural counties.

Nebraska is a geographically large area with 99.3% of its land area classified as rural based on population size in 2010, according to the U.S. Census Bureau. And the National Center for Frontier Communities, using the state office of rural health definition of frontier, classified 39 of the 93 Nebraska counties as frontier based on 2010 census data. In 2017, 88 of Nebraska’s 93 counties were designated as federal mental health professional shortage areas. Given these barriers, individuals across the state can identify and locate behavioral health services nearest to their home through the online resource Network of Care. DBH contracts for the Nebraska Network of Care, an online resource for people with behavioral health needs, their caregivers, and service providers that lets people access information about issues such as treatments, resources and diagnoses, and wellness recovery action plans. Consumers can also choose to communicate directly with other participants and to organize and store their own personal health information.

Behavioral health services funded through the CMHSBG and the SAPTBG are identified above in Criterion 1. These are services available to maintain a continuity of care for individuals who have been served through programs providing outreach and services for rural residents, older adults, and individuals who experience homelessness in frontier, rural and urban areas.

Partnerships and collaboration with public and private systems, as well as with individuals, families, and communities, are important components in systems of care surrounding each individual served. For example, other state agencies (e.g., State Probation through the Nebraska Supreme Court, the Nebraska Department of Correctional Services (NDCS), the Nebraska Department of Education Vocational Rehabilitation (NDE-VR), and the Veterans Administration) fund or support behavioral health services for specific populations. The DBH collaborates with the NDCS to ensure those individuals released from correctional facilities are connected with the services they need to meet their rehabilitation needs. The DBH works with NDE-VR in the provision of Supported Employment services to individuals with serious mental illness and substance use disorders.

DBH supports the Nebraska Rural Response Hotline with financial support for the telephony hotline service and payment of redeemed vouchers for service with licensed behavioral health counselors. With the aim of providing cost free, confidential mental health crisis counseling readily available to distressed farm and rural families, Interchurch Ministries of Nebraska established the Counseling, Outreach and Mental Health Therapy (COMHT) Program. Access to this program is gained by calling the Nebraska Rural Response Hotline. During the call, the person is offered the names and telephone numbers of participating licensed mental health providers located within the caller’s geographical area, along with a voucher to cover costs of the one hour session. The caller has 30 days to use the voucher with the licensed mental health provider of their choice.

**b.** Describe your state’s targeted services to the homeless population.

Persons who are homeless and have mental illness in Nebraska have specialized needs that may not be met by more traditional service delivery methods. Projects for Assistance in Transition from Homelessness (PATH) works with local area providers in areas with the highest rates of homelessness who work to meet the immediate needs of homeless individuals and at the same time assist consumers in developing self-sufficiency through referral and attainment of services. In addition to the PATH funds that support the RBHAs in serving the population areas with the highest rates of homelessness, the Nebraska Homeless Assistance Program (NHAP) within the DHHS Division of Children and Family Services supports a network of shelter, supportive housing, and service providers. These providers plan for and provide a balance of emergency, transitional, and permanent housing and service resources to address the needs of people who are homeless so they can make the critical transition from homelessness to jobs, independent living, and permanent housing. For more information on NHAP see the DHHS web site at: http://dhhs.ne.gov/Pages/Homeless-Assistance.aspx

Stable living at discharge from all services is a provider, region and state performance measure reviewed monthly. The DBH, through state funds, provides housing related assistance funds to support transition to safe and affordable permanent housing. DBH also targets support of recovery housing such as Oxford Houses which provide access to housing to persons in recovery who might otherwise be homeless.

**c.** Describe your state’s targeted services to the older adult population.

The Nebraska Care Management Program was created through a legislative mandate in 1987 and established a statewide system of care management units through the Area Agencies on Aging. Care managers assist older persons with functional disabilities, both physical and mental, and help their families select and obtain a variety of services that allow them to remain in a residence of their choosing. Counseling Services provides information and advice for older individuals in regard to public and private insurance, public benefits, lifestyle changes, legal matters and other appropriate matters. Included in Counseling Services are...
Legal Assistance, Financial Counseling, Volunteer Placement, Case Management, Employment Program, Ombudsman and Mental Health Counseling. Mental Health Counseling services provide counseling to an individual by a licensed mental health professional which is intended to address a diagnosed mental health condition.

DBH staff work with system partners on training and outreach to nursing facilities and assisted living facilities who serve the older population to better identify and screen and respond to their behavioral health needs. The Pre-Admission Screening and Resident Review (PASRR) functionality resides within DBH to ensure individuals appropriately meet nursing facility level of care and if specialized behavioral health service needs are identified, they are provided.
Describe your state’s management systems.

The Division of Behavioral Health (DBH) ensures block grant funds and state dollars are used in accordance with SAMHSA’s expectations that the FY2018/2019 block grant funds to be directed toward four purposes:

1. To fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
2. To fund those priority treatment and support services not covered by CHIP, Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;
3. For SABG funds, to fund primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing SUD treatment; and
4. To collect performance and outcome data to determine the ongoing effectiveness of promotion/SUD prevention, treatment and recovery supports and to plan the implementation of new services.

The DBH contracts with the six RBHAs to enroll providers in their networks. The four purposes related to block grant funding are passed through to RBHAs in the Regional Budget Planning Guidelines.

DBH regulations define the financial eligibility criteria for consumers seeking care. Within these regulations (NAC 206, Chapter 6.005), it clearly defines that DBH reserves the right to be the payer of last resort and that DBH will not reimburse providers for any Medicaid reimbursable service provided to Medicaid consumers. with the exception of social detoxification in some Regions.

Requirements for prevention activities within regulations and subawards require the use of the Strategic Prevention Framework for funded initiatives. RBHAs are required to utilize and fund the six prevention strategies and have a minimum amount of funding that must be dedicated to substance abuse prevention activities each year.

Each service provider funded through the DBH directly, or through RBHAs, is required to submit client demographic, service and encounter data to the DBH as a condition of their contract. This allows DBH to analyze this data to demonstrate performance and outcome measures to ensure quality, effective services are being purchased.

DBH is committed to creating a culture that fosters improvement; a culture where data is collected, reported and used to guide policy and implementation. The DBH administrative oversight includes, but is not limited to, the use of statewide data, including:

- Capacity and Waiting Lists
- Utilization
- DBH Centralized Data System activities
- Annual Consumer Survey
- National Outcome Measures (NOMs)
- Professional Partner Program (PPP)
- Emergency System Report
- Uniform Reporting System (URS)
- Treatment Episode Data Set (TEDS)

The DBH holds itself accountable for strategic plan results through Results-Based Accountability (RBA) methodology. DBH provides training and technical assistance to build the capacity of DBH and its contracted RBHAs to use RBA for its Performance Accountability System. Within the RBA performance dashboard framework, the DBH and RBHAs utilize Continuous Quality Assurance and Improvement processes to measure outcomes for established performance metrics.

RBA methodology provides:

- Consistency in language
- Identification of state priorities to measure
- Framework for interpreting and studying data to help “turn the curve”
- Reporting successes and planning for work that remains
- Preparation for performance contracting

Through the CQI program, DBH links data, knowledge, structures, processes, and outcomes which enables DBH to implement improvements throughout the system. Within the public Nebraska Behavioral Health System, DBH operationalizes the CQI Core Principles, including:

- Customer Focused
- Strength Based
- Recovery Oriented
DBH sets clear direction through an annual CQI plan. The DBH CQI program establishes accountability through:
- Data Calls
- Annual Report
- Annual Consumer Survey
- Partnership Survey
- Services provided to consumers and families in the state of Nebraska
- Business Plan and Performance Dashboards
- Strategic Plan and Updates

The DBH has implemented an in-house Centralized Data System (CDS) to monitor and report on treatment and programmatic activities within the Nebraska Behavioral Health System. Functionality within the CDS includes:
- Consumer demographics
- Encounter, capacity and waitlist management
- Alert and notifications to the end users
- Authorizations and Appeals
- Business rule engine to hold the logic by which authorization criteria are met
- Utilization Management and Billing – billing to be built in a separate system (the DBH in-house Electronic Billing System), but will have a very close synchronization with the CDS
- Reports and dashboards

The DBH has implemented an in-house Electronic Billing System (EBS) for the purpose of contract management and reporting of various funds to assist Community-Based Consumers. EBS is a billing system, not a claims system. The EBS structure includes five principal layers: Service; Provider; Contract; Payment Methodology, and Spending Authority. Functionality within EBS includes: Contract building; Budgeting; Payment Processing; Reallocation of Funds; and, Reports and dashboards including costs per service and costs per person served.

DBH administrative tools, including the annual Regional Budget Plan Guidelines and the contracts with the six RBHAs, are the primary mechanisms to support program integrity. Each year, the RBHAs are statutorily required to submit a Regional Budget Plan. The Plan overviews the comprehensive mental health and substance use disorder services with sufficient capacity for designated geographic area that are based on a comprehensive needs assessment/strategic plan as well as pertinent fiscal and utilization data. This budget plan is submitted to the DBH per specific specifications and expectations detailed in Regional Budget Plan Guidelines. Within these guidelines, federal program requirements are listed including the populations to be served with the funding, allowable and unallowable expenditures, and audit requirements, as well as the specific purposes identified by SAMHSA for the block grant. This document, along with their respective plans, are incorporated into the subsequent subaward issued by the DBH. The RBHAs, in turn, pass these same terms and requirements to subsequent recipients of the funds, which is verified in the Network Services Review in which DBH reviews compliance to contractual requirements.

In addition, it is a shared responsibility of the DBH and RBHAs to monitor, review, and perform programmatic, administrative, and fiscal accountability and oversight functions on a regular basis with all subcontractors. If the RBHA is a direct provider of services, the DBH is responsible for the oversight functions for the services provided directly by the RBHA.

The DBH and the RBHAs use internal and external measures for oversight of services purchased through the subawards between the DBH and the RBHA.

External measures are performed by outside entities and include:
1. Fiscal audit as conducted by a certified public accountant, and
2. Accreditation by a nationally recognized accrediting body.

Internal measures are performed by DBH and the RBHAs, and include:
1. Services Purchased Verifications (unit/fiscal to ensure that services billed were in fact provided and verified by review of client files as well that expenditures billed were allowable and reasonable.)
2. Program Fidelity Reviews (address adherence to service, statutory and regulatory requirements by all providers)
3. Internal Controls (self-review & monitoring)
   a. In compliance with the Committee Of Sponsoring Organizations (COSO) documents:
      i. Standards for Internal Control in Federal Government
      ii. Internal Control Integrated Framework
4. Financial Reliability of Sub-recipients
   a. Pre-award and ongoing
      i. Required use of a form or checklist for risk assessment
   ii. Sub-recipient required to relate financial data to performance accomplishments of the Federal Award
b. Audit findings – systematic review and follow-up

c. Written policies
   i. Cash management
   ii. Allowable costs-in accordance with cost principles (2 CFR 200.302)
**Footnotes:**

Footnote to Criterion 3:
DBH contracts with the six RBHAs for targeted case management based on a high fidelity wraparound approach. The philosophy of the Professional Partner Program is to be strength-based, family-centered, and acknowledge families as equal partners. The Program provides a flexible, individualized approach that promotes utilization of the least restrictive, least intrusive developmentally appropriate interventions in accordance with the strengths and needs of the youth. The purpose of the program is to improve the lives of children with serious emotional disturbances and their families. The mission of the program is to use the wraparound approach to coordinate services and supports to these families. The service coordinator, referred to as a Professional Partner, works in partnership with each youth and his or her family entering the Professional Partner Program. The Partner, as a part of the child and family team, assists the family with obtaining a comprehensive assessment, developing an Individual Family Support Plan (IFSP), purchasing both traditional services and flexible supports identified in the IFSP, and monitoring the outcomes.
Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question
Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:
   a) A full continuum of services
      i) Screening 〇 Yes 〇 No
      ii) Education 〇 Yes 〇 No
      iii) Brief Intervention 〇 Yes 〇 No
      iv) Assessment 〇 Yes 〇 No
      v) Detox (inpatient/social) 〇 Yes 〇 No
      vi) Outpatient 〇 Yes 〇 No
      vii) Intensive Outpatient 〇 Yes 〇 No
      viii) Inpatient/Residential 〇 Yes 〇 No
      ix) Aftercare; Recovery support 〇 Yes 〇 No
   b) Services for special populations:
      Targeted services for veterans? 〇 Yes 〇 No
      Adolescents? 〇 Yes 〇 No
      Other Adults? 〇 Yes 〇 No
      Medication-Assisted Treatment (MAT)? 〇 Yes 〇 No
Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 8. Primary Prevention-Required SABG.
Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  
   Yes  No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  
   Yes  No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  
   Yes  No

4. Does your state have an arrangement for ensuring the provision of required supportive services?  
   Yes  No

5. Has your state identified a need for any of the following:
   a) Open assessment and intake scheduling  
      Yes  No
   b) Establishment of an electronic system to identify available treatment slots  
      Yes  No
   c) Expanded community network for supportive services and healthcare  
      Yes  No
   d) Inclusion of recovery support services  
      Yes  No
   e) Health navigators to assist clients with community linkages  
      Yes  No
   f) Expanded capability for family services, relationship restoration, and custody issues?  
      Yes  No
   g) Providing employment assistance  
      Yes  No
   h) Providing transportation to and from services  
      Yes  No
   i) Educational assistance  
      Yes  No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   In July 2017, the Centralized Data System (CDS) began tracking the delivery date of (federally defined) interim services for individuals placed on a waiting list (including PWWDC); thus allowing for more precise tracking and monitoring of program compliance. Additionally, an online capacity tracking will offer weekly review of capacity over 90% to ensure adequate capacity for services exist in Nebraska. Capacity used percentages over 90% will be displayed as an alert for monitoring and follow up as applicable. The Division continues to work with the RBHAs providing guidance on expectations for PWWDC, providing information and annually collecting information on trainings on this topic done by RBHAs. In addition, the Division conducted a “secret shopper review” to monitor compliance with interim service provision.
**Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program**

**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
   
   a) 90 percent capacity reporting requirement  
   Yes ☑ No
   
   b) 14-120 day performance requirement with provision of interim services  
   Yes ☑ No
   
   c) Outreach activities  
   Yes ☑ No
   
   d) Syringe services programs  
   Yes ☑ No
   
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation  
   Yes ☑ No

2. Has your state identified a need for any of the following:

   a) Electronic system with alert when 90 percent capacity is reached  
   Yes ☑ No
   
   b) Automatic reminder system associated with 14-120 day performance requirement  
   Yes ☑ No
   
   c) Use of peer recovery supports to maintain contact and support  
   Yes ☑ No
   
   d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?  
   Yes ☑ No

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   In the State to RBHA contract for substance abuse services, RBHAs are required to adhere to the priority populations admission process in providing substance abuse treatment. Priority admission requirements apply to all Substance Use Disorder services contracted by DBH receiving State or Federal Dollars, including Dual Diagnosis Services and Supported Housing Services. The RBHA ensures that this priority population list is maintained at the provider level via inclusion in the RBHA to Network Provider contract.

   Regional providers of substance abuse services are required to admit Persons Who Inject Drugs (PWID) into services within 48 hours of initial contact. Admission may be immediate into the appropriate recommended treatment, or, placement on the waiting list with the provision of interim services within 48 hours, with these interim services continuing until the PWID is admitted into the recommended treatment. Should the Provider not have an opening immediately available, the Provider works with RBHA personnel to find openings within the RBHA and throughout the state to offer the PWID. Should the PWID choose to wait for an opening with the intake provider, the person’s name is placed on the waitlist, according to his/her priority, and no later than 48 hours following initial contact, is admitted into interim services. The intake provider contacts the PWID weekly to follow his/her progress and to update her on available openings with the intake provider as well as available openings statewide. The provider maintains this weekly contact with the PWID until she is admitted into services or declines substance abuse treatment.

   Providers of substance abuse services are required to submit to the respective RBHA and DBH through entry into the Centralized Data System (CDS), information regarding consumers by priority type who are receiving services in addition to information for all consumers according to their priority level who are placed on the provider’s waiting list for specified services. Priority levels include: (1) pregnant injecting drug users; (2) other pregnant substance users; (3) other injecting drug users; (4) women with dependent children; and, (5) all others, including those consumers with Mental Health Board Commitments. With incorporation of provider submitted data by RBHA, the resultant reports, the (Statewide) Weekly Substance Abuse Capacity Report, and, the (Statewide) Weekly Substance Abuse Priority Waiting/Interim Services List for Priority Populations, are compiled and distributed to the RBHAs to monitor and to share with providers.

   In the weekly reporting of provider capacity and priority waiting/interim services information, the provider maintains responsibility to ensure services are provided to the PWID seeking substance abuse services within 48 hours. In addition, the PWID is contacted at least one time per week to assess her satisfaction with interim services and update her as needed should treatment openings in the recommended service become available. The information submitted for the weekly reports ensures that this process is followed, with follow-up as needed by the RBHA.

   Through the annual Services Purchased and tri-annual Program Fidelity reviews and audits, the RBHA conducts formal reviews of individual consumer’s substance abuse treatment at the provider level. A component of these reviews is the timeliness of admission into interim and recommended substance abuse services. At least once per three year cycle, and, using a DBH developed Substance Abuse Treatment and Prevention Block Grant tool, providers are assessed for their capability in providing
Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (i) Yes (ii) No

2. Has your state identified a need for any of the following:
   a) Business agreement/MOU with primary healthcare providers (i) Yes (ii) No
   b) Cooperative agreement/MOU with public health entity for testing and treatment (i) Yes (ii) No
   c) Established co-located SUD professionals within FQHCs (i) Yes (ii) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Nebraska has implemented a system to ensure that providers submit the data required to meet the requirements of block grant reporting on strategies used to identify compliance problems and corrective action used to address identified problems related to tuberculosis services made available to individuals receiving SUD treatment. The system includes the capability of reporting that information to the DBH.

   These processes are achieved through the propagation of the annual Regional Budget Plan Guidelines and State to RBHA contract. In the State to RBHA contract for substance abuse services, the RBHA will ensure that providers receiving State or Federal Dollars will routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery. The RBHA ensures that this requirement is maintained at the provider level via inclusion in the RBHA to Network Provider contract.

   Each RBHA has established procedures that ensure that the following TB services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
   a. Screening of all admissions for TB
   b. Positive screenings shall receive test for TB
   c. Counseling related to TB
   d. Referral for appropriate medical evaluations or TB treatment
   e. Case management for obtaining any TB services
f. Report any active cases of TB to state health officials
g. Document screening, testing, referrals and/or any necessary follow-up information

Tools include a Network Contractual Compliance Checklist which specifically verifies Network Administration and Management Systems ensure the RBHA provider network has the capacity to provide such substance abuse prevention services and substance abuse services, and the mechanisms the RBHA employs to address requirements and monitor timeframes. The Network Contractual Compliance Checklist tool identifies the need for corrective actions, plan of corrective status and next steps by the Provider/RBHA.

The DBH Program Fidelity Review process monitors program plans and services delivered to ensure consistence and conformance with SAPTBG requirements (interim services, tuberculosis and HIV requirements, subcontractor compliance and charitable choice) for agencies designated as, and providing services for, specified priority consumer populations (IV drug users, pregnant women, women with dependent children) This fidelity review is conducted a minimum of once every three years for those agencies who receive SAPTBG funds and is conducted at the time of the services purchased review. Please see PWID question #3 above for more detail.

**Early Intervention Services for HIV (for "Designated States" Only)**

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?  
   - Yes  
   - No

2. Has your state identified a need for any of the following:
   a) Establishment of EIS-HIV service hubs in rural areas  
      - Yes  
      - No
   b) Establishment or expansion of tele-health and social media support services  
      - Yes  
      - No
   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  
      - Yes  
      - No

**Syringe Service Programs**

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C\$ 300x-31(a)(1)(F))?  
   - Yes  
   - No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  
   - Yes  
   - No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  
   - Yes  
   - No
   
   If yes, please provide a brief description of the elements and the arrangement
Criterion 8,9&10

Service System Needs
1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state’s approach for improvement  
   Yes  No

2. Has your state identified a need for any of the following:
   a) Workforce development efforts to expand service access  
      Yes  No
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services  
      Yes  No
   c) Establish a peer recovery support network to assist in filling the gaps  
      Yes  No
   d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)  
      Yes  No
   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations  
      Yes  No
   f) Explore expansion of services for:
      i) MAT  
         Yes  No
      ii) Tele-Health  
         Yes  No
      iii) Social Media Outreach  
         Yes  No

Service Coordination
1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?  
   Yes  No

2. Has your state identified a need for any of the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services  
      Yes  No
   b) Establish a program to provide trauma-informed care  
      Yes  No
   c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education  
      Yes  No

Charitable Choice
1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?  
   Yes  No

2. Does your state provide any of the following:
   a) Notice to Program Beneficiaries  
      Yes  No
   b) An organized referral system to identify alternative providers?  
      Yes  No
   c) A system to maintain a list of referrals made by religious organizations?  
      Yes  No

Referrals
1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?  
   Yes  No

2. Has your state identified a need for any of the following:
   a) Review and update of screening and assessment instruments  
      Yes  No
   b) Review of current levels of care to determine changes or additions  
      Yes  No
   c) Identify workforce needs to expand service capabilities  
      Yes  No
d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

**Patient Records**

1. Does your state have an agreement to ensure the protection of client records?
   - Yes ☐ No ☐

2. Has your state identified a need for any of the following:
   a) Training staff and community partners on confidentiality requirements
      - Yes ☐ No ☐
   b) Training on responding to requests asking for acknowledgement of the presence of clients
      - Yes ☐ No ☐
   c) Updating written procedures which regulate and control access to records
      - Yes ☐ No ☐
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure
      - Yes ☐ No ☐

**Independent Peer Review**

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?
   - Yes ☐ No ☐

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   Starting July 1, 2013 the Division of Behavioral Health (DBH) established a new approach consistent with revised SAMHSA program policy on using private accreditation bodies to meet this Independent Peer Review requirement under both the MHBG and SABG. In place of the DBH contracting with the Nebraska Association of Behavioral Health Organizations to conduct the independent peer reviews, there is now an expectation of most SABG and MHBG fund recipients to have National Accreditation through the The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organization(s) approved by the Director (Chapter 5, section 001.3).

   The only exceptions would be for substance abuse prevention funds or when a nationally recognized accreditation organization appropriate to the organization’s services cannot be identified.

3. Has your state identified a need for any of the following:
   a) Development of a quality improvement plan
      - Yes ☐ No ☐
   b) Establishment of policies and procedures related to independent peer review
      - Yes ☐ No ☐
   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations
      - Yes ☐ No ☐

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?
   - Yes ☐ No ☐

   If Yes, please identify the accreditation organization(s)
   i) ☑ Commission on the Accreditation of Rehabilitation Facilities
   ii) ☑ The Joint Commission
   iii) ☑ Other (please specify)

   Other: Commission on Accreditation.
**Criterion 7&11**

**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  
   - Yes ☑️  No ☐

2. Has your state identified a need for any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  
      - Yes ☑️  No ☐
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  
      - Yes ☑️  No ☐

**Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state’s substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   a) Recent trends in substance use disorders in the state  
      - Yes ☑️  No ☐
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  
      - Yes ☑️  No ☐
   c) Performance-based accountability  
      - Yes ☑️  No ☐
   d) Data collection and reporting requirements  
      - Yes ☑️  No ☐

2. Has your state identified a need for any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs  
      - Yes ☑️  No ☐
   b) Addition of training sessions designed to increase employee understanding of recovery support services  
      - Yes ☑️  No ☐
   c) Collaborative training sessions for employees and community agencies’ staff to coordinate and increase integrated services  
      - Yes ☑️  No ☐
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  
      - Yes ☑️  No ☐

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC?  
      - Yes ☑️  No ☐
   b) Mental Health TTC?  
      - Yes ☑️  No ☐
   c) Addiction TTC?  
      - Yes ☑️  No ☐
   d) State Targeted Response TTC?  
      - Yes ☑️  No ☐

**Waivers**

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32(f)).*

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations regarding women  
      - Yes ☑️  No ☐

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   a) Tuberculosis  
      - Yes ☑️  No ☐
   b) Early Intervention Services Regarding HIV  
      - Yes ☑️  No ☐

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment  
      - Yes ☑️  No ☐
   b) Professional Development  
      - Yes ☑️  No ☐
Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

NDHHS Division of Behavioral Health Rules & Regulations – Title 206 Behavioral Health Services public access via URL:
http://dhhs.ne.gov/Pages/Title-206.aspx
Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question
In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state’s CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?  
   Yes ☐  No ☐

   Please indicate areas of technical assistance needed related to this section.

   None at this time.

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Footnotes:
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12. Trauma - Requested

Narrative Question

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing business as usual. These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.

57 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

58 Ibid

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?  Yes  No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?  Yes  No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?  Yes  No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  Yes  No

5. Does the state have any activities related to this section that you would like to highlight.

The Division of Behavioral Health (DBH) has a public policy statement to promote the provision of a Trauma-Informed System of Care which describes our commitment to transform publicly funded systems by strengthening the understanding of the broad effect of trauma, including safety, on the lives and communities of all Nebraskans. The State of Nebraska is committed to infusing trauma informed awareness, knowledge and skills into the organizational cultures, practices and policies that impact the system of care for children and adults.

DBH has included definitions and language in the regulations to support trauma-informed care and provide clarity in
The DBH believes that all system of care stakeholders and providers:

a) Understand their role and capacity to ensure trauma-informed responses in every interaction with children, adolescents and adults;

b) Are informed about the effects of psychological trauma and ensure agency wide commitment to a trauma-sensitive environment;

c) Ensure staff at every level is equipped with appropriate competencies to effectively address trauma;

d) Ensure that early assessment for trauma occurs utilizing research based strategies;

e) Ensure that all consumer interactions and services are recovery-oriented and trauma-sensitive; and

f) Understand that re-traumatization may occur if safe, effective, responsive services and practices are not available.

Through the DBH Regional Budget Plan (RBP) Guidelines and contracts with the six Regional Behavioral Health Authorities (RBHAs), it is expected that providers connect individuals with trauma histories to trauma-focused therapy. Expectations include that RBHA network development and coordination must develop and implement strategies to ensure that all behavioral health providers are informed about the effects of trauma, consistently screen for trauma symptoms and history of traumatic events, provide ongoing assessment of trauma symptoms and problems related to that trauma, offer services that are recovery oriented and trauma sensitive and are made aware that re-traumatization may occur if safe, effective, responsive services are not available.

DBH directs providers to screen clients for a personal history of trauma. Disclosure of trauma information by consumers takes a trusting relationship and may not be best captured right at the time of admission. Trauma screening information may be available at admission but is not required until discharge, thus allowing for rapport between the consumer and provider to be established. Trauma information can be updated in the DBH Centralized Data System (CDS) at any time the provider identifies new information relevant to the treatment program. Data is constantly available to the RBHAs and providers for review through the CDS. DBH uses the philosophy of trauma screening as a universal precaution. When screenings were initiated, the DBH provided specific instructions to providers about the process of screening which was based on the Harris and Fallot Universal Trauma Screening Guidelines (2001). Key principles include being aware of the individual’s needs, strengths and vulnerabilities prior to the screening, and using the screening as early as possible (and appropriate) in the assessment process.

RBHAs must also annually submit a list of the number of the trauma specific services that providers have available, to support consumer choice in selecting trauma services. Over the last few years, the DBH noted a range of services listed as trauma specific. A repository was developed and placed on our Network of Care website.

http://dhhs.ne.gov/Reports/Trauma%20Informed%20Services%20Fiscal%20Year%202015.pdf

The DBH Strategic Plan requires effectiveness and specifies a continuous quality improvement (CQI) process for services funded by the DBH, focusing on a number of factors including trauma. Providers were initially trained on the Harris and Fallot TIC tool and required to complete the self/peer assessment in 2013. Reassessment occurred in 2017 and will continue. After the Trauma-Informed Care (TIC) assessment was completed, results were reviewed and strengths for continued growth as well as opportunities for improvement were reviewed. Focus has been aimed at improvement in consideration of trauma across all service components including but not limited to: Program Procedures and Settings; Formal Service Policies; Trauma Screening, Assessment, and Service Planning; Program Procedures and Settings; Administrative Support for Program-Wide Trauma-Informed Services; Human Resources Practices; and Staff Trauma Training and Education. Analyses is conducted for continuation of improvement efforts and to identify ongoing training needs. Data submission will continue in the next BG cycle to determine provider and Region progress and needed training for TIC.

DBH promotes Trauma Informed Care through a statewide initiative, Trauma Informed Nebraska (TIN). The purpose of TIN is to promote the development and implementation of a statewide, consumer-driven, recovery-oriented, trauma-informed system that ensures all behavioral health providers are informed about the effects of psychological trauma and are aware of the origin and effects of trauma on survivors. Through TIN, the DBH, and the Behavioral Health Education Center of Nebraska (BHECN), multiple trainings called Trauma 101 and Recovery, have been completed over the last several years. A train the trainer process was established to ensure there is ongoing training throughout the state. Trauma 101 and Recovery includes: Introductions/Opening Exercise; Define PTSD and Trauma; Trauma Informed and Trauma Specific; Symptoms of PTSD/Triggers; ACES Study/Survey/Applications; Screening: Healing Neen Video; PTSD and Substance Use Disorder; Memory and Trauma; Creating Safe Environments; Vicarious Trauma – Exercise; Treatment Approaches; Trauma/Addiction/Recovery; Resources.

Trauma educational opportunities and resources about trauma specific services are not uncommon. Materials on Seeking Safety, PCIT and TF-CBT are examples. Nebraska has had a number of providers and RBHAs involved in the National Learning Community on trauma. Training material and resources continue to be shared.

DBH places great importance on continuing the strengthening of partnerships to help address trauma needs system wide. A June 2019 National Association of Alcohol and Drug Abuse Counselors included training on trauma informed care. The DBH, in collaboration with the Administrative Office of the Courts and Probation, have planned a Statewide Behavioral Health – Justice
Conference scheduled for October 2019. Presentations include addressing trauma from individual and workforce perspectives.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:
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13. Criminal and Juvenile Justice - Requested

Narrative Question
More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

5. Does the state have any activities related to this section that you would like to highlight?

The Justice Behavioral Health Committee (JBHC), formerly known as the Justice Substance Abuse Team, was created in 2003 to help improve communication and collaboration between the criminal justice and treatment systems. JBHC is staffed by the Administrative Office of Probation. This group meets quarterly and consists of 34 members representing the Executive and Judicial branches as well as behavioral health treatment providers and consumers. JBHC has established the Data, Curriculum, Sex Offender, and Provider sub-committees to assist in fulfilling its mission. The Division of Behavioral Health (DBH), in partnership with justice partners, and through the work of the Justice Behavioral Health Committee, established assessment standards and core curriculum rubrics incorporated into justice and behavioral health trainings. Confirmation of the rubrics and associated trainings are reviewed annually with the committee which includes representatives from Corrections, Parole, Probation, Problem Solving Courts, Regional Behavioral Health Authorities (RBHAs) and providers, Licensing Boards, Medicaid, Public Health, Child and Family Services, Public Defense, research and academia.

The committee is currently addressing problem solving court standards review, standards of care, work force development, data integration and quality of care. For example, JBHC is exploring opportunities to work with the Behavioral Health Education Center.
of Nebraska to create clinical rotations and residency in the criminal justice system facilities and cross training opportunities. The group is identifying potential interfaces between data systems for data sharing purposes and case reviews.

The DBH and the Office of Probation Administration, with support and guidance from JBHC, are planning for a Behavioral Health – Justice: Building a Comprehensive Community Response statewide conference in late 2019.

DBH and statewide partners and stakeholders are participating in a GAINS Center’s Criminal Justice Learning Collaborative focused on Competency to Stand Trial and Competency Restoration. Priorities are to reduce the number of persons referred for competency evaluations and reduce the wait time for competency restoration. Strategies include education, data integration, diversion and screening.

The Nebraska System of Care (NeSOC) efforts are supported through a SAMSHA SOC Expansion and Sustainability grant. Currently in year 3 of a 4 year grant the NeSOC partners, which includes but is not limited to, the Administrative Office of the Courts (AOC), The Administrative Office of Probation and the Nebraska Department of Health and Human Services has focused the past year on development of training for clinicians who serve individuals who experience SED and ID/DD. Additionally, training is underway for clinicians treating youth with sexually harmful behaviors. Both training initiatives were brought forward as needs from the AOP/AOC.

Crisis Intervention Team: In Omaha, a Crisis Intervention Team (CIT) model was developed and adopted as a cooperative community partnership involving law enforcement agencies, mental health service providers, mental health consumers, family members, and community funders. Through participation in this program, CIT police officers learn to recognize common forms of mental illness and to utilize the most effective means of communicating with people undergoing crisis. The officers are trained to de-escalate the individuals in crisis and allow the consumer to participate in the decision-making regarding their treatment. CIT officers must successfully complete 40 hours of training to become certified. This training has been offered to law enforcement providers in other RBHAs. To learn more about the Heartland Crisis Intervention Team program see The Kim Foundation website at: http://www.thekimfoundation.org/html/edu_training/crisis-intervention.html

Behavioral Health Threat Assessment (BETA): RBHA Region V Systems and the Lincoln Police Department provide Behavioral Health Threat Assessment (BETA), a 40-hour advanced training designed to assist Nebraska law enforcement personnel to obtain better outcomes when working on issues involving persons with mental illness. The training is also open to behavioral health professionals. This training includes advanced mental health training (such as how to identify and describe signs and symptoms of mental illness), systems issues, and how to conduct a basic threat assessment. There will be heavy involvement in the training by consumers of mental health, helping students learn to connect at several levels and improve positive outcomes between law enforcement and people who have mental health problems. This training has been offered to law enforcement providers in other RBHAs. For more information on BETA see the website at: http://region5systems.net/whats-happening/training/

Crisis Response Team: This is a statewide service pairing mental health professionals and emergency community support staff providing law enforcement with expert consultation and resources. This is designed to prevent custody relinquishment for behavioral health consumers when less restrictive measures will promote safety and allow access to services. Teams use natural supports and resources to build upon a consumer’s strengths to help resolve an immediate behavioral health crisis in the least restrictive environment by assisting the consumer to develop a plan to resolve the crisis. The service is provided by licensed behavioral health professionals who complete brief mental health status exams and substance use disorder screenings, assess risk, and provide crisis intervention, crisis stabilization, referral linkages, and consultation to hospital emergency room personnel, if necessary. The goal of the service is to avoid an Emergency Protective Custody hold or inpatient psychiatric hospitalization. This service is available in all RBHAs.

Through SAMHSA’s SOC grant, Youth Mobile Crisis Response (YMCR) was launched statewide in May 2019. An initial effort of the NeSOC work requested by system partners was statewide Youth Mobile Crisis Response (YMCR). The YMCR went statewide 05/01/2017. Since implementation the YMCR:
• Has consistently maintained 73% of youth served in their current living situation at the time of service. (N=1142)
• Only 2% of youth served were referred to Children and Family Services or AOP for placement. (N=1142)

Please indicate areas of technical assistance needed related to this section.

None at this time.

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPS 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  
   - Yes  
   - No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  
   - Yes  
   - No

3. Does the state purchase any of the following medication with block grant funds?  
   - Yes  
   - No
   a) Methadone  
   b) Buprenorphine, Buprenorphine/naloxone  
   c) Disulfiram  
   d) Acamprosate  
   e) Naltrexone (oral, IM)  
   f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately?  
   - Yes  
   - No

5. Does the state have any activities related to this section that you would like to highlight?

   The Nebraska Division of Behavioral Health (DBH) contracts with the six Regional Behavioral Health Authorities (RBHAs) and includes a provision in these contracts that SUD providers may not refuse to serve individuals receiving Medication Assisted Treatment (MAT). DBH will continue to promote and sponsor training opportunities and disseminate materials to increase provider competence in this area and to educate consumers on how to effectively use these services.

   To promote education of providers, the DBH maintains linkages on its website (http://dhhs.ne.gov/Pages/State-Opioid-Response.aspx) to the Pain and Substance Use Disorder Project ECHO as well as the American College of Academic Addiction Medicine. Once on the DBH site, providers can also access a variety of resources, information and training materials on MAT. DBH partners with a variety of entities to educate providers on the utility of MAT. Discussion continues with systems partners, including the Division of Medicaid and Long Term Care, Department of Corrections, Office of Probation and others, gathering information on current expenditures, utilization and other data to make informed decisions about moving forward.

   Additionally, Nebraska is a 2017 recipient of the State Targeted Response to the Opioid Crisis Grant and a 2018 recipient of the State Opioid Response grant, both which are purposed to mitigate the effects of opioid use disorders, including both prescription opioids and illicit drugs, such as heroin, by identifying statewide needs, increasing access to treatment, including medication assisted treatment, and reducing prescription drug overdose deaths through the provision of prevention, treatment and recovery activities.
*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:
Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question
In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.61 SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises62.

“Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization.”

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   a) ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) ☑ Psychiatric Advance Directives
   c) ☑ Family Engagement
   d) ☑ Safety Planning
   e) ☑ Peer-Operated Warm Lines
   f) ☑ Peer-Run Crisis Respite Programs
   g) ☑ Suicide Prevention

2. Crisis Intervention/Stabilization
   a) ☐ Assessment/Triage (Living Room Model)
   b) ☐ Open Dialogue
   c) ☑ Crisis Residential/Respite
   d) ☑ Crisis Intervention Team/Law Enforcement
   e) ☑ Mobile Crisis Outreach
   f) ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support
   a) ☑ Peer Support/Peer Bridgers
   b) ☑ Follow-up Outreach and Support
   c) ☑ Family-to-Family Engagement
   d) ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
   e) ☑ Follow-up crisis engagement with families and involved community members

4. Does the state have any activities related to this section that you would like to highlight?

The Nebraska Division of Behavioral Health (DBH) recognizes the importance of having services in place to assist individuals in crisis. DBH contracts with the Regional Behavioral Health Authority (RBHA) networks to have a minimum capacity to provide emergency services 24 hours per day on an unscheduled basis to address acute psychiatric or substance use emergencies. All emergency services shall be coordinated through the provider network by network management between DBH, Mental Health Boards, law enforcement, hospital emergency services and current and anticipated providers of care for the individual. The minimum capacity of emergency services include:

1. A 24 hour clinician on call
2. Mobile outreach and crisis intervention
3. Emergency shelter
4. Emergency Protective Custody holding and evaluation
5. Emergency evaluation services

Dependent upon consumer needs, all emergency services provided by network providers focus on outcomes which lead to a referral to the least restrictive, least intensive level of care, or a rapid return to community living with appropriate supports, as necessary. For people in crisis, services within the Continuum of Care include:

- Crisis Response;
- Emergency Protective Custody;
- Inpatient Treatment; and,
- Outpatient Treatment.

The DBH manages implementation of the statewide emergency system through ongoing contact with each of the Regional Emergency System Coordinators (RECS), as a group and individually, as needed, to insure an effective continuum of care for crisis services. DBH organizes and conducts a conference call once per month with RECS and quarterly in person meetings. The DBH and RECS review complex cases in the community, system issues and system strengths. DBH also organizes and staffs weekly in person meetings with the residually based Lincoln Regional Center (LRC). DBH and LRC work together to insure the individuals at LRC are at the least intrusive most appropriate level of care. They review complex cases and work together to develop strategies and solutions for individuals with complex needs. These meetings maintain relevancy with crisis centered activities within each RBHA and at LRC, and to insure that consumers are receiving treatment in accordance with their strengths and needs. They allow opportunities for individual case reviews, brainstorming for solutions to meet the complex needs of consumers, identification of strengths and needs in statewide treatment options, and the sharing of local developments that are occurring with all RBHA/LRC partner networks.

The DBH encourages RECSs to be in ongoing communication with each other and with LRC staff, and to work together to meet consumer needs when those treatment options are not available within a RBHA. DBH also utilizes the statewide mental health and substance abuse waiting list information as a measure in determining capacity for, and access to, treatment for consumers with mental health board commitments.

Regional providers of mental health and substance abuse services are required to enter in the Centralized Data System (which is available to the RBHAs and to DBH), consumers, including priority status, and who are placed on the provider’s waiting list for services. Priority levels for admission to services for SUD services include: (1) pregnant injecting drug users; (2) other pregnant substance users; (3) other injecting drug users; (4) women with dependent children; and, (5) all others including those consumers with Mental Health Board Commitments. Priorities for admission to mental health services include persons discharging from Lincoln Regional Center, persons discharging from local hospitals, and persons who are outpatient committed by a mental health board.

State regulations provide service definitions that describe the types of crisis services individuals can receive in different areas of Nebraska. Below is the list of crisis services available along with their definition:

- Emergency Psychiatric Observation: Emergency Psychiatric Observation provides less than 24 hours of care in a secure, medically supervised hospital setting for evaluation and stabilization of acute psychiatric and/or substance use disorder symptoms.
- Crisis Stabilization: Crisis Stabilization is intended to provide immediate, short-term, individualized, crisis-oriented treatment and recovery services needed to stabilize acute symptoms of mental illness, alcohol and/or other drug use, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance use disorder crisis with a moderate to high risk for harm to self/others and need short-term, protected, supervised, residential placement. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individual’s typical living situation.
- Crisis Assessment: Crisis Assessment is a thorough assessment for a consumer experiencing a behavioral health crisis. The Crisis Assessment must be completed by the appropriate professional. The Crisis Assessment takes place in a setting such as a Mental Health Center, Hospital, or Substance Abuse Treatment Center. The Crisis Assessment will determine behavioral health diagnosis, risk of dangerousness to self and/or others, recommended behavioral health service level and include the consumer’s stated assessment of the situation. Based on the Crisis Assessment, appropriate behavioral health referrals will be provided.

f) ✔ Recovery community coaches/peer recovery coaches

g) ✔ Recovery community organization

f) ✔ Recovery community coaches/peer recovery coaches

g) ✔ Recovery community organization

Does the state have any activities related to this section that you would like to highlight?

The Nebraska Division of Behavioral Health (DBH) recognizes the importance of having services in place to assist individuals in crisis. DBH contracts with the Regional Behavioral Health Authority (RBHA) networks to have a minimum capacity to provide emergency services 24 hours per day on an unscheduled basis to address acute psychiatric or substance use emergencies. All emergency services shall be coordinated through the provider network by network management between DBH, Mental Health Boards, law enforcement, hospital emergency services and current and anticipated providers of care for the individual. The minimum capacity of emergency services include:

1. A 24 hour clinician on call
2. Mobile outreach and crisis intervention
3. Emergency shelter
4. Emergency Protective Custody holding and evaluation
5. Emergency evaluation services

Dependent upon consumer needs, all emergency services provided by network providers focus on outcomes which lead to a referral to the least restrictive, least intensive level of care, or a rapid return to community living with appropriate supports, as necessary. For people in crisis, services within the Continuum of Care include:

- Crisis Response;
- Emergency Protective Custody;
- Inpatient Treatment; and,
- Outpatient Treatment.

The DBH manages implementation of the statewide emergency system through ongoing contact with each of the Regional Emergency System Coordinators (RECS), as a group and individually, as needed, to insure an effective continuum of care for crisis services. DBH organizes and conducts a conference call once per month with RECS and quarterly in person meetings. The DBH and RECS review complex cases in the community, system issues and system strengths. DBH also organizes and staffs weekly in person meetings with the residually based Lincoln Regional Center (LRC). DBH and LRC work together to insure the individuals at LRC are at the least intrusive most appropriate level of care. They review complex cases and work together to develop strategies and solutions for individuals with complex needs. These meetings maintain relevancy with crisis centered activities within each RBHA and at LRC, and to insure that consumers are receiving treatment in accordance with their strengths and needs. They allow opportunities for individual case reviews, brainstorming for solutions to meet the complex needs of consumers, identification of strengths and needs in statewide treatment options, and the sharing of local developments that are occurring with all RBHA/LRC partner networks.

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- Crisis Assessment: Crisis Assessment is a thorough assessment for a consumer experiencing a behavioral health crisis. The Crisis Assessment must be completed by the appropriate professional. The Crisis Assessment takes place in a setting such as a Mental Health Center, Hospital, or Substance Abuse Treatment Center. The Crisis Assessment will determine behavioral health diagnosis, risk of dangerousness to self and/or others, recommended behavioral health service level and include the consumer’s stated assessment of the situation. Based on the Crisis Assessment, appropriate behavioral health referrals will be provided.

f) ✔ Recovery community coaches/peer recovery coaches

g) ✔ Recovery community organization
• Emergency Protective Custody Crisis Stabilization: Crisis Stabilization is designed to provide custody, screening, emergency mental health evaluation, and crisis intervention to individuals placed in emergency protective custody under the auspices of Nebraska Mental Health Commitment Act by law enforcement. Crisis Stabilization services include immediate, short-term, individualized, crisis-oriented treatment and recovery needed to stabilize acute symptoms of mental illness, alcohol and/or other drug abuse, and/or emotional distress. Individuals in need exhibit a psychiatric and/or substance use disorder crisis as defined under the Commitment Act at risk for harm to self/others and need short-term, protected, supervised services. The intent of the service is to treat and support the individual throughout the crisis; provide crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assist in transition back to the individual’s typical living situation.

• 24-Hour Crisis Line: The 24-Hour Crisis Line must be answered by a live voice 24 hours a day and 7 days a week and have the ability to link to a licensed behavioral health professional, law enforcement, and other emergency services. The 24-Hour Crisis Line is designed to assist consumers in pre-crisis or crisis situations related to a behavioral health problem. The desired outcome is ensuring the safety of the consumer in a time of distress that has the potential to lead to a life-threatening situation.

• Mental Health Respite: Mental Health Respite is designed to provide shelter and assistance to address immediate needs which may include case management on a 24/7 basis to consumers experiencing a need for transition to another home or residential setting or a break from the current home or residential setting. Mental Health Respite provides a safe, protected, supervised residential environment on a short-term basis. The intent of the service is to support a consumer throughout the transition or break, provide linkages to needed behavioral health services, and assist in transition back into the community.

• Emergency Community Support: Emergency Community Support is designed to assist consumers who can benefit from support due to a behavioral health need and who are either currently residing in a community setting or transitioning from a psychiatric hospital into a community setting. Emergency Community Support services include case management, behavioral health referrals, assistance with daily living skills, and coordination between consumer and/or consumer’s support system and behavioral health providers.

• Crisis Response: Crisis Response is designed to use natural supports and resources to build upon a consumer’s strengths to help resolve an immediate behavioral health crisis in the least restrictive environment by assisting the consumer to develop a plan to resolve the crisis. The service is provided by licensed behavioral health professionals who complete brief mental health status exams and substance use disorder screenings, assess risk, and provide crisis intervention, crisis stabilization, referral linkages, and consultation to hospital emergency room personnel, if necessary. The goal of the service is to avoid an Emergency Protective Custody hold or inpatient psychiatric hospitalization.

• Urgent Medication Management: Urgent Medication Management is the level of outpatient treatment where the sole service rendered by a qualified provider is the evaluation of the consumer’s need for psychotropic medications and provision of a prescription. Urgent Medication Management is provided within 72 hours of contact and referrals for this service must come from a provider within a RBHA’s behavioral health network.

• Hospital Diversion: Hospital Diversion is a peer-operated service designed to assist consumers in decreasing psychiatric distress, which may lead to hospitalization. It is designed to help consumers rethink crisis as an opportunity to change toward a more self-determined independent life. Trained Peer Companions are help other consumers utilize self-help tools. Peer Companions provide contact, support, and/or referral for services, as requested, during and after the stay as well as manning a Warm Line. Hospital Diversion is located in a family/home setting in a residential district that offers at least 4-5 guest bedrooms and is fully furnished for comfort. Participation in the service is voluntary.

Through the efforts of the Nebraska System of Care (NeSOC) work, Nebraska has expanded to include a Youth Mobile Crisis Response service which is designed for youth and adolescents. Mobile Crisis Response, which had only been available in pocketed areas of the state, was expanded statewide on May 1, 2017. Youth Mobile Crisis Response teams provide immediate crisis counseling to those in need in the community. Youth Mobile Crisis Response may partner with law enforcement to assist with risk assessment, provide crisis intervention, crisis stabilization and refer families to health resources in their communities. Depending on location, services are offered face-to-face or via telehealth. Youth Mobile Crisis Response may be accessed through the Nebraska Family Helpline, providing a consistent statewide access point. In addition, consumers eligible for Medicaid benefits have access to other crisis interventions, such as Crisis therapy, under the Medicaid program.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:
Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components: health (access to quality health and M/SUD treatment); home (housing with needed supports); purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  
Yes  No

Required peer accreditation or certification?  
Yes  No

Block grant funding of recovery support services.  
Yes  No

Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system?  
Yes  No

Does the state measure the impact of your consumer and recovery community outreach activity?  
Yes  No

Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The Division of Behavioral Health (DBH) NAC Title 206 Chapter 2 – Definitions offer the following terms which support recovery and recovery values:  

- Peer Support Services
- Person Centered Care
- Recovery
- Recovery-Oriented System of Care (ROSC)
- Rehabilitation
- Secondary Consumer
- Strength-based
- Trauma-informed Services
- Trauma-informed System
- Treatment

DBH has promulgated new regulations for the training and certification of peer support (mental health/substance use). Service standards, including peer run services, are within the Title 206 Behavioral Health Services Regulations and Service Definitions. One example of a service that utilizes a peer-run model is Hospital Diversion. The basic definition is:

Hospital Diversion is a peer-operated service designed to assist consumers in decreasing psychiatric distress, which may lead to hospitalization. It is designed to help consumers rethink crisis as an opportunity to change toward a more self-determined independent life. Meaningful involvement can ensure that consumers lead a self-determined life in the community, rather than remaining dependent on the behavioral health system for a lifetime. Hospital Diversion offers consumers the opportunity to take control of their crisis or potential crisis and develop new skills through a variety of traditional self-help and proactive tools designed to maintain wellness. Trained Peer Companions are the key ingredients in helping other consumers utilize self-help tools. Peer Companions provide contact, support, and/or referral for services, as requested, during and after the stay as well as manning a Warm Line. Hospital Diversion is located in a family/home setting in a residential district that offers at least 4-5 guest bedrooms and is fully furnished for comfort. Participation in the service is voluntary.

The Mental Health Association of Nebraska is CARF Accredited and operates Keya House (Hospital Diversion Services). Community Alliance is CARF Accredited and operates Safe Harbor Peer Services.

Nebraska also has:
- Family Peer Support Navigators
- Peer-Run Crisis Diversion Services
- Peer-Run Warmlines- Lincoln, Omaha, and North Platte
- Housing Related Assistance (MH/SUD)
- Supported Employment
- Peer Support services (Individual, Family, Youth)
- Recovery Houses
- Wellness Recovery Action Planning
- Person Centered Planning
- Self-directed Care

Case management facilitates the achievement of individual wellness through advocacy, assessment, planning, linking, communication, education, resource management, and service facilitation. Additionally, block grant funded providers are to be welcoming, engaging and continually improving integrated services to the populations they serve, including those with developmental disabilities who have mental health and substance abuse disorders and all other individuals who have complex needs. Recovery support services are initiated at the onset of the individual’s treatment planning and service delivery process. To the extent possible, the development of a service plan is to be a collaborative process involving the consumer, family members, and other support/service systems. A key component of service coordination is the expectation to develop and sustain strong working relationships with community partners who provide the necessary supports and services which assist individuals with behavioral health disorders. Establishing strong working relations with law enforcement, community hospital(s), housing
promote quality improvement by participating in statewide youth system coordination, enhance Nebraska System of Care (NeSOC) engage in activities that address the behavioral health needs of youth transitioning into adulthood. Youth Systems Coordinators their community, whenever possible. They also collaborate with the RBHA Network providers and other agencies serving youth to partners to ensure that children and youth with behavioral health disorders receive the most appropriate services located within their respective RBHA. The Youth Systems Coordinator coordinates activities and collaborates with community based providers, system partners and the many stakeholders of the behavioral health system work in a coordinated manner that supports individuals across the life span to promote resiliency and achieve recovery. Each RBHA has established multi-stakeholder collaborative structures to coordinate efforts in formal functional areas for Consumers (including youth) and Family Involvement and Inclusion, Network Management, Emergency Services System, Prevention Services System, and Youth System of Care (YSC). Each RBHA has a Professional Partner Program (PPP) using a fidelity-based version of the wraparound care coordination model to support services to families who have children with serious emotional disorders and to ensure that youth and families have a voice and ownership in developing an accessible, comprehensive, individualized family support plan.

In collaboration with system partners, the DBH developed and implemented guidelines, as outlined in the PPP manual, for children and young adults with mental and substance use disorders and their families for individualized care planning. The PPP manual is reviewed at least annually, with updates identified and incorporated as needed based upon quality improvement processes led by DBH. The PPP program evaluation, outcomes, and admission criteria are being re-assessed in order to continue to identify improvements that better assess the impact of PPP on children and youth, better measure family functioning over time, improve quality care, increase access to High Fidelity Wraparound Services, increase involvement of children, youth, and families, and continue in efforts to build strong partnerships across child serving agencies to implement family centered care.

With ten wraparound components at its core, an individualized service plan is developed for each youth/young adult and his/her family, based upon the strengths and concerns of the youth/young adult and his/her family across life domains, including mental health, substance abuse, residential, family, education, vocational, financial, social/recreational, medical, legal, safety, and cultural.

The Professional Partner, youth/young adult and family identifies wraparound team members who will contribute to the development of an Individual Family Service Plan (IFSP) (or Plan of Care - for the purposes of transition aged programs). The IFSP must be a clear, outcome focused plan with time sensitive and measureable goals and objectives that are purposed to support the safety, well-being, recovery and resiliency of the youth. The identified goals and objectives will directly reflect the information reported in the Intake/Interpretative Summary.

The format for the IFSP plan may vary but must include at a minimum:
• Clear demonstration of youth/young adult/family partnership in the plan development
• Youth/young adult and Family Strengths
• Presenting Problems
• Goals and Expected Outcomes/Pre-Discharge Plan
• Objectives/Interventions must be measureable and timely
• Team Members, both formal and informal
• Safety planning

Each RBHA Network includes a Youth Systems coordination function, responsible for the children’s behavioral health system within their respective RBHA. The Youth Systems Coordinator coordinates activities and collaborates with community based partners to ensure that children and youth with behavioral health disorders receive the most appropriate services located within their community, whenever possible. They also collaborate with the RBHA Network providers and other agencies serving youth to engage in activities that address the behavioral health needs of youth transitioning into adulthood. Youth Systems Coordinators promote quality improvement by participating in statewide youth system coordination, enhance Nebraska System of Care (NeSOC)
principles, assess RBHA Network providers of youth services for Family Centered Practice models (FCP), and provide technical assistance when needed and as appropriate to increase providers’ ability to incorporate FCP and NeSOC principles into their practices.

The youth systems services infrastructure facilitates the involvement of youth, families, and system partners at the regional and individual family levels. The structures in each RBHA, alongside parallel structures for child welfare through the CFS’s five Service Areas (SAs) are long-standing and provide a key component of the foundation upon which the NeSOC strategic plan implementation efforts are built. While their geographic boundaries are not fully aligned, there is much overlap and each RBHA works with assigned SAs. This enhanced regional alignment is key to sustainability, as both RBHAs and SAs have established networks among NeSOC stakeholders in each RBHA.

The population of focus for Nebraska System of Care Strategic Plan is defined, inclusively, as: Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska’s child-serving systems. Our vision, mission and values describe our hopes and intentions for the future, guides our efforts and provides a foundation for a system of care for children, youth and their families.

Vision Simply Said: All Nebraska children, youth and families will reach their full potential by experiencing improved wellness and mental health, exhibiting greater well-being, functioning successfully in the community and realizing greater stability in their living situation.

Mission Simply Said: Nebraska will improve the lives of children, youth and families by working within partnerships to improve service delivery systems, including the cost and quality of care, as a means of providing meaningful benefits and measureable outcomes to children, youth and families as experienced in the context of everyday living.

Values: Youth-guided; family-driven; individualized; culturally and linguistically competent; accessible; cost-effective, trusted partnerships.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
Also see response to Question # 3 as services and infrastructure are integrated.

The Division of Behavioral Health Strategic Plan is designed to move the system to improve services for these populations through “person-centered and self-directed” approaches of care in recovery-oriented systems. Within the framework of recovery-oriented systems of care, the person centered approach allows for greater flexibility for cultural adaptations within service delivery.

The peer support service definition and requirements for training/curriculum and certification of peer specialist workforce are integrated for mental health and substance use. The curriculum is a trauma informed and culturally competent model of peer support and is based upon the SAMHSA domains of peer support. Additional information on the new training and certification process and its implementation is located at DHHS – DBH – Office of Consumer Affairs website.
http://dhhs.ne.gov/Pages/Consumer-Advocacy.aspx

The DBH offers multiple training opportunities for the professional workforce on recovery principles and recovery oriented practice and systems, including the role of peer providers. Clinical supervision of nonclinical staff and peer to peer supervision are training breakout sessions planned for the 2019 Behavioral Health – Justice Conference. DBH and the University of Nebraska Medical Center and Behavioral Health Education Center of Nebraska (BHECN) continue to collaborate on peer workforce development, the role of peers, and curriculum improvements. In 2018, BHECN was awarded the MH – ATTC and it is anticipated that the competency of and the role of peers in the workforce will grow. Additionally, though funding support of the State Targeted Response to the Opioid Crisis grant, DBH offered training specific to Medication Assisted Treatment to peer support specialists in the state. Additional training need are being assessed and will be developed to meet identified needs. Research is currently underway to identify specific peer support training curriculum standards that could be considered to establish a specialized endorsement in SUD peer support. Other potential training endorsements being considered include Youth Peer Support and Family Peer Support.

5. Does the state have any activities that it would like to highlight?
In May 2019, DBH conducted an Employment Summit available to all contracted providers to review and identify strategies that treatment and rehabilitation providers can implement to increase the conversation with consumers regarding the importance of work, and how to incorporate these conversations into all aspects of screening, assessment, treatment and discharge. Meaningful work / employment promotes and supports wellbeing and recovery

Please indicate areas of technical assistance needed related to this section.
None at this time.

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Footnotes:
Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question
The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA’s mission to reduce the impact of M/SUD on America’s communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court’s Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

**Please respond to the following items**

1. Does the state’s Olmstead plan include:
   - Housing services provided.
   - Home and community based services.
   - Peer support services.
   - Employment services.

2. Does the state have a plan to transition individuals from hospital to community settings?

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   In reviewing its response to the Olmstead Decision of 1999, Nebraska is implementing Legislative Bill (LB) 1033, signed into law by the Governor on April 18, 2016, and LB 570, signed into law by the Governor on May 17, 2019, to ensure qualified persons with disabilities are receiving services in the most integrated community-based service settings.

   LB 1033 required the Nebraska Department of Health and Human Services (DHHS) to:

   1. Convene a team consisting of persons from each of the six divisions of the department to assess components of the strategic plan which may be in development;
      a. In 2016, DHHS convened a team consisting of persons from each of the six divisions of the Department to assess components of the strategic plan which may be in development.

   2. Consult with other state agencies that administer programs serving persons with disabilities; and
      a. In 2016, DHHS consulted with other state agencies that administer programs serving persons with disabilities and identified representatives to serve on a stakeholder advisory committee.

   3. Appointing and convening a stakeholder advisory committee to assist in the review and development of the strategic plan (hereinafter “The Plan”);
      a. In 2016, DHHS assembled the Disability Services Stakeholder Olmstead Planning Advisory Committee.
      b. In 2017, the committee issued a Request for Information designed to gather information to assist DHHS in issuing a Request for Proposals for consultation with the task of developing a new comprehensive strategic plan in compliance with the terms and
conditions of Nebraska Legislative Bill 1033 (2016). DHHS contracted with the Technical Assistance Collaborative (TAC) to complete this work.

In 2019, the committee amended the TAC contract to include tasks to evaluate progress towards plan implementation and need for plan revisions or modifications as established by Nebraska Legislative Bill 570 in 2019, which modified Nebraska Legislative Bill 1033.

The Plan must cover all populations, including people with intellectual, developmental, psychiatric and physical disabilities, aging populations, as well as persons at serious risk of institutionalization or segregation. The Plan should also assess and provide strategies to improve self-directed, long-term and attendant care, housing, transportation, employment and training, education, health and mental health, accessible and universally-designed technology, and support services for families. In addition, the Plan will assure that Nebraska is in compliance with relevant federal and state provisions intended to protect the civil rights of individuals with disabilities, and specifically the US Supreme Court’s Olmstead decision.

Prior to the 2019 legislative session, a review of the activities of DHHS to implement LB 1033 led to the recognition of the value in expanding the DHHS collaborative to include other partners beyond health care service agencies. This resulted in the introduction and passage of LB 570 in 2019. LB 570 expands the state agencies directed to collaborate in the development of a comprehensive strategic plan for providing services to qualified persons with disabilities in the most integrated community-based settings. Now in addition to the DHHS, partner agencies in this collaboration include the state departments of Economic Development, Labor, Transportation, Education, Correctional Services, and Veterans’ Affairs and the Nebraska Equal Opportunity Commission and University of Nebraska. DHHS has established a steering committee to lead this collaboration.

The stakeholder advisory committee membership was expanded to include representatives from the Public Service Commission, the Commission for the Deaf and Hard of Hearing, Transportation and the Commission for the Blind and Visually Impaired. Existing membership included representatives from the State Advisory Committee on Mental Health Services, the Advisory Committee on Developmental Disabilities, the Nebraska Statewide Independent Living Council, the Nebraska Planning Council on Developmental Disabilities, the Division of Rehabilitation Services in the State Department of Education, a housing authority in a city of the first or second class and a housing authority in a city of the primary or metropolitan class, the Assistive Technology Partnership, the protection and advocacy system for Nebraska, an assisted-living organization, the RBHAs, mental health practitioners, developmental disability service providers, an organization that advocates for persons with developmental disabilities, an organization that advocates for persons with mental illness, an organization that advocates for persons with brain injuries, and an area agency on aging, and including two persons with disabilities representing self-advocacy organizations, and, at the department’s discretion, other persons with expertise in programs serving persons with disabilities.

The DHHS is now authorized to continue work with an independent consultant to assist with developing and completing the Olmstead Plan due to the Legislature and the Governor by December 15, 2019. DHHS procured a consultant, the Technical Assistance Collaborative (TAC); for this purpose. Future consultation, post Plan, is authorized for the purpose of the continued analysis and revision of the Plan and determine whether the benchmarks, deadlines, and timeframes are in substantial compliance. Continued reporting on progress and changes or revisions to Plan are required to be submitted to the Legislature by December 15, 2021, and every three years thereafter.

A summary of the activities and tasks organized to complete the strategic plan by December 15, 2019 is provided below.

**Task - Activity Project Management**

Project Management and Coordination will occur monthly or bi-monthly on an ongoing basis.

Meetings with steering committee and stakeholder advisory committee, providing updates and progress reports and obtaining input/feedback on an ongoing basis.

**Task - Develop and Submit Final Olmstead Strategic Plan**

Refine and prioritize goals, strategies, and measures with DHHS Divisions by September 2019.

Meet with partner departments and agencies to establish Plan goals, strategies, and measure by September 2019.

Prepare draft plan for DHHS partners to review and revisions to be completed by November 2019.

Presentation of the revised draft plan to stakeholder advisory committee in November 2019.

Prepare revised draft plan for DHHS partners by December 2019.

Delivery of Final Plan to DHHS by December 20, 2019.

**Task - Evaluation of Year 1 Progress Towards Plan Implementation and Need for Plan Revisions or Modification**

Meetings with steering committee and stakeholder advisory committee May 2020 through April 2021.

Stakeholder interviews and listening sessions scheduled and conducted September – October 2020.

Plan progress evaluation and compliance activities September – November 2020.

Draft Year 1 Progress Report and Recommendations by December 1, 2020.

Final Year 1 Progress Report and Recommendations by December 31, 2020.

**Task – Evaluation of Year 2 Progress Towards Plan Implementation and Need for Further Plan**

Meetings with steering committee and stakeholder advisory committee May 2021 through December 2021.

Stakeholder interviews and listening sessions scheduled and conducted August – September 2021.

Plan progress evaluation and compliance activities August – October 2021.

Draft Year 1 Progress Report and Recommendations by December 1, 2021.

Final Year 1 Progress Report and Recommendations by December 31, 2021.
Please indicate areas of technical assistance needed related to this section.

None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question
MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:
1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?  
      • Yes  □  No
   b) The recovery and resilience of children and youth with SUD?  
      • Yes  □  No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a) Child welfare?  
      • Yes  □  No
   b) Juvenile justice?  
      • Yes  □  No
   c) Education?  
      • Yes  □  No

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?  
      • Yes  □  No
   b) Costs?  
      • Yes  □  No
   c) Outcomes for children and youth services?  
      • Yes  □  No

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?  
      • Yes  □  No
   b) Mental health treatment and recovery services for children/adolescents and their families?  
      • Yes  □  No

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system?  
      • Yes  □  No
   b) for youth in foster care?  
      • Yes  □  No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH) serves as the chief behavioral authority for the State of Nebraska as dictated in Neb. Rev. Stat. §71-806. In relationship to Nebraska's System of Care (NeSOC), DBH has the authority and responsibility to direct and coordinate the public behavioral health system, including integration and coordination of the system; comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care; develop and manage data and information systems; prioritize and approve all expenditures of funds received and administered by the division; and promote activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services. DBH works through and in partnership with six Regional Behavioral Health Authorities (RBHAs) to carry out its charge.

   The RBHAs have structures and mechanisms to support a coordinated system of care approach to support recovery and resilience of children and youth with behavioral health needs. The RBHAs develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS Divisions of Children and Family Services (CFS) and Medicaid and Long-Term Care (MLTC), Developmental Disabilities (DD), Administrative Office of Probation and the Courts, county leaders, local system stakeholders, and community leaders and members.

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efforts. The desired outcomes remained relatively unchanged however activities of focus for the next 18 months were identified.

In January, the NeSOC Leadership Board met to revisit the identified desired outcomes and the governance structure of the NeSOC Leadership and Service Delivery Teams. The localized Leadership and Service Delivery Teams are facilitated by the RBHAs. In January, the implementation committee, youth and family advisory councils, five standing statewide work teams and six localized development. Additionally there were performance measures identified for each phase.

The NeSOC implemented a phased work plan which guides the NeSOC efforts. The work plan had 64 action steps identified over a 3 year period which addressed: NeSOC infrastructure, Service Design and Delivery, Evaluation and CQI and Workforce development. Additionally there were performance measures identified for each phase.

In addition, DBH contracts with the Lincoln Medical Education Partnership to make the School Community Intervention and Prevention (SCIP) program available statewide. SCIP provides prevention, education, and early intervention services and works to educate teachers and other school personnel to work on behalf of students and their families. Each school’s SCIP team members are also educated on a variety of mental and behavioral health disorders that affect children and adolescents, providing them with a knowledge-base of various disorders including risk factors, signs and symptoms, and effects. They are given strategies on how to interact and support affected students, and provided with additional resources. SCIP connects participating schools to area behavioral health agencies, providing all students with the opportunity to receive access to professional assistance when needed.

SCIP also networks with multiple community partners, working together to ensure communities are well educated and youth have the appropriate resources to meet their needs to reach their full potential.

DHHS DBH received a grant in September of 2016 to expand and sustain the Nebraska System of Care. Nebraska refers to this grant as the NeSOC. Partners from across the state are working to implement the elements which were identified through the System of Care strategic plan. The NeSOC is a public/private partnership building on the strengths of our system partners.

To ensure these goals are met and families are being better served, a baseline data analysis was completed as a starting point. The baseline data for the System of Care, inclusive of data from the DHHS Divisions of Medicaid, Behavioral Health, and Children and Family Services/Nebraska Families Collaborative and the Office of Probation, represents 37,996 unique youth involved with any of these agencies for any period of time during FY15. Annual analysis continues to measure statewide systemic progress in meeting targeted goals aimed at ensuring youth are supported academically, have access to the least intensive, community-based service needed and as appropriate to increase providers’ ability to incorporate FCP and NeSOC principles into their practices. The youth systems services infrastructure facilitates the involvement of youth, families, and system partners at the regional and individual family levels. Over time the DBH and CFS have coordinated services provided and to date both contract to provide FN/FPS. The structures in each RBHA, alongside parallel structures for child welfare through the CFS’s five Service Areas (SAs) are long-standing and provide a key component of the foundation upon which the NeSOC strategic plan implementation efforts are built. While their geographic boundaries are not fully aligned, there is much overlap and each RBHA works with assigned SAs. This enhanced regional alignment is key to sustainability, as both RBHAs and SAs have established networks among NeSOC stakeholders in each region.

In addition, DBH contracts with the Lincoln Medical Education Partnership to make the School Community Intervention and Prevention (SCIP) program available statewide. SCIP provides prevention, education, and early intervention services and works to educate teachers and other school personnel to work on behalf of students and their families. Each school’s SCIP team members are also educated on a variety of mental and behavioral health disorders that affect children and adolescents, providing them with a knowledge-base of various disorders including risk factors, signs and symptoms, and effects. They are given strategies on how to interact and support affected students, and provided with additional resources. SCIP connects participating schools to area behavioral health agencies, providing all students with the opportunity to receive access to professional assistance when needed.

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The NeSOC implemented a phased work plan which guides the NeSOC efforts. The work plan had 64 action steps identified over a 3 year period which addressed: NeSOC infrastructure, Service Design and Delivery, Evaluation and CQI and Workforce development. Additionally there were performance measures identified for each phase.

Nebraska also implemented a NeSOC Operational Structure in 2016. The operational structure identified an appointed Leadership Board, Implementation Committee, Youth and Family Advisory Councils, five standing statewide work teams and six localized Leadership and Service Delivery Teams. The localized Leadership and Service Delivery Teams are facilitated by the RBHAs. In January of 2019, the NeSOC Leadership Board met to revisit the identified desired outcomes and the governance structure of the NeSOC efforts. The desired outcomes remained relatively unchanged however activities of focus for the next 18 months were identified.
Additionally the governance structure of the NeSOC was changed to be more inclusive of the larger child and family services/supports efforts. To that end, in June 2019, the Leadership Board agreed to both a name change as well as a new charter. The newly created Children’s Impact collective (CIC) replaced the previous Leadership Board. Additionally the Leadership Board decided to increase the frequency of meetings from quarterly to monthly. The Leadership Board also eliminated the implementation committee as the meeting were somewhat duplicative as both meetings/groups consisted of similar participant compositions as well as agendas. The Youth Advisory and Family Advisory Councils remained unchanged. Finally the five standing work teams referenced above have moved to ad hoc work teams which will be called upon by the CIC as needed.

Additionally Nebraska completed a financial investment blue print outlining several areas where cost efficiencies may be found in the youth and family serving systems which could be reinvested into the behavioral health system to development of additional evidence-based services and supports and work force development.

Since implementation of the NeSOC efforts, Nebraska has added capacity to the Professional Partner Program which serves the state through a contract with the behavioral health authorities to provided centralized case management using the Wraparound approach. Additionally, Nebraska has added a state wide mobile crisis support service accessed through a centralized intake line which will connect families with a licensed clinician either in person or via telehealth within one hour. Other highlighted results of the NeSOC efforts include clinical training (expanded capacity in Child and Parent Psychotherapy, Intensive Outpatient Therapy, Mental health services in schools, Multi-systemic Therapy (MST), Parent Child Interaction Therapy, Parents and Children Together, Therapeutic consultation and youth and family peer support. Competency development has been an area focus for the NeSOC efforts. Clinical endorsement training was provided to increase competency among clinicians serving youth with low cognitive disorders and SED. During summer 2019, clinical endorsement training to serve youth with problematic sexual behavior will be provided as will training in the TIP Model. Through the NeSOC efforts the Lead Family Contact (in coordination with the Family Advisory Council) has developed a Family Leadership Academy. The Academy includes a general training as well as a train the trainer option.

7. Does the state have any activities related to this section that you would like to highlight?

Please see Question 6 response concerning the SCIP program and Mobile Crisis Response service.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Footnotes:
Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state’s suicide prevention plan in the last 2 years?  ◯ Yes  ☒ No

2. Describe activities intended to reduce incidents of suicide in your state.

   The 2016-2020 Nebraska State Suicide Prevention Plan provides a framework to help Nebraskans work together to prevent suicide. This plan sets out shared strategies for suicide prevention and sets the stage for action plans created by communities, agencies and organizations across the state. This plan is intended to promote a reduction in the incidents of suicide in Nebraska and will be supported by the Division of Behavioral Health (DBH) and Regional Behavioral Health Authorities (RBHAs). Nebraska’s plan builds on the 2012 National Strategy for Suicide Prevention by embracing an ecological approach to suicide and the organization of goals and objectives in four interconnected strategic directions.

   There are eight key activities identified in this plan to ensure suicide prevention becomes an expected component of service delivery and data collection.

   Healthy Empowered Individuals, Families & Communities

   Strategy 1: Increase Nebraskans’ knowledge of factors promoting wellness and recovery.

   This strategy sets the stage for communities and organizations to come together to make suicide prevention a priority by increasing the factors that protect us from suicide risk. Health promotion and enhancement of pro-social activities (i.e., sharing, helping others, providing support) create connections among people, which in turn decrease suicide risk. Wellness and recovery are supported when communities embrace getting help for mental illness as a sign of strength. This also helps break down the stigma associated with getting mental health treatment.

   Strategy 2: Increase the number of Nebraskans who know warning signs and how to help someone who is at risk for suicide.

   Promoting widespread awareness of suicide warning signs and how to help will increase the likelihood that a person is identified and connected to help early. This strategy creates an understanding that Nebraskans of all ages can make a difference and save a life by knowing what to look for, the questions to ask and resources to help.

   Clinical & Community Prevention Services


   This strategy creates the expectation that every system in Nebraska (education, healthcare, justice, etc.) have suicide prevention as a part of their service, training and culture. Using proven interventions and data collection to move culturally sensitive strategies into the evidence informed category will ensure that Nebraskans are served well.

   Strategy 4: Increase local/regional collaborations addressing health promotion and early prevention.

   Nebraskans regularly come together and collaborate. This strategy expands the focus of new and existing collaborations to include promotion of healthy behaviors and prevention of risk factors for suicide as early as possible. Collaborations are encouraged to embrace the ecological approach by implementing interventions that promote health at all levels (individual, relationships, community, and society). The Nebraska State Suicide Prevention Coalition serves as a networking hub for local coalitions and collaborative groups specifically addressing suicide.
Treatment & Support Services Strategy

Strategy 5: Increase clinical expertise in assessment and management of suicide risk across the state.

Mental health treatment and support services in Nebraska are not readily available in all areas of the state. This strategy addresses the availability and quality of treatment services in Nebraska by insisting that professionals offering mental health services have the knowledge and skill to appropriately assess and manage suicide risk. Clinical settings (mental health, substance abuse and healthcare) are encouraged to adopt practices that move Nebraska closer to the desired outcome of zero suicides.

Strategy 6: Increase availability of crisis management services across the state.

A critical component of suicide prevention is the availability and accessibility of services when someone is in need of them. Crisis intervention, management and support services are prioritized for development or enhancement as part of this strategy. Postvention services (serving survivors immediately after a suicide death) are critical in the aftermath of suicide and serve a crisis management function for survivors. These services are delivered in communities (e.g., Local Outreach to Survivors of Suicide – LOSS – teams) and in organizations such as schools or universities by crisis response teams.

Surveillance, Research and Evaluation Strategy

Strategy 7: Expand the use of regularly collected data to measure progress toward achievement of suicide prevention goals and action plans at all levels (state, regional, local, organizational).

A variety of data is collected and reported locally, regionally and at the state level. This goal encourages use of this data to assess progress toward achieving goals related to suicide prevention that are set at regional or state levels. Incorporating evaluation and tracking protocols in action plans that minimize the burden of data collection by using existing datasets when possible will be more sustainable over time.

Strategy 8: Increase coordination of data dissemination at all levels.

Data is collected and reported in every system (e.g., education, health, justice, etc.) at every level (state, regional, local, organizational). Coordination and agreement of what to track and how to report it will increase evidence informed decision making and the overall understanding of progress made in the area of suicide prevention. Accessible, easily understood reporting should be the goal of data reporting at every level.

Additionally, Nebraska was awarded a Garret Lee Smith Suicide Prevention Grant in 2014 which will end September 2019. The purpose of the Nebraska Youth Suicide Prevention Project was to prevent suicides and reduce the number of suicide attempts for youth ages 10-24. We have served youth across the entire state of Nebraska with two populations of focus: Youth in K-12 Schools (ages 10-21) and Youth at high risk for behavioral health disorders (ages 10-24). The project promoted use of evidence-based practices in suicide prevention for schools, clinical settings, and communities and has supported support web-based or in-person training for 28,055 gatekeepers and clinicians (5,611 annually); suicide risk screening for 5,706 at risk youth (1145 annually); postvention for 500 suicide survivors and attempters (100 annually); and outreach/awareness touching 1.4 million Nebraskans. System change was promoted by working through Nebraska Department of Health and Human Services and RBHAs to ensure youth suicide prevention becomes an expected component of service delivery and data collection.

The goals of the grant were to:

Goal #1. Prevent youth suicides in Nebraska
• 50% of licensed Nebraska clinicians are trained to assess, manage and treat youth at risk
  o There have been a total of 598 behavioral health professionals trained in Assessing and Managing Suicide Risk (AMSR).
  o 52 clinicians have been trained on Collaborative Assessment and Management of Suicidality (CAMs)
• Increase # of at risk youth identified & referred who receive services
  o 28,867 people have been trained in Question, Persuade, Refer (QPR), many of which work in K-12 school settings.
• Reduce the youth suicide rate by 50% in five years
  o Final evaluation will show results for the programs put in place that aim to reduce youth suicide such as means restriction through gun locks and prescription lock boxes as well as a transition program protocol for youth who are admitted to the hospital for a suicide attempt.

Goal #2. Standardized screening protocols are in place for youth at risk for suicide in child serving systems
• 100% of K-12 public school personnel receive youth suicide prevention training
  o 60,543 unique users to the Kognito system for Nebraska.
  o 87,226 total completed pre/post assessments.
• Screening protocols are implemented by regional network providers serving youth with behavioral disorders
  o Through the Professional Partner Screening Program, 2,280 youth were screened resulting in 1,217 youth referred to services
• Screening protocols are adopted by post-secondary settings (campuses, workforce development agencies, specialty services/schools)
Goal #3. Nebraska communities implement culturally appropriate suicide prevention strategies
- 75% of adults in Nebraska report general awareness of signs of suicide and the National Hotline
- Culturally appropriate suicide prevention strategies are supported in each of the six RHBAs in Nebraska
- LOSS postvention teams are available in each of the six RBHAs in Nebraska
  - Nebraska currently has 9 LOSS teams

Although the grant is not ended yet, we believe many of the grant goals have been met; evaluation will be completed following the close of the grant.

3. Have you incorporated any strategies supportive of Zero Suicide?  
   - Yes  
   - No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  
   - Yes  
   - No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?  
   - Yes  
   - No

If so, please describe the population targeted.

Nebraska’s University of Nebraska Public Policy Center was awarded another GLS Suicide Prevention Grant beginning October 2019. The purpose of Nebraska’s project is to reduce the number of suicides and attempts for youth ages 10-24 with a focus on outreach to 15-24 year olds because their suicide rate is increasing in Nebraska, exceeding the US rate. Prevention activities are concentrated in southeast Nebraska because the youth suicide rate for this area is over the state and US rate. We reach the entire state by including suicide prevention in coordinated school health plans for K-12 schools and workforce development for clinicians serving youth in crisis. Nebraska will promote the zero suicide approach for health and behavioral health organizations along with evidence-based strategies and practices to prevent youth suicide. The project has four goals. 1) Decrease the youth suicide rate 80% in RBHA Region V Systems by 2024. 2) 100% of Nebraska public school districts will have policies and protocols in place for suicide prevention, post-suicide intervention, and transition back to school after a suicide crisis by 2024. 3) Twenty (20) Nebraska providers or healthcare systems will implement the zero suicide approach by 2024. 4) 100% of Nebraska’s child serving systems will adopt evidence-based practices to follow-up with youth after a suicide attempt or hospitalization by 2024. During the course of the grant we will reach 70,000 15 to 24-year-olds in RHBA Region V Systems, and embed suicide prevention practices in 244 school districts reaching 187,000 public school students in grades 5-12 statewide. We will train at least 200 clinicians by introducing 30 organizations to the zero-suicide initiative, embed suicide screening with school psychologist services in 17 educational service units and 12 treatment organizations, We will implement evidence-based follow-up after youth experience a suicide crisis in five child serving systems and two healthcare systems, and implement evidence-based post-suicide intervention practices on five post-secondary campuses impacting lives of 40,000 college age students.

In addition to the above mentioned activities, Nebraska’s Department of Education (NDE) is a recipient of SAMHSA’s Project AWARE grant. As a key partner, the DBH is actively involved in grant management and grant implementation activities. Mental Health prevention, promotion, early identification and suicide prevention are all targeted activities within this grant.

Please indicate areas of technical assistance needed related to this section.

None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question
The success of a state’s MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state’s office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state’s ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  
   - Yes  
   - No

2. Has your state identified the need to develop new partnerships that you did not have in place?  
   - Yes  
   - No

If yes, with whom?
DBH provides leadership in the administration, integration and coordination of the public behavioral health system. DBH utilizes a system of care conceptual framework to support cross system activities serving the Nebraska adult and youth systems of care. Services are administered by a variety of different system partners, including the Administrative Office of Probation, DHHS: MLTC, DPH, CFS, DDD and Veterans' Affairs, Nebraska Association of Behavioral Health Organizations, Nebraska Departments of Correctional Services, Education and Insurance, Nebraska Tribes, Nebraska University System, Regional Behavioral Health Authorities, and treatment, prevention and support service providers.

Cross system partnerships at the state level are facilitated through state agency representative membership on advisory committees, including the DBH Joint Advisory Committee (State Advisory Committees on Mental Health and Substance Use Disorder Services) and DBH Prevention Advisory Committee.

Nebraska’s Adult System of Care incorporates this conceptual framework and the associated system of care guiding principles and core values into a spectrum of effective, community-based services and supports that is organized within a coordinated system of care network.

DBH works through and in partnership with six Regional Behavioral Health Authorities (RBHAs) to carry out its charge to support a coordinated system of care approach to children and youth services. The RBHAs have structures and mechanisms to support a coordinated system of care approach to support recovery and resilience of children and youth with behavioral health needs. The RBHAs develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS Divisions of Children and Family Services.
System partners include public agencies and private organizations, including state and local governmental agencies, Tribal organizations, private organizations and individuals and families. The Nebraska System of Care (NeSOC) Leadership Board is led by the Nebraska Department of Health and Human Services (DHHS) Chief Executive Officer.

System partners include:

• DHHS – Division of Behavioral Health
• DHHS – Divisions and Office of:
  o Children & Family Services
  o Development Disabilities
  o Medicaid & Long-Term Care
  o Office of Health Disparities
• Nebraska Judicial System - Administrative Office of the Courts
• Nebraska Judicial System - Administrative Office of Probation
• Nebraska Judicial System - Court Improvement Project
• Nebraska Children’s Commission
• Family Organizations
  o Speak Out
  o Families Care
  o Parent to Parent Network
  o Families Inspiring Families
  o Healthy Families Project
  o Nebraska Family Support Network
• Youth Partners
• Family Partners
• Nebraska Children and Families Foundation
• Omaha Tribe of Nebraska
• Ponca Tribe of Nebraska
• Santee Sioux Nation
• Winnebago Tribe of Nebraska
• Tribal Society of Care (Inter-tribal initiative led by Santee Sioux Nation)
• Nebraska Department of Education
• Regional Behavioral Health Authorities
• MCOs – Heritage Health (3)
• Behavioral Health Education Center of Nebraska (BHECN)
• UNL Public Policy Center

The Division of Behavioral Health developed three new Memoranda of Understand (MOUs) and nine contracts with the following system partners.

MOUs:
State of Nebraska Judicial Branch – Nebraska Probation System
DHHS Medicaid & Long-Term Care
DHHS Children & Family

Services Contracts:
University of Nebraska Public Policy Center
RBHA Region 1 Behavioral Health Authority
RBHA Region II Health Services
RBHA Region 3 Behavioral Health Services
RBHA Region 4 Behavioral Health System
RBHA Region 5 V Systems
RBHA Region 6 Behavioral Healthcare
Behavioral Health Education Center of Nebraska

Sharon Darylmple - Family Lead Contact

System of Care in Nebraska has worked towards

<> Operationalizing the strategies for system coordination across state, regional and local leadership teams and workgroups.
<> Implementing a phased work plan.
<> Developing and implementing a communication plan to educate partners, families and stakeholders.

The DBH and the DHHS Division of Medicaid and Long Term Care (MLTC) comprise the largest funders within the public behavioral health system. Coordination of activities and alignment of priorities across these two divisions is critical to ensuring appropriate
resource allocation. The DBH and MLTC have continued to work together on system initiatives including but not limited to:

- State Targeted Response (STR) to the Opioid Crisis Grant in partnership with DHHS Division of Public Health
- Prescription Drug Monitoring Program prevention and workforce capacity with DHHS Division of Public Health
- NeSOC
- Peer Support service development
- Improving access to care through telehealth service delivery
- Parity review activities, and
- Ongoing review of service expectations for those services that are available through each funding stream.

Additionally, through new Memoranda of Understanding, the DBH and MLTC will share specific utilization data to better understand the utilization of services across these funding streams. Additional MOUs include a new functionality within the DBH Centralized Data System to allow for Medicaid eligibility data to be auto-checked on service authorization requests; this will help to ensure that providers who serve both Medicaid and non-Medicaid eligible services are billing the appropriate system. On January 1, 2017, the MLTC also implemented Heritage Health, a new managed care system that integrates physical health, behavioral health and pharmacy benefits. The DBH has been working closely with Heritage Health managed care vendors to ensure a smooth transition, identify joint needs and coordinate initiatives.

The Cross Division Solutions Team (CDST) was developed by Department of Health and Human Services Chief Executive Officer to find solutions for individuals and/or families who have complex issues and who may need services or supports from multiple Divisions within DHHS. Prior to this team, Divisions did not have a direct venue to work together on cases. The Divisions of Behavioral Health, Children and Family Services, Developmental Disabilities, and Medicaid and Long-Term Care, as well as Legal Services and Internal Audit meet weekly to review these cases. The Division of Public Health is involved as needed. Referrals for the CDST come from the DHHS CEO, the Division Directors, Ombudsman’s office, senators’ offices, and other system partners. Key individuals from each Division have been chosen by the various Division Directors to be members of the Cross-Division Solution Team. The members of the CDST meet weekly to review the case referrals, and as a whole, develop solutions to meet the needs of individuals and families. The members take a “can do” approach and think out of the box without going outside of the Department rules and regulations. The goals of the CDST are: Evaluate each individual’s and/or family’s complex needs to determine how the Divisions can work together to increase accessibility, identify system gaps and make recommendations resulting in better outcomes and increase participant knowledge on available services provided within the Department.

The DBH has been working closely with the Division of Developmental Disabilities (DDD) to provide continuity of care. The DDD has a monthly meeting with their key stakeholders (i.e. family of persons served, senators, providers, persons served) to inform them of the important topics that are occurring within the DDD and across DHHS. The DBH goes and presents important changes, trainings and the work DBH has been doing for that particular month.

In support of DBH’s goals to reduce the suicide rate for veterans, a newer relationship in the last includes the University of Nebraska-Lincoln Military & Veteran Success Center. The Center is dedicated to helping veterans, active duty military, and their families, achieve success in their pursuit of a degree from UNL while providing a network of support, and friendship on and off campus. DBH has shared a variety of training opportunities with Center staff targeting clinicians, peers, and general awareness efforts. Through this work, DBH is also working closer with the newly restructured Nebraska Department of Veterans Affairs and partnered in September of 2016 to sponsor an In-State Policy Academy with the Service Members, Veterans, and their Families (SMVF) Technical Assistance (TA) Center. This facilitated discussion helped to identify behavioral health issues facing SMVF and explore integrating planning efforts.

DBH is collaborating with the DHHS Division of Public Health on several initiatives.

1. State Targeted Response (STR) to the Opioid Crisis Grant in partnership with MLTC
2. Prescription Drug Monitoring Program prevention and workforce capacity with MLTC

Collaborative efforts continue to support the work of PDMP partners in prescription drug overdose prevention. This has included prescriber and dispenser in-person, live webinar, and on-demand training (mandatory training was required on 5/10/2017), ongoing PDMP user registration, and increased access and use of the PDMP by medical professionals.

In 2019, the state began exploring interstate data sharing, and looking at expanding capabilities for integration and trying to promote and support interoperability, which is being encouraged at the federal level. Providers will be required to query PDMPs when prescribing controlled substances for Medicaid and Medicare patients starting in 2020.

For more information please see:
http://dhhs.ne.gov/Pages/Drug-Overdose-Prevention-Resources.aspx and
http://dhhs.ne.gov/Pages/Drug-Overdose-Prevention-PDMP-Reporting.aspx

DBH has expanded its collaboration with the Nebraska Judicial System - Administrative Office of Probation to begin exploring opportunities for information exchange across data systems to address efficiency in service utilization and funding and avoidance of duplication of services. These discussion include building a data interface with the DBH Centralized Data System.
The Nebraska Injury Prevention Program (NIPP) is a Centers for Disease Control and Prevention funded Core Violence and Injury Prevention Program and is working toward a safe and injury-free life for all Nebraskans. The NIPP works cooperatively with the Division of Behavioral Health on a number of initiatives including in suicide prevention, prevention efforts related to underage drinking and education efforts related to prescription drug overdose.

DBH has expanded its collaboration with the Nebraska Health Information Initiative (NeHII) to include participation in broader technology discussions, for example, DBH technology capacity to interact with information exchanges and interfaces.

DBH has created new collaborations with the Behavioral Health Education Center of Nebraska (BHECN) to grow the workforce of professionals who address mental health and substance use disorders treatment in order to provide improved access to prevention, treatment, and recovery services. These include:

- BHECN offers training programs to introduce high school and college students to mental health and substance use treatment centers. Graduate students pursuing such careers rotate among rural hospitals in North Platte, Hastings and Kearney.
- The University of Nebraska Medical Center (UNMC) and Creighton University School of Medicine have adjusted their training of family practice physicians and staff, incorporating behavioral health instruction. Behavioral health care providers are increasingly working in primary care settings across the state, to provide more coordinated care.
- Counseling and psychology interns are working in 24 rural primary care clinics that have behavioral health services integrated into patients’ overall care.
- New ECHO telehealth are being funded with opioid targeted response grant funds to expand statewide education related to pain management and substance use treatment, including medication assisted treatment.
- UNMC and Children’s Hospital & Medical Center (Children’s) are expanding their use of telehealth to increase the availability of behavioral health services for older and younger patients. UNMC telehealth services help fill the state’s shortage of mental health physicians by having its psychiatric team conduct virtual visits to 80 nursing homes and a few assisted-living facilities and community sites. More than 450 virtual visits take place each year. As new UNMC-trained doctors start practicing in less-populated parts of the state, the network is expected to expand as they tap into the lifeline to psychiatric services on the main campus. Children’s is working with primary care providers to schedule virtual visits for better and faster access to behavioral health care for younger children. More than 200 virtual visits are taking place annually.
- BHECN is expanding its footprint in rural Nebraska to support efforts to increase retention of behavioral health providers, recruitment and establishing a statewide network of behavioral health providers. In May 2018, BHECN hosted the inaugural Rural Provider Support Network Conference in Scottsbluff, located in the Nebraska Panhandle. In 2015, BHECN opened the BHECN office at the University of Nebraska – Kearney, a rural hub in central Nebraska.

Project AWARE
In September 2018, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) awarded the State of Nebraska the Project AWARE (Advancing Wellness and Resilience in Education) - State Education Agency (SEA) grant. This five year program supports the development and implementation of a comprehensive plan of activities, services, and strategies to decrease youth violence and support the healthy development of school-aged youth.

Nebraska’s AWARE-SEA Project is being jointly undertaken by the Nebraska Department of Education (NDE) and Nebraska Department of Health and Human Services – Division of Behavioral Health (DBH) to build and enhance partnerships and collaboration between State and local systems. The project focuses on the high level of mental and behavioral health needs of school-age children in rural schools, including depression, anxiety, suicide ideation, trauma, and substance use. Educators statewide feel unprepared to handle the severity of mental health issues arising daily in schools. Training for school staff to better address students’ mental and behavioral health needs has been identified as a critical priority.

In response, NDE and DBH are partnering at the State level to collaborate with the three Local Education Agencies (LEAs) to improve school-based mental health services. The LEAs of Chadron, Hastings, and South Sioux City are demographically and geographically diverse, with varying levels of poverty and scarcity of mental health resources. Two sites have higher free/reduced lunch rates, indicative of poverty and student mobility. Each differs in racial/ethnic composition, with higher proportions of Hispanic and Native American students. All three LEAs have strong, long-standing track records of successful collaborations with State and local partners, including mental health providers, community coalitions, civic organizations, the business and private sector, and stakeholders, including students and families.

This project is intended to build and expand the capacity of the NDE, in partnership with the DBH and the three LEA Site partners, to:
- Prevent the development of mental health and behavioral disorders among students by providing a positive, supportive, and trauma-informed learning environment.
- Increase awareness of mental health issues among school-aged youth and skills fostering resilience and pro-social behaviors through strength-based approaches and social-emotional learning.
- Increase the school-based mental health services available and connect students with mental health issues and their families to the appropriate services.
- Increase schools’ capacity to identify and immediately respond to the mental health needs of students exhibiting behavioral or psychological signs requiring clinical intervention.
• Increase schools’ capacity to identify and intervene in bullying and aggressive or violent behaviors of students that may contribute to school violence.

The strong collaborative relationship already established between NDE and DBH puts Nebraska’s AWARE Project in a unique position to build upon infrastructure created through the NeSOC Initiative. NDE has representatives on NeSOC’s Leadership Board, Implementation Committee and all work teams, ensuring cohesive alignment and coordinated implementation across both SAMHSA-funded initiatives. The AWARE Project Directors also serve on the Governor’s School Safety Task Force, Legislature’s Children Commission, Nebraska Joint Juvenile Justice Coalition / Juvenile Services Committee, Supreme Court Commission on Children in the Courts, ESU Coordinating Council’s School-Mental Health Committee, and NDE’s Facility-Based Schools Community of Practice.

Nebraska Psychiatric Bed Registry Pilot Project with RBHA Region 6 Behavioral Healthcare

Nebraska was selected as one of 23 states in a new crisis intervention registry project designed to reduce the time those with an acute psychiatric emergency wait to admit into inpatient psychiatric beds. The registry funding is a joint project between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD). Nebraska is the only state in the Midwest to have been selected.

Nebraska’s registry will be piloted in the state’s most populous RBHA, Region 6 Behavioral Healthcare, which includes Cass, Dodge, Douglas, Sarpy and Washington counties in eastern Nebraska. Region 6 Behavioral Healthcare has a diverse mix of publicly contracted hospitals and private hospitals that afford the opportunity to capture capacity issues and process variables. Data from the pilot will be used to analyze the bed capacity, workforce, and system barriers to access. In addition, the data will be used to inform policy decisions about alternate payment models such as value-based contracting and innovations to payment structures supporting efficient service delivery. Nebraska’s registry will have the opportunity to learn from best practices from the other 22 states developing crisis intervention registry projects.

The planning process began in the spring of 2019. The DBH and Region 6 Behavioral Healthcare have developed a workgroup, which will include representatives from the RBHA, DHHS, local emergency departments, public and private hospitals, law enforcement, behavioral health providers, county attorneys, community stakeholders and consumers with lived experience. The workgroup will develop a centralized, real-time system to track inpatient beds and assess capacity for inpatient psychiatric beds in the area.

Through the registry, the workgroup hopes to reduce the time that consumers wait at emergency departments for acute beds once the determination has been made that the consumer needs acute care, improve communication between emergency departments and acute hospitals, identify system issues such as placement of consumers with high needs such as violence, staffing issues, and increase consistency in capacity data reporting.

The current projection is that the pilot will be implemented in Region 6 Behavioral Healthcare during the summer of 2019.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Nebraska Division of Behavioral Health Nebraska System of Care (NeSOC) integrates the state educational system as a cornerstone in its work. The NeSOC connects and coordinates the work of State child-serving agencies, nonprofit and local governments, behavioral health care providers, families and patient advocates. It helps children, youth, and families function better at home, in school, in the community, and in life.

In 2013-2014, over 1,000 families, youth, service providers and other stakeholders were involved in the development of a System of Care Strategic Plan. The Nebraska Department of Health and Human Services - Division of Behavioral Health received a grant in 2016 to expand and sustain the System of Care. Partners from across the state are working to implement the elements which were identified through the System of Care strategic plan.

The state-level leadership team actively engages with multiple state agency offices to improve overall state infrastructure in order to globally enhance the state’s capacity to improve access and service provision to children and youth and families. This work includes the representatives of partners serving as members and representatives on the Nebraska State Advisory Committee on Mental Health Services.

The educational system is often the first system families turn to when they have concerns about their children’s social emotional development or behavioral health. Additionally, the education system provides strong ongoing support to youth and their families. The NeSOC is building upon existing relationships with the Nebraska Department of Education as well as local school districts and the educational service units. Partners from the education field are embedded throughout the NeSOC governance structure serving on the Leadership Board, Implementation Committee and all five work teams.

As stated above, DBH is actively engaged in the implementation and management of the Project AWARE grant in partnership with the Nebraska Department of Education.
Please indicate areas of technical assistance needed related to this section.

None at this time.

Footnotes:
Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question
Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning council members monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

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Please consider the following items as a guide when preparing the description of the state’s system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

      The Division of Behavioral Health administers, oversees, and coordinates the state’s public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The Nebraska Behavioral Health Services Act is the enabling legislation which mandates the Division of Behavioral Health (DBH) role’s as the chief behavioral health authority for the State of Nebraska. This legislation also established the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. When meeting in joint session, the two advisory committees serve as a joint behavioral health advisory committee.

      The joint committee continues its active involvement in the state plan guiding the public health behavioral system by providing advice and assistance to the DBH on the ongoing planning efforts that inform and shape planning at state, regional, and local levels. This includes guiding review of behavioral health strategic plan initiatives, needs assessments, consumer surveys, results-based accountability, continuous quality improvement and other efforts guiding activities across the systems, and prioritization of state planning activities in the state application.

      August 23, 2018 Joint Committee Meeting
      Meeting topics included: 2019 Legislative Update, Director’s Update including DBH Business Plan and Dashboards, SAMHSA Combined Block Grant Mini-Application updates, review and recommendation to seek a plan modification to Planning Table 1, SMART Recovery presentation, input/feedback regarding Medicaid’s Peer Support Service Definition proper vs. Peer Support Services to enhance recovery.

      November 15, 2018 Joint Committee Meeting
      Meeting topics included: Director’s Update including NeSOC and Project AWARE and Behavioral Health Resource Guide for Schools, DBH and Governor’s Dashboard tracking data focused on areas aligned with the Governor’s priorities as best applicable to DBH with JAC recommendation(s), review of the draft Block Grant Mental Health and Substance Abuse Implementation Report with updates, draft FY2020 Synar Report, Consumer employment - statistics and work as both recovery and intervention and recommendations on prioritization of Supported Employment action items.

      April 4, 2019 Joint Committee Meeting
      Meeting topics included: Transfer Technology Initiative grant with focus on crisis response and bed capacity in RBHA 6, SAMHSA and GAINS Center learning collaborative on competency restoration, Disaster Behavioral Health impact due to March storm events, Recommendations for budgeting training and technical assistance, Peer Support Certification activity,
CFS presentation on Family First Prevention Services Act initiative, DBH Needs Assessment review of current and discussion on future needs.

August 29, 2019 Joint Committee Meeting
Meeting topics included: DBH Director Update; Nebraska Combined FFY 2020-2021 MH/SA Block Grant Application – Review and recommendations on the Needs Assessment, Application; Priority Areas (Comments on the state block grant plan as attachment.); Disaster Behavioral Health Recovery activity of ISP and RSP. See Attachment to C.21.: JAC comment on the State Plan – Combined FFY2020-2021 MH/SA Block Grant Application.

The DBH web page URL for Joint Advisory Committee meeting agenda and minutes is: http://dhhs.ne.gov/Pages/Advisory-Committees-on-Mental-Health-and-Substance-Abuse.aspx

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?  

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

2. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Nebraska Revised Statute 71-814 (2) establishes the responsibilities and duties of the State Advisory Committee on Mental Health Services: “The committee shall be responsible to the division and shall (a) serve as the state’s mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division.”

Nebraska Revised Statute 71-815 (2) establishes the responsibilities and duties of the State Advisory Committee on Substance Abuse Services: “The committee shall be responsible to the division and shall (a) conduct regular meetings, (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska, (c) promote the interests of consumers and their families, (d) provide reports as requested by the division, and (e) engage in such other activities as directed or authorized by the division.”

Committee meetings include two opportunities (near the beginning and the end of meetings) for public comment regarding discussions and issues that are before the committees. Throughout the day, committee members are engaged in discussion of agenda items and following each topic committee members are asked for recommendations to the DBH regarding actions or next steps for the DBH to consider when moving forward in each respective area. All committee members have equal voice/vote in committee recommendations. Administrative staff from DBH, including representatives of the Office of Consumer Affairs, attend meetings to listen to committee discussion as well as public comment for a better understanding of committee perspective.

A lunch presentation during each meeting typically revolves around individuals with lived experience sharing successes, barriers and challenges in their individual roads to recovery. This keeps the consumer perspective in front of the committee as well as DBH staff, and allows successes and challenges to have “face” to support the reality of challenges and to highlight active recovery experiences for those we serve.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷⁰

Footnotes:

⁷⁰There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Comment on the State Plan – Nebraska Combined FFY 2020-2021 Block Grant Application

The Substance Abuse Mental Health Services Administration (SAMHSA) provides for a combined application for the Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG).

The Nebraska Department of Health and Human Services Division of Behavioral Health (DBH) invited public comment on the development and content of the Nebraska State Plan - SAMHSA Combined FFY 2020-2021 Block Grant Application.

The Division of Behavioral Health administers, oversees, and coordinates the state’s public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The Nebraska Behavioral Health Services Act is the enabling legislation which mandates the Division of Behavioral Health (DBH) role’s as the chief behavioral health authority for the State of Nebraska. This legislation also established the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. When meeting in joint session, the two advisory committees serve as a behavioral health advisory council.

The joint committee continues its active involvement in the state plan guiding the public behavioral health system by providing guidance to the DBH on the ongoing planning efforts that inform and shape implementation at State, regional, and local levels. This includes guiding review of behavioral health strategic plan initiatives, needs assessments, consumer surveys, Results-based Accountability, Continuous Quality Improvement and other efforts across the system. They also assist in prioritization of state planning activities in the state block grant application.

Recent activities include:

<> August 23, 2018 Joint Committee Meeting

Meeting topics included: 2019 Legislative Update, Director’s Update including DBH Business Plan and Dashboards, SAMHSA Combined Block Grant Mini-Application updates, review and recommendation to seek a plan modification to Planning Table 1, SMART Recovery presentation, input/feedback regarding Medicaid’s Peer Support Service Definition proper vs. Peer Support Services to enhance recovery.

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Meeting topics included: Director’s Update including NeSOC and Project AWARE and Behavioral Health Resource Guide for Schools, DBH and Governor’s Dashboard tracking data focused on areas aligned with the Governor’s priorities as best applicable to DBH with JAC recommendation(s), review of the draft Block Grant Mental Health and Substance Abuse Implementation Report with updates, draft FY2020 Synar Report, Consumer employment - statistics and work as both recovery and intervention and recommendations on prioritization of Supported Employment action items.

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Meeting topics included: Transfer Technology Initiative grant with focus on crisis response and bed capacity in RBHA 6, SAMHSA and GAINS Center learning collaborative on competency
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<> August 29, 2019 Joint Committee Meeting

Meeting topics included: DBH Director Update; Nebraska Combined FFY 2020-2021 MH/SA Block Grant Application – Review and recommendations on the Needs Assessment, Application; Priority Areas (Comments on the state block grant plan below.); Disaster Behavioral Health Recovery activity of ISP and RSP. See Attachment to C.21.: JAC comment on the State Plan – Combined FFY2020-2021 MH/SA Block Grant Application.

The DBH web page URL for Joint Advisory Committee meeting agenda and minutes is: http://dhhs.ne.gov/Pages/Advisory-Committees-on-Mental-Health-and-Substance-Abuse.aspx

Comments Received from Joint Committee Meeting August 29, 2019

State Advisory Committee on Mental Health Services & State Advisory Committee on Substance Abuse Services - The Joint Committee - Meeting agendas and minutes are posted at:

http://dhhs.ne.gov/Pages/Advisory-Committees-on-Mental-Health-and-Substance-Abuse.aspx

The focus of the August 29, 2019 meeting was to review Nebraska’s Behavioral Health Disaster Response, the block grant planning steps, and block grant Priority Areas and Annual Performance Indicators. The seven priority areas are 1) SAP: Alcohol use Among Youth and Young Adults, 2) SAP: Increase Use of Evidence-based Strategies, 3) SAT, MHS: Consumers in Stable Living Arrangements, 4) SAT, MHS: Consumer Employment, 5) SAT: Access for Priority Populations to Substance Use Disorder Services, 6) MHS: First Episode Psychosis, and 7) SAT: Tuberculosis

No recommendations were put forward by the committees. Members’ comments received on the block grant application and planned activities presentation are reported below.

<> Support aggressive target outcomes for employment but concerned about possible effect of existing Vocational Rehabilitation Order of Selection process.

<> First Episode of Psychosis (FEP) teams’ collaboration with substance abuse professionals or use of dual licensed professionals is an important consideration for the teams, given substance abuse complicates diagnosis.

<> Additional attention should be paid to Binge Drinking behavior, as surveyed by BRFSS, particularly information to assist with understanding the frequency of binge drinking and a spectrum of number of drink consumed.

<> Prevention activities should include additional attention on drinking itself in addition to binge drinking. This should include more education on what constitutes binge drinking, and activities related to awareness among young adults.

<> Prevention messaging should be designed with consideration of the whole person – at various age groups - wherever they are on the spectrum of use. And, both prevention and treatment messaging should be delivered to targeted audiences on the diverse media platforms, for example, X-Box and other gaming portals.
With whom is information developed through the BRFSS shared? Is the information available on a local level for area coalitions’ prevention planning activities?

Incorporating additional advisory groups composed of youth and young adults would be useful when planning and developing prevention and treatment messaging activities.

Comments Received from On-Line Posting of Draft Application.

On August 21, 2019, the following email was sent to DBH audiences and Listserv groups for dissemination to the larger stakeholder body. More than 1,350 individuals received the email directly, including members of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services, state Prevention Advisory Council, Peoples Council, Family Organizations, Certified Peer Specialists, Regional Behavioral Health Authorities, Preventionist listserv, NBHS Network Providers via the DBH Centralized Data System listserv.

-Start Notice Sent-

Please be aware we will be sending out emails to multiple contact lists and list serves so I apologize in advance if you receive multiple copies of this e-mail.

Nebraska has been invited to submit an application to the Federal Substance Abuse Mental Health Services Administration (SAMHSA) for the Uniform FFY 2020-2021 Block Grant Application for Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant. This is an application for SAMHSA’s Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SAPTBG) as authorized by sections 1911-1920 of Title XIX, Part B, Subpart I of the Public Health Service Act (42 U.S.C.§§ 300x-300x-9) and sections 1921-1935 of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C.§ 300x-21-35), respectively, and sections 1941-1956 of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§§ 300x-51-66).

Public Comment is welcomed on Nebraska State Application for SAMHSA Uniform FFY 2020-2021 MHBG and SAPTBG. The application will be due September 3, 2019. Opportunities to review and comment on this application include:

- The draft of the Nebraska State Application for SAMHSA Uniform FFY 2020-2021 MHBG and SAPTBG will be posted to the Division of Behavioral Health website: http://dhhs.ne.gov/Pages/Behavioral-Health.aspx
- Comment may be made by clicking on the Nebraska DRAFT FFY 2020/21 Uniform Block Grant Application link which includes a cover page with additional links for Public Comment, a Survey for comments, and reference documents that may be of interest.
- Attendance at the Joint State Advisory Committee on Mental Health Services and State Advisory Committee on Substance Abuse Services. The application will be reviewed meeting on August 29, 2019 from 9:00 a.m. to 2:00 p.m. at the Country Inn and Suites, 5353 No 27th Street, Lincoln, NE. The latest Meeting Agenda information is found here: http://dhhs.ne.gov/Pages/Advisory-Committees-on-Mental-Health-and-Substance-Abuse.aspx. Comments will be accepted at the designated times during the meeting. To make public comments at this meeting, please sign up on the Public Comment Sign-in List sheet available at the meeting located at the entrance of the meeting room.
Comments will be accepted up to five (5) days prior to the due date noted above for the grant application. Please send written comments by US Mail or e-mail to the Nebraska Department of Health and Human Services, Division of Behavioral Health.

John Trouba – Federal Aid Administrator
John.Trouba@nebraska.gov
Nebraska Department of Health and Human Services
Division of Behavioral Health
301 Centennial Mall South, 3rd Floor
PO Box 95026
Lincoln, NE 68509-5026

On the morning of August 21, 2019 the draft of the Nebraska application for the Nebraska State Plan - SAMHSA Combined FFY 2020-2021 Block Grant Application was posted on the DBH website. The comment period officially on August 30, 2019.

The link to the Block Grant Application page was on the DBH main page. The link to this web page is: http://dhhs.ne.gov/Pages/Behavioral-Health.aspx

The person could click on a web link titled Nebraska FY2020-2021 Combined MH & SA Block Grant DRAFT Application. While visiting the web site, the visitor was given the option to click on a survey to record comments. At the time of submission of the application, there were no responses to the Survey Monkey survey. The survey, along with the submitted application, will be maintained on the DBH website until grant award. The survey included four questions, including free-form text responses, are identified below.

Survey Monkey: 2020-2021 Block Grant Application Feedback: Please submit your feedback to us.

Q1. After reviewing the Block Grant application draft, do you expect that the priorities identified below will improve the state behavioral health system?

<table>
<thead>
<tr>
<th>Question</th>
<th>Response (Yes; No; Possibly; Undecided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of binge drinking among youth and young adults</td>
<td></td>
</tr>
<tr>
<td>Increase the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use</td>
<td></td>
</tr>
<tr>
<td>Increase support for consumers to secure and maintain permanent housing</td>
<td></td>
</tr>
<tr>
<td>Increase support for consumers to sustain and acquire employment</td>
<td></td>
</tr>
<tr>
<td>Increased access to community-based services for priority populations</td>
<td></td>
</tr>
<tr>
<td>Increase the number of persons admitted into treatment for first-episode psychosis</td>
<td></td>
</tr>
<tr>
<td>Referral to services for persons with tuberculosis</td>
<td></td>
</tr>
</tbody>
</table>

Q2. If you answered “No” to any of the items above, please explain:

Q3. Are there any other outcome measures that will help us to know the system is improving for each of the priority areas? (Text Box Responses)

Prevention of binge drinking
Use of evidence-based services

Support for consumers to secure and maintain permanent housing

Support for consumers to sustain and acquire employment

Access to community-based services for priority populations

Persons experiencing first-episode psychosis

Tuberculosis

Q4. What other comments, concerns, recommendations, or suggestions do you have for our consideration? (Text Box Responses)

No other comments were received via other media up to the time of grant submission. The submitted application will be uploaded to replace the draft application on the DBH website; the survey will be maintained on the DBH website, too, until grant award.
Environmental Factors and Plan

Advisory Council Members
For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership*</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email(if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Ann Borgeson (MH)</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td></td>
<td>12503 Anne Street Omaha NE, 68137 Ph: 402-444-6413</td>
<td><a href="mailto:Maryann.borgeson@douglascounty-ne.gov">Maryann.borgeson@douglascounty-ne.gov</a></td>
</tr>
<tr>
<td>Jeffrey Courtier (SA)</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td></td>
<td>1413 16th Avenue Scottsbluff NE, 69361 Ph: 308-632-6845</td>
<td><a href="mailto:jeff@therockne.com">jeff@therockne.com</a></td>
</tr>
<tr>
<td>Margaret Damme (MH)</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>6433 Havelock Avenue Lincoln NE, 68507 Ph: 402-326-1875</td>
<td><a href="mailto:megd@freshstarthome.org">megd@freshstarthome.org</a></td>
</tr>
<tr>
<td>Suzanne Day (MH)</td>
<td>State Employees (Individuals in Recovery (to include family members of adults with SMI))</td>
<td>Dept of Education, Office Voc Rehab</td>
<td>13106 Hamilton Street Omaha NE, 68154 Ph: 402-699-5447</td>
<td><a href="mailto:Suzanne13106@hotmail.com">Suzanne13106@hotmail.com</a></td>
</tr>
<tr>
<td>Lindy Foley (MH)</td>
<td>Persons in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Dept of Education, Office Voc Rehab</td>
<td>301 Centennial Mall South, 6th Floor Lincoln NE, 68509 Ph: 402-471-3644</td>
<td><a href="mailto:lindy.foley@nebraska.gov">lindy.foley@nebraska.gov</a></td>
</tr>
<tr>
<td>Victor Gehrig (SA)</td>
<td>Persons in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Dept of Education, Office Voc Rehab</td>
<td>304 East 9th Street Gordon NE, 69343 Ph: 308-282-1101</td>
<td><a href="mailto:vgehrig@gpcom.net">vgehrig@gpcom.net</a></td>
</tr>
<tr>
<td>Jacob Hausman (MH)</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>8919 South 67 Street Papillion NE, 68133 Ph: 402-371-2745</td>
<td>8919 South 67 Street Papillion NE, 68133 Ph: 402-371-2745</td>
<td><a href="mailto:hausman.jacob@gmail.com">hausman.jacob@gmail.com</a></td>
</tr>
<tr>
<td>Laurie Holman (MH)</td>
<td>State Employees</td>
<td>Nebraska Crime Commission</td>
<td>301 Centennial Mall South, 5th Floor Lincoln NE, 68509 Ph: 402-471-2259</td>
<td><a href="mailto:laurie.holman@nebraska.gov">laurie.holman@nebraska.gov</a></td>
</tr>
<tr>
<td>Jay Jackson (SA)</td>
<td>Persons in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>30612 205th Avenue Columbus NE, 68601 Ph: 402-562-3755</td>
<td>30612 205th Avenue Columbus NE, 68601 Ph: 402-562-3755</td>
<td><a href="mailto:jayjack@jackson-services.com">jayjack@jackson-services.com</a></td>
</tr>
<tr>
<td>Kristen Larsen (MH)</td>
<td>State Employees</td>
<td>DHHS Div Public Health</td>
<td>301 Centennial Mall South Lincoln NE, 68509 Ph: 402-471-0143</td>
<td><a href="mailto:Kristen.Larsen@nebraska.gov">Kristen.Larsen@nebraska.gov</a></td>
</tr>
<tr>
<td>Name</td>
<td>Membership Type</td>
<td>Affiliation and Description</td>
<td>Address</td>
<td>Contact Email</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Phyllis McCaul</td>
<td>MH</td>
<td>Parents of children with SED/SUD</td>
<td>933 A Street Lincoln NE, 68502</td>
<td><a href="mailto:pmccaul@region5systems.net">pmccaul@region5systems.net</a></td>
</tr>
<tr>
<td>Diana Meadors</td>
<td>SA</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>24224 Martin Avenue Valley NE, 68064</td>
<td><a href="mailto:dmeadors@heartprograms.com">dmeadors@heartprograms.com</a></td>
</tr>
<tr>
<td>Pamela Otto</td>
<td>MH</td>
<td>State Employees Dept of Econ Dev - Div Community and Housing</td>
<td>301 Centennial Mall South, 4th Floor Lincoln NE, 68509</td>
<td><a href="mailto:Pamela.otto@nebraska.gov">Pamela.otto@nebraska.gov</a></td>
</tr>
<tr>
<td>Ashley Pankonin</td>
<td>MH</td>
<td>Parents of children with SED/SUD</td>
<td>33060 Road 769 Grant NE, 69140</td>
<td><a href="mailto:ashleypankonin@gmail.com">ashleypankonin@gmail.com</a></td>
</tr>
<tr>
<td>Amy Rhone</td>
<td>MH</td>
<td>State Employees Dept of Education - Special Education</td>
<td>301 Centennial Mall South, 6th Floor Lincoln NE, 68509</td>
<td><a href="mailto:amy.rhone@nebraska.gov">amy.rhone@nebraska.gov</a></td>
</tr>
<tr>
<td>Nancy Rippen</td>
<td>MH</td>
<td>Providers</td>
<td>2205 Norris Avenue McCook NE, 69001</td>
<td><a href="mailto:nancyrippen@r2hs.com">nancyrippen@r2hs.com</a></td>
</tr>
<tr>
<td>Daniel Rutt</td>
<td>SA</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>835 South Burlington Street Hastings NE, 68901</td>
<td><a href="mailto:dan@reviveinc.org">dan@reviveinc.org</a></td>
</tr>
<tr>
<td>Ashley Sacriste</td>
<td>MH</td>
<td>State Employees DHHS Div of Behavioral Health - LRC</td>
<td>Folsom and West Prospector - LRC Lincoln NE, 68509</td>
<td><a href="mailto:Ashley.Sacriste@nebraska.gov">Ashley.Sacriste@nebraska.gov</a></td>
</tr>
<tr>
<td>Stacey Scholten</td>
<td>MH</td>
<td>State Employees DHHS Div Children &amp; Family Services</td>
<td>301 Centennial Mall South, 3rd Floor Lincoln NE, 68509</td>
<td><a href="mailto:stacey.scholten@nebraska.gov">stacey.scholten@nebraska.gov</a></td>
</tr>
<tr>
<td>Carisa Schweitzer Masek</td>
<td>MH</td>
<td>State Employees Nebraska Medicaid &amp; Long-Term Care</td>
<td>301 Centennial Mall South, 5th Floor Lincoln NE, 68509</td>
<td><a href="mailto:Carisa.SchweitzerMasek@nebraska.gov">Carisa.SchweitzerMasek@nebraska.gov</a></td>
</tr>
<tr>
<td>Randy See</td>
<td>SA</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Hall County Juvenile Services Grand Island NE, 68801</td>
<td><a href="mailto:randy.see@hallcountyne.gov">randy.see@hallcountyne.gov</a></td>
</tr>
<tr>
<td>Mary Thunker</td>
<td>MH</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>8911 Decatur Street Omaha NE, 68114</td>
<td><a href="mailto:mthunker@gmail.com">mthunker@gmail.com</a></td>
</tr>
</tbody>
</table>

*Council members should be listed only once by type of membership and Agency/organization represented.

**Footnotes:**

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults with SMI)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Parents of children with SED/SUD*</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Vacancies (Individuals and Family Members)</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Others (Advocates who are not State employees or providers)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Representatives from Federally Recognized Tribes</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total Individuals in Recovery, Family Members &amp; Others</td>
<td>19</td>
<td>54.29%</td>
</tr>
<tr>
<td>State Employees</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Total State Employees &amp; Providers</td>
<td>16</td>
<td>45.71%</td>
</tr>
<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

Footnotes:

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Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

**Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51)** requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings?  
      ✐ Yes  ☐ No

   b) Posting of the plan on the web for public comment?  
      ✐ Yes  ☐ No

      If yes, provide URL:
      http://dhhs.ne.gov/Pages/Behavioral-Health.aspx

   c) Other (e.g. public service announcements, print media)  
      ✐ Yes  ☐ No

Footnotes:

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